Flores Dermatology
Diseases of Skin, Hair and Nails
Cosmetic And Reconstructive Skin and Laser Surgery

Dr. Javier Flores

PATIENT INFORMATION FORM
(Información del Paciente)

DATE: _____
(Fecha)

NAME: _____
(Nombre)

SEX: M F **(Sexo)** **DATE OF BIRTH:** _____ **(Fecha de Nacimiento)** **AGE:** _____ **(Edad)**

SOCIAL SECURITY: _____ **(Seguro Social)** **MARITAL STATUS: S() M() D() W()** **(Estado Civil)**

ADDRESS: _____
(Dirección)

_____ **City (Ciudad)** _____ **State (Estado)** _____ **Zip Code (Código Postal)**

TELEPHONE #: _____ **Home (Casa)** _____ **Work (Trabajo)** **Ext.:** _____
(Teléfono)

CELLULAR #: _____

OCCUPATION / EMPLOYER: _____
(Ocupación/ Empleador)

IF UNDER 18 YEARS OF AGE, NAME OF PARENT / GUARDIAN: _____
(Si es menor de 18 años, nombre del padre/s o guardian)

SPOUSE'S NAME: _____ **(Nombre del Esposo/a)** **SPOUSE'S OCCUPATION:** _____ **(Ocupación del Esposo/a)**

PRIMARY PHYSICIAN: _____ **(Médico Primario / de Cabezera)** **PHYSICIAN'S TELEPHONE:** _____ **(Teléfono de su Medico)**

Referred by: _____
(Referido a nosotros por:)

Preferred Pharmacy: _____ **(Farmacia preferida)** **Pharmacy Telephone:** _____ **(Teléfono de la farmacia)**

Pharmacy Address: _____
(Dirección de la farmacia)

City: _____ **(Ciudad)** **State:** _____ **(Estado)** **Zip Code:** _____ **(Código Postal)**

BILLING INFORMATION
(Información de cobro)

PERSON RESPONSIBLE FOR BILL: _____
(Persona responsable por cuenta)

BILLING ADDRESS: _____
(Dirección donde enviar la cuenta)

TYPE OF PAYMENT: **CHECK ()** **CASH()** **CREDIT CARD ()** **INSURANCE ()**
(Método de pago) **(Chéque)** **(Efectivo)** **(Tarjeta de Crédito)** **(Seguro de Salud)**

INSURANCE INFORMATION
(Información sobre su seguro de salud)

INSURANCE COMPANY: _____
(Nombre de la compania de seguro de salud)

INSURANCE SUBSCRIBER'S NAME: _____
(Póliza de Seguro a nombre de)

MEMBER IDENTIFICATION #: _____ **GROUP #:** _____
(Número de identificación del miembro principal del seguro) **(Número de grupo)**

MEDICARE #: _____ **MEDICAID #:** _____

CONSENT FOR TREATMENT
(Autorización para ser atenfido)

I, _____**, give my permission to be evaluated, examined and treated by Dr. Javier Flores.**

(Yo, _____**, doy mi permiso al Dr. Javier Flores para evaluarme, examinarme y tratarme)**

SIGNATURE: _____ **DATE:** _____
(Firma) **(Fecha)**

I authorize Dr. Javier Flores to take and use photographs for presentation at medical meetings and for publications in medical literature.

(Yo autorizo a el Dr. Javier Flores la toma y uso de mis fotografías en presentaciones o publicaciones médicas.)

SIGNATURE: _____ **DATE:** _____
(Firma) **(Fecha)**

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ASSIGNMENT OF INSURANCE BENEFITS
(Autorización de pago)

I hereby authorize direct payment of surgical / medical benefits to Dr. Javier Flores for services rendered by her/him. I understand that I am financially responsible for any balance not covered by my insurance.

Yo autorizo el pago directo al Dr. Javier Flores por los servicios suministrados. Entiendo que soy responsable por cualquier cantidad que no sea cubierta por mi seguro de salud.

MEDICARE/MEDICAID PATIENTS
(Pacientes de Medicare /Mecaid)

I certify that all information given by me is correct. I authorize release of all records on request I agree that payment of authorized benefits be made on my behalf (A photocopy of these assignments shall be valid as the originals.)

Yo certifico que la información que he dado sobre mi seguro (método de pago) es correcta. Autorizo la entrega de historial médico necesaria. Autorizo y estoy de acuerdo que a se efectue el pago directo al Dr. Javier Flores en mi nombre.

AUTHORIZATION TO RELEASE INFORMATION
(Autorizacidn para revelar información médica)

I hereby authorize Dr. Javier Flores to release any medical or incidental information that may be necessary for either medical care or in processing for financial benefits.

Yo autorizo al Dr. Javier Flores para revelar cualquier informacion que pudiera ser necesaria para mi asistencia medica o para procesar la reclamación de beneficios a mi seguro de salud.

PATIENT SIGNATURE: _____ **DATE:** _____
(Firma del paciente) **(Fecha)**

PARENT/ GUARDIAN SIGNATURE: _____ **DATE:** _____
(Firma del padre 6 persona responsable por el menor de edad) **(Fecha)**

WITNESS: _____ **DATE:** _____
(Testigo) **(Fecha)**

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Javier Flores, M.D.

PATIENT AGREEMENT
(Acuerdo del paciente)

You have chosen to receive medical care from a physician group who will endeavor to provide you with quality care. Such care includes an interest and concern for your physical as well as emotional well-being. The delivery of our patient care involves time and expertise.

Unfortunately, there have been situations wherein patients have failed to assume their financial responsibility for our services. Due to those instances it has become necessary for us to now require that our patients and responsible party, if any, sign this agreement to guarantee payment for rendered patient care.

If we are filing your insurance, please, note that you remain responsible for this account. It is the policy of this office to allow six weeks for insurance settlement, at which time payment is expected by you.

PATIENT: _____

For and in consideration of services rendered or to be rendered by Flores Dermatology, the undersigned hereby guarantees payment of any and all charges incurred by:

_____.

(Name of pacient/ Nombre del paciente)

Guarantor: _____ **Date:** _____

_____ _____

Relationship of guarantor to patient **Address of guarantor**

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Javier Flores M.D.
Board Certified Dermatologist

Lilian Gonzalez MSN, ARNP-
Nurse Practitioner

Patient Name: _____
(Nombre)

Date of Birth: _____
(Fecha de Nacimiento)

Starting January 2011 we will be updating our system.
(Comenzando enero del 2011 nosotros actualizaremos nuestro sistema)

Please let us know how you would rather be contacted:
(Por favor avisenos como prefieren ser contactados)

Email ☐ **or** **Phone** ☐
(Correo electrónico) **(o)** **(Teléfono)**

Email: _____

Phone: _____

***If there has been any change in address, phone number, email or insurance please let us know so that we can change our records.**

(Si a habido algun cambio de dirección, número de teléfono, correo electrónico o seguro por favor avisenos de modo que podamos cambiar nuestros archivos)

Thank you,
(Gracias)

Javier Flores, M.D.

NEW PATIENTS WITH OUT INSURANCE CARDS WILL ***NOT*** BE SEEN.

IF INSURANCES HAVE BEEN CHANGED PATIENTS MUST SHOW NEW INSURANCE CARDS BEFORE BEING SEEN.

PACIENTES NUEVOS SIN TARJETAS DE SEGURO AL MOMENTO DE LA VISITA ***NO*** PODRAN SER VISTOS.

SI HAN CAMBIANDO EL SEGURO, LA NUEVA TARJETA ES NECESARIA PARA PODER SER VISTOS POR EL DOCTOR.

Patient Authorization for Use and Disclosures of Protected Health Information to Third Parties

_____

Name of Practice

Section Must be completed for all authorizations

I hereby authorize the use of disclosure of my individually protected health information. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name:_____
ID Number:_____

Persons/Organizations Receiving Information:

	Name	Relationship
1		
2		
3		
4		
5		

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ____/___/_____ (MM/DD/YYYY) Initials: _____

2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any effect on any actions they took before they received the revocation. Initials: _____

_____ _____

Signature of patient or representative (Form MUST be completed before signing) Date

Printed name of patient's representative:_____

Relationship to patient:_____

TMC **YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**

Total Medical Consultants

HIPAA Notice of Privacy Practices

_____ [Name]

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____ Date_____