Welcome to Patron Medical

Name of the Patient	**Birth Sex: M [ ] F [ ]** **Optional:** Sexual Orientation: _____ Gender Identity: _____	Marital Status: Single [ ] Married [ ] Separated [ ] Divorced [ ] Widow [ ]

Address: Apt	Date of Birth	**Social Security Number:**
City State Zip Code	Age:	**Do You Have a Living Will**? Yes [ ] No [ ]
Email Address: ***Very Important for all notifications, updates and Patient Portal**	Cell Phone:	

Race: White [ ] Black/African American[ ] American Indian/ Alaska Native[ ] Asian[ ] Island Pacific or Other _____

Ethnicity: Hispanic or Latino [ ] Not Hispanic/Latino [ ]

Preferred Language: English [ ] Spanish [ ] other:_____

Employment Status: Employed Full-Time [ ] Employed Part-Time [ ] Unemployed [ ] Self Employed [ ] Retired [ ] Stay-At- Home [ ]

Student Status: Current Student Full Time [ ] Current Student Part-Time [ ]

Name of Employer Or School	**Occupation:**	**Phone Number:**

(Main Insured) Name of person **Financially** Responsible	Relation: **Self** [ ] **Spouse** [ ] **Parent(s)** [ ]	**Main Insured** Date of Birth _____/____/_____	**Main Insured** Social Security

(Main Insured) Employer	**Main Insured** Occupation

Name of Spouse, Partner, Significant Other OR Parent or Guardian **OF THE PATIENT**	Contact Phone Number

Person to Contact in Case of Emergency ***Important***	**Relationship to Patient**	**Telephone Number**
Name Of your Previous Physician	City	Telephone
Name of Patient Pharmacy **Required**	City	Telephone

Lifetime Signature

I certify that the information contained on this form is correct to the best of my knowledge. I also understand that if at any given date or time **my insurance information changes or updates, it will be my sole responsibility as the patient to inform and update the office**. In addition, I authorize the release of all medical information necessary to process claim(s) for all treatment(s) and payments. I also authorize the payment(s) of medical benefits to **Patron Medical** [NPI:1346336211] provider and Or supplier of services. I hereby agree, regardless of insurance coverage, that I am responsible for all charges incurred. Payment is EXPECTED at the time of service. We will bill your insurance as a courtesy. However, I as the patient understand that I am **accountable, to know and understand my insurance policy and coverage**. Furthermore, I understand that I am financially responsible for any services not covered by my insurance carrier and I agree to pay all charges, collection costs, attorney fees, or any other charges associated to the collection of any unpaid amount(s) and or balance(s) outstanding. This consent is to include but not limited to any outstanding tests, pending results or procedures and laboratory charges incurred. I, the undersigned, hereby authorize the provider and whomever else he may designate as assistant(s), to administer those treatments and procedures which in his/her opinion are deemed necessary.

_____

Patient Signature **Date**

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, I _____certify that I have read, received and reviewed a copy of the *Notice of Privacy Practices* (attached) from the office of **Andres Patron D.O., P.A.** Our *Notice of Privacy_Practices* provides information about how we may use and disclose your protected health information.

_____ _____

Signature of Patient Date

In Case of Emergency:

Please provide information for those individuals you would like to have contacted or that we may contact in the **event of an emergency** or circumstance of a serious threat to your safety or the safety of others.

Name: _____ Phone#_____

Relationship: _____ Additional Phone #_____

Name: _____ Phone#_____

Relationship: _____ Additional Phone #_____

********For Office Use Only********

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s)

- Patient / Individual refused to sign
- Communications barriers prohibited obtaining an acknowledgement
- An Emergency Situation prevented us from obtaining an acknowledgement
- Other_____

Attempt was made by: _____

[Office Staff Name]

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Andres Patron D.O. P.A. / Patron Medical

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule
Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices
We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its web site.

You have the right to authorize other use and disclosure
This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication
This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI
this means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI
This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information
This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request disclosure accountability
This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice
You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

NOTICE OF PRIVACY PRACTICES

How We May Use or Disclose Protected Health Information
Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment
We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices
We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment
Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services, we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations
We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization
The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare
Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures
We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints
You have the right to complain to us, or directly to the Secretary of the Department 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 the Privacy Manager at:

We will not retaliate against you for filing a complaint.

Address: 10796 Pines Blvd

Suite: 205

City: Pembroke Pines

State: FL

Zip Code: 33026

CONSENT FOR TREATMENT & FINANCIAL RESPONSIBILITY

The Office of **Dr. Andres Patron** appreciates the confidence you have shown in choosing us to provide your healthcare.

I, _____, hereby authorize **Dr. Andres Patron and Patron Medical**, through its appropriate personnel, to perform or arrange appropriate medical evaluations, testing, and treatment as deemed medically necessary for myself or the above-named patient.

I understand that services rendered imply financial **responsibility** on my part. As a courtesy, our office will verify insurance coverage and submit claims to my insurance carrier. However, I understand that **verification of benefits is not a guarantee of payment**, and I remain responsible for all charges not paid by my insurance carrier.

I authorize **Patron Medical** to release any information necessary to process my insurance claims and assign benefits. If my insurance carrier does not respond, denies payment, or does not cover certain services, I understand that I will be **billed directly** and remain responsible for payment. I also understand that I am responsible for any **deductibles, co-payments, and co-insurance** required by my insurance plan.

All balances are **due within thirty (30) days** of the invoice date. Balances over 30 days may accrue interest at **18% annually**, and accounts over **90 days** may be subject to collection fees and referral to a collection agency. I agree to pay all legally allowable **interest, collection costs, and reasonable legal fees** incurred in the collection of any delinquent balance.

I have **read, understand, and agree** to the terms above.

Patient / Guarantor Signature: _____

Printed Name: _____

Date: _____

MEDICAL RECORDS RELEASE FORM

We, the office of Dr. Andres Patron wants to make your transition as smooth as possible and for the purpose of medical treatment, It is important we obtain a copy of your past medical record(s). Therefore, if you would complete the form below so we may submit it, as necessary to any of your previous attending Physicians, Specialists, Hospitals and or Pharmacies in order to obtain vital background, history and medical information.

I HEREBY AUTHORIZE (with my Signature below) AND REQUEST THAT YOU SEND A COPY OF MY COMPLETE MEDICAL RECORD TO:

PCP: Andres Patron, D.O. / Patron Medical PHONE (954) 885-5555

ADDRESS: 10796 PINES BLVD SUITE 205 PEMBROKE PINES, F L 33026 **FAX (954) 885-5333**

Or FrontDesk@PatronMedical.com

PATIENT'S NAME: _____ **Relationship to Patient**_____

SSN: _____ **DOB:** _____

ADDRESS: _____

I hereby authorize the release of all medical documentation and other information including protected health information that I could personally obtain upon request, which may be in the possession of any health care provider, medical care facility, insurer, physician, hospital, ambulance service or nurse and or any other covered entity under HIPAA Accountability Act of 1996.

Please Provide any Pertinent Information along with the (✔) Requested Information below:

History & Physical	Laboratories	Eye Exam
Progress Note	Xray/Scans	Pap/Cervical Screen
Consultation/Counseling	EKG/EEG	Mammo
Narrative Summary	Treatment Plan	Colo Kit/Colonoscopy

This may also authorize Patron Medical to release /obtain general health Information as well as 1). psychiatric/psychological treatment, 2). HIV/AIDs diagnosis as well as 3). Alcohol and 4). Drug Abuse information, from my medical record, in *accordance with Florida Statutes and Federal regulations.* In addition, but not limited to any test, counseling and results of treatment(s), thereof are also authorized. I understand that my records have a privilege and confidential status, and I am in approval and acceptance of such order/request in an effort to establish, provide and set forth an accurate medical patient history and physical Upon Presentation of this authorization or photocopy of you are authorized to release a copy of the records to any person who is my personal representative. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the personal representative and may no longer be protected by federal law. The purpose of the disclosure is to enable the person(s) named above to fully act as my personal representative under HIPAA, including the ability to access and re-release my medical records. This authorization shall be deemed to comply with all the requirements of HIPAA; 45cfr section 16.

PATIENT OR LEGAL GUARDIAN SIGNATURE: _____

This authorization shall become effective on the date it is signed and expire two years after my death. I understand that I may revoke this authorization at any time, without regard to my mental or physical condition, by indicating and sending a written and certified notice to my medical provider(s). **Therefore, this consent shall and will remain in effect without expiration.** _____ **(Initials)** If I choose to rescind, this such said release The Office of Dr. Andres Patron agrees, to Null, Void and destroy this form.

Patron Medical

I, _____, authorize The Office of Dr. Andres Patron and its providers to access and review my external prescription history through the Surescripts EMR RxHub system.

This authorization allows our office to obtain my medication history from pharmacies, insurance companies, and other healthcare providers involved in my care. Access to this information helps ensure that my medication list is accurate and up to date and helps reduce the risk of medication errors, adverse drug reactions, or inaccurate medication information, including medication name, dosage, and frequency.

I understand that this prescription history may include information from multiple unaffiliated providers, pharmacies, and insurance sources and may be viewed by authorized providers and staff of Dr. Andres Patron's office for purposes related to my medical care.

By signing below, I certify that I have read and understand the scope of this authorization and consent to the access and review of my prescription history.

Signature: _____

Date of Birth: _____ Date: _____

Email: _____

Medical Decision Maker

NSDM (Non-Surrogate Decision Maker): This means you make your own medical decisions and do not have another person legally designated to make healthcare decisions for you.
Are you your own medical decision maker? _____ (Please answer Yes or No)

SDM (Surrogate Decision Maker): This means you have legally designated another person (such as a healthcare proxy, agent, or representative) to make medical decisions on your behalf if necessary.
Do you have a legal proxy, agent, or surrogate decision maker? _____

(Please answer Yes or No)

Andres Patron D.O., P.A.
Diplomate American Board of Internal Medicine

10796 Pines Blvd Suite 205
Pembroke Pines, Florida 33026
Telephone: (954) 885-5555 Facsimile: (954) 885-5333
E-Mail: APatron@PatronMedical.com

APPOINTMENT CANCELLATION POLICY

Our office schedules appointments so each patient receives the proper time and attention from the physician and staff. Because appointment times are reserved specifically for you, we ask that you **arrive on time and keep your scheduled appointment.**

As a courtesy, we may send **appointment reminders by text, email, or phone** when contact information is available. However, **it remains the patient's responsibility to keep, cancel, or reschedule their appointment.**

24-Hour Notice Required
If you need to cancel or reschedule an appointment, you must notify our office **at least 24 hours before your scheduled appointment time.**

$50 No-Show Fee
Appointments not cancelled or rescheduled with **at least 24 hours' notice** will result in a **$50.00 No-Show Fee** applied to the patient's account. This fee **is not covered by insurance and is the patient's responsibility.**

Definitions
- **No-Show:** Failure to arrive for a scheduled appointment.
- **Same-Day Cancellation:** Cancellation with **less than 24 hours' notice.**
- **Repeated missed appointments** may result in **limited scheduling privileges or dismissal from the practice.**

If you have questions regarding this policy, please speak with our staff.

Acknowledgment

I acknowledge that I have read and understand the **Appointment Cancellation Policy and $50 No-Show Fee**. I understand that failure to cancel or reschedule with **24 hours' notice** will result in a **$50.00 charge to my account**, which **cannot be billed to my insurance.**

Patient Name: _____

Patient Signature: _____

Date: _____