Mariela Perez MD PA
Family Medicine
2048 North East 8th Street
Homestead, FL 33033-4702
Phone: (305) 245-8858 Fax: (305) 245-8865

Patient Information Form

Name: _____ Primary Language: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birth date: _____ Age: _____ Sex: _____

Social Security #: _____ Marital Status: Single Married Divorce Widow

Pharmacy: _____ Location :_____
(please circle)

Driver's License #: _____

Email Address: _____

Employed by: _____ Occupation: _____

Address: _____ Work Phone: _____

Spouse / Emergency Contact: _____ Phone #: _____

Referred by: _____

PLEASE PROVIDE PHOTO ID & CURRENT INSURANCE CARD(S)

PRIMARY INSURANCE: _____ Effective Date: _____

ID#: _____ Group: _____ Co-pay: _____

Insured's Name: _____ Insured's Date of Birth: _____

SECONDARY INSURANCE: _____ Effective Date: _____

ID#: _____ Group: _____ Co-pay: _____

Insured's Name: _____ Social Security #: _____

We do not accept Worker's Compensation and Car Insurance

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents**. I acknowledge and understand that I am ultimately responsible for all charges of all services rendered to me and/or dependents including co-payments and deductibles.**

Signed: _____ Date: _____

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Communication Authorization Form

Our practice is dedicated to maintaining the privacy of your and every patients protected health information (PHI).

The methods of communication and the substance of the messages that our practice will leave a patient are as described in our Notice of Privacy Practices, which you have the opportunity to review. Further, any message that our practice would leave at your place of employment will be either to remind you of an appointment with our office or to ask you to call the office concerning your medical matters. Our practice will not leave a message of a personal nature or give out any private information.

Please indicate below if you acknowledge and authorize Dr Mariela Perez as well as the office staff to:

Patient's Initials

Confirm scheduled appointments? Yes No _____

Leave a message at your place of employment? Yes No _____

Fax laboratory / biopsy result to you? Yes No _____

If yes, fax number: _____

Discuss your medical matters with another member of your household / family? Yes No _____

If yes, with whom?: _____

phone: _____

Discuss your billing matters with another member of your household / family? Yes No _____

If yes, with whom?: _____

phone: _____

Patient's Name (Print) Patient's Signature Date

Parent's / Guardian's Name (Print) Parent's / Guardian's Signature Date

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Consent for Use & Disclosure of Health Information

(please read the following carefully)

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, health care operations, claims and request(s) for payment.

Notice of Privacy: You have the right to read the practice's Notice of Privacy Practices before you decide to sign this consent. The notice provides a description of our health care operations and manner of patient treatment. The notice also outlines the use and disclosure of your protected health information as needed to address payment activities with insurance companies / responsible party. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. You may also obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting our office.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain any and all modifications. Such modifications may apply to your protected health information that we maintain.

Right to Revoke: The patient / guardian has the right to revoke this consent at any time by submitting written notice of revocation to our office. Please understand that revocation of this consent will not affect any action the practice took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

Acknowledgement:

I acknowledge that I have had full opportunity to read and consider the contents of this consent form as well as the Notice of Privacy Practices. I further acknowledge that by signing this consent form, I am granting my consent to the practice's use and disclosure of my protected health information in order to carry out health care, treatment, claims and payment activities.

Patient's Name (Print) Patient's Signature Date

Patient's Address: _____ Phone #: _____

Patient's Social Security #: _____

Parent's / Guardian's Name (Print) Parent's / Guardian's Signature Date

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Insurance Acknowledgement Form

Under the Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

Dr Mariela Perez has chosen not to carry medical malpractice insurance.

This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Acknowledgement:

I acknowledge that I have had full opportunity to read and consider the contents of this form. By signing this form, I further acknowledge that Dr. Mariela Perez does not carry malpractice Insurance.

Patient's Name (Print)	Patient's Signature	Date

Parent's / Guardian's Name (Print)	Parent's / Guardian's Signature	Date

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Laboratory Acknowledgement Form

Acknowledgement:

I understand that I have the option of going to my insurance specified laboratory to have my blood drawn but should I choose to have my blood drawn at this facility, I agree to payment of a twenty dollar ($20.00) convenience service fee in addition to any co-payment or deductible due at time of service

Patient's Name (Print)	Patient's Signature	Date

Parent's / Guardian's Name (Print)	Parent's / Guardian's Signature	Date