CENTER FOR UROGYNECOLOGY & ADVANCED LAPAROSCOPIC SURGERY, PA

Rafael J. Pérez, M D

7000 SW 62 AVE, STE 545-A, South Miami, FL 33143

Patient Name: ______________________________ Nombre del paciente

Home Phone: ______________________________ Telefono de hogar

Home Address: ______________________________ Dirreccion Del Hogar

Work Phone: ______________________________ Telefono Del Trabajo

Cellular Number: ______________________________ Numero de celular

City: __________ Ciudad State: __________ Estado Zip Code: __________ Codigo Postal

Date of Birth: ______________________________ Fecha de Nacimiento

Occupation: ______________________________ Ocupacion

Social Security #: ______________________________ Numero de seguro social

Employer: ______________________________ Empleo

Marital Status: ______________________________ Estado Civil

Emergency Contact: ______________________________ Contacto de Emergencia

Phone Number: ______________________________ Telefono

Referred By: ______________________________ Referido Por

Driver's License # ______________________________ Numero de licencia de conducir

Allergies/Alergias ______________________________

E-mail address: ______________________________

' IF YOUR VISIT IS FOR A WELL WOMAN EXAM, CHECK HERE__ SI SU VISITA ES PARA UN EXAMEN ANUAL, MARQUE AQUI__*

INSURANCE INFORMATION

Name of Primary Insurance: ______________________________ Nombre del suguro

Phone Numbers: ______________________________ Telefono

Address: ______________________________ Direccion

Policy or I.D. Number: ______________________________ Numero de poliza

Group Number: ______________________________ Numero de Grupo

Date of birth: ______________________________ Fecha de Nacimiento

Name of Subscriber: ______________________________ Nombre Del Subcriber's Employer s Asegurado

Subscriber's SocSec#: ______________________________ Numero de seguro social Del asegurador

Name of Secondary Insurance:** ______________ Nombre del seguro secundario

Phone Number: ______________________________ Telefono

Address: ______________________________ Direccion

Policy I.D. Number: ______________________________ Numero de Poliza

Group Number: ______________________________ Numero de Grupo

Date of Birth: _________ Fecha de Nacimiento Relation to patient __________________ Relacion al paciente

Name of subscriber's: ______________________________ Nombre Del Asegurado

Subscriber's Employer: ______________________________ Empleo Del Asegurado

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept Visa, Master Card, and American Express . Your medical insurance is a contract between you and your insurance Carrier and the terms of the contract vary according to the terms of your policy. Final payment for all charges is the patient's responsibility and should it be necessary for this Account to be turned over to either an attorney or collections agency for collection; I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio.Aceptamos Visa, Mastercard, y American Express y efectivo . **No aceptamos cheques**.
Su seguro medico es un contrato entre usted y su Compania de seguro. Pagos por nuestros servicios dependen de los terminus de su poliza. El pago final de todos los cargos es su sabilidad. Si es necessario tomar accion Legal Para cobrar esta deuda, usted es responsible de los gastos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgment up to the Minimum Amounts pursuant to s.458.320 (5) (g).Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgment arising from claims of medical Malpractice. This notice is pursuant to Florida law.

Hemos elegido no llevar seguro de negligencia medica o para no demostrar de otra manera responsabilidad financiera. Sin embargo satisfacer cualquier juicio adverso hasta Cantidades minimas conforme a s.458.320 (5) (g). Florida impone penas contra los medicos de los no-asegurados que no pueden satisfacer los juicios adversos que se presenta de demandas de la negligencia medica. Este aviso eata conforme a la ley de la Florida.

PHYSICIAN'S RELEASE AND ASSIGMENT

I hereby authorize payment directly to(Center for Urogynecology & Advanced Laparoscopic Surgery, P.A.) of all benefit applicable and otherwise payable to me from my insurance carrier, HMO, or other third party payer, for services Rendered by C.U.A.L.S I understand that I am financially responsible to C.U.A.L.S for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a C.U.A.L.S.por beneficiios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho De percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Y o entiendo que soy Responsible Por todos los cargos no cubiertos bajo mi seguro medico.

PATIENT'S/GUARANTOR'S SIGNATURE: ______________________________ DATE: ____________________

THANK YOU! !GRACIAS!

CENTER FOR UROGYNECOLOGY & ADVANCED LAPAROSCOPIC SURGERY, P.A.
FINANCIAL POLICY

Thank you for choosing C.U.A.L.S as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is A statement of our Financial Policy, which we require for you to read and sign prior to any treatment.

ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT

CANCELLED APPOINTMENTS: THERE WILL BE A $25.00 FEE ON CANCELLATIONS NOT REPORTED WITHING 24 HOURS.

INSURANCE: **We will bill your insurance company for your visit. Due to difficulty in obtaining payments from your insurance plans, we may ask for your assistance in getting your claim paid. Please be advised that it is the patient's responsibility to verify that we are a participating provider of your insurance plan. Ultimately it is the patient's responsibility to satisfy any financial obligation for a medical service rendered by the physician that the insurance carrier does not cover. Please note that this office always verifies benefits, prior to a patient being seen by the physician, as a courtesy to the patients and that, ultimately, it is your responsibility to know and verify your health benefits with your insurance plan. Please know that verification of benefits does not guarantee payment of medical services to your physician by your insurance company.**

HMO/REFERRALS: It is your responsibility to obtain a referrals and authorizations from your primary care physician if your Insurance carrier requires it for your visits. It is the patient's responsibility to know and understand the requirements of their insurance plan. Our office is not responsible to obtain referrals for patients on HMO plans. If you arrive without a referral for your visit and required to bring one, your appointment will be rescheduled.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of the bill.

RETURNED CHECKS: Any checks returned for any reasons will be subject to a $30.00 fee for administrative services.

COLLECTIONS: Should your account become a collection problem, the patient/debtor assumes all costs Of collection including but not limited to collection agency fees(30%-40% of pending balance), court cost, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

NON COVERED SERVICES: You will be responsible for payments of services "not covered" by Your insurance plan. It is your responsibility to understand your insurance plan's benefits and /or limitations.

I HAVE READ AND FULLY UNDERSTAND the financial policy. I hereby agree to render payment in accordance with the terms and conditions ser forth.

Patient/Responsibility Party Signature:______________________________ Date:________________

Print Patient Name:____

THANK YOU! !GRACIAS!

CENTER FOR UROGYNECOLOGY AND ADVANCED LAPOROSCOPIC SURGERY, P.A.

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDMENT OF THE NOTICE OF PRIVACY PRATICES AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I acknowledge that I was provided with a copy of the (C.U.A.L.S) notice of privacy practices, describing how my health information may be used or disclosed under federal law. Provided that (center for urogynecology and Advanced Laparoscopic surgery) continues in its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to use and disclose of my health information for purposes and activities permitted under the federal privacy law, which are described in the notice of privacy practices.

I understand that I should read the notice of privacy practices carefully. I am aware that notice may be changed at any time. I may obtain a revised copy of the notice by requesting one at this office.

I authorize the following individuals to obtain any and all information pertaining to my medical records.

______________________	______________________
Print Name and Date	Authorized Individual and Relation to Patient
______________________	______________________
Signature of the Patient	Authorized Individual and Relation to Patient

NOTIFICATIONES DE PRIVACIDAD EN LAS PRACTICAS MEDICAS

ACUERDO DEL PACIENTES SOBRE LA NOTIFICATION DE PRIVACIDAD EN LAS PRATICAS Y COMO PUEDE SER DIVULGADA U UTILIZADA LA INFORMATION MEDICA PERSONAL.

Yo certifico que se me proveyo una copia sobre la notification de privacidad en las practicas medicas en la Officina de (C.U.A.L.S) que describe como se puede utilizar a divulger mi informacion medica personal Para seguir tratamiento, realizar UN pago o actividades relacionadas con la salud y para otros propositos permitidos o required por la ley federal los cuales tambien estan descritos en la noticia de privacidad en las practicas medicas.

Yo entiendo que debere leer la notification de privacidad en las practices medicas cuidadosamente. Yo Reconosco que algunos terminus de esta notification podran cambiar en cualquier momento, Yo entiendo que Puedo obtener una copia revisada de la Notification de Practicas Medicas llamando a la officina C.U.A.L.S (CENTER FOR UROGYNECOLOGY AND ADVANCED LAPOROSCOPIC SURGERY) por correo o en la officina.

Yo autorizo a las siguintes personas a obtener cualquiera y toda informacion medica relacionada a mi.

______________________	______________________
Nombre del Paciente	Persona Autorizada y Relaciona a la Paciente
______________________	______________________
Firma del paciente	Persona Authorizada y Relacion al la Paciente

***** THANK YOU/ GRACIAS*****