Daniel Gaitan Personalized Healthcare

REGISTRATION/UPDATE INFORMATION

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Sex ____M ____F Birthdate _____ SSN _____

Home Phone _____ Cell Phone _____ Email _____

In case of an emergency, who should we notify? _____

PRIMARY INSURANCE INFORMATION

Insurance Name _____ I.D. Number _____

Insurance. Address _____ Group Number _____

Policy Holder _____ Relation to patient _____

Address/Phone (if different from patient) _____

Policy Holder Employer _____ Employer Phone _____

SECONDARY INSURANCE INFORMATION

Insurance Name _____ I.D. Number _____

Insurance. Address _____ Group Number _____

Policy Holder _____ Relationship to patient _____

Address/Phone (if different from patient) _____

Policy Holder Employer _____ Employer Phone _____

PHARMACY INFORMATION

Preferred Retail Pharmacy (name and phone #) _____

Preferred Mail Order Pharmacy (name and phone #) _____

I hereby assign all insurance benefits to Daniel Gaitan Healthcare Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges incurred. I authorize said assignee to release all medical information necessary to secure the payment. I authorize the release of my medical information by or between any of my treating physicians involved in the administration of my healthcare and health benefits.

Signature _____ Date _____

425 North New Ballas Road, Suite 107 St. Louis, MO 63141

Daniel Gaitan Personalized Healthcare

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

_____ _____

Patient Name Date of Birth

Has authorized confidential communication of protected health information, both verbal and written, with the following individuals:

Name: _____

Relationship to Patient: _____

Telephone Number: _____

Address: _____

Name: _____

Relationship to Patient: _____

Telephone Number: _____

Address: _____

This authorization may be revoked or terminated by submitting a written revocation to Dr. Daniel Gaitan and Daniel Gaitan Personalized Healthcare, LLC.

_____ _____

Patient Signature Date

Daniel Gaitan Personalized Healthcare

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ SSN: _____

I hereby authorize use or disclosure of protected health information about me as described below:

1. The following specific person or class of persons or facility is authorized to make the requested use or disclosure (List of doctors/entities where records are coming from):

   _____

   _____

   _____

2. The following person or class of persons may receive disclosure of protected health information about me (where information is going):

   Dr. Daniel Gaitan, MD, FACP, FACE
   425 North New Ballas Road, Suite 107
   St. Louis, MO 63141 (FAX: 314-432-2595)

   ***FAX ALL RECORDS: HARD COPIES REQUESTED**

3. The specific information that should be disclosed is: **ALL MEDICAL RECORDS**

4. I may revoke this authorization by notifying the office manager of Daniel Gaitan Healthcare in writing of my desire to revoke it. I understand that any action taken already In reliance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

5. I understand that the information used or disclosed may be subject to redisclosure by the person or class of persons or facility receiving it, and would no longer be protected by federal privacy regulations.

6. This authorization expires on _____ or upon the event that relates to the purpose of the intended use of this authorization for disclosure of information.

7. I understand that the mentioned medical record may include Alcohol /Drug Abuse, Psychiatric treatment records, or HIV / AIDS testing and treatment and are covered by Federal Regulations and cannot be disclosed without my written consent, unless otherwise provided for in the regulations.

8. Daniel Gaitan Healthcare, its employees, officers and physicians are hereby released from all legal liability or responsibility for the release of the records to the extent indicated and authorized herein.

_____ _____
Signature of Patient Date

_____ _____
Signature of Guardian/Representative /Relationship Date

Daniel Gaitan Personalized Healthcare

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of Daniel Gaitan Healthcare, Inc. on this date.

_____

Signature of Patient or Authorized Representative

_____

Name of Patient

_____

Date

STAFF USE ONLY

We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could NOT be obtained because:

_____: Individual refused to sign

_____: Communication barriers prohibited obtaining acknowledgement

_____: An emergency situation occurred preventing us from obtaining acknowledgement

_____: Other

_____

Signature of Practice Staff Member and Title

_____

Name of Staff Member

_____

Date