Reiss, Kang, Jayanetti & Pereda, M.D., P.A.
6200 Sunset Drive, Suite 505
South Miami, FL 33143
(305) 668-1660

Patient Information: **Date:** _____

Name: _____ Date of birth: _____

Address: _____

_____

SSN#: _____ Age: _____ Marital status: _____ Sex: _____

Home Number: _____ Mobile Number: _____

Ethnicity:_____ Race:_____ Email: _____

Pharmacy Name & Phone #: _____

Referred By: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Emergency Contact: Name: _____ Relationship:_____

Phone Number: _____

Race: ☐ White ☐ American Indian ☐ Asian ☐ African American ☐ Other _____

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other _____

Insurance Information: Primary Insurance: _____
Secondary Insurance: _____ Name Responsible Party: _____

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law to subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law. I HAVE READ AND UNDERSTAND THE ABOVE MEDICAL MALPRACTICE NOTICE

Bajo la ley de la Florida , Los medicos son generalmente requeridos de llevar un seguro medico para negligencia o de otra manera demonstrar reponsabilidad financiera para cubir los reclamos potenciales contra negligencia medica. SU MEDICO HE DECIDIDO NO LLEVAR SEGURO DE NEGLIGENCIA MEDICA. Esto es permitido bajo la ley de la Florida sujeto a ciertas condiciones. La ley de la Florida impone penalidades contra medicos que no estan asegurados que fallen de satisfacer juicios adversos originando de reclamos de negligencia medica. Esta Notificacion esta proporcionada de acuerdo con la ley del estado de la Florida. YO LEI Y ENTIENDO LA NOTIFICACION DE NEGLIGENCIA MEDICA.

REISS, KANG, JAYANETTI & PEREDA, M.D, P.A, AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

1. I hereby authorize the following individual(s) or Organization(s):

☐Baptist Hospital ☐South Miami Hospital ☐Homestead Hospital ☐Baptist West Kendall Hospital
☐Mariners Hospital ☐Doctors Hospital ☐Jackson South Hospital ☐Jackson Memorial Hospital
☐ Other: _____

Patient Name: _____ Date of Birth: _____

2. The health information described below may be used by or disclosed to the following:

Reiss, Kang, Jayanetti & Pereda,M.D., P.A.
6200 Sunset Drive, Suite 505
South Miami, FL 33143
P: (305) 668-1660
F: (305) 668-1650

3. Describe the health information you are authorizing to be used/disclosed:
☐All Records ☐Operative Reports ☐Laboratory ☐HIV/ AIDS
☐ Consultation ☐Pathology Report ☐Discharge Summary ☐Progress Note
☐Imaging Studies Report ☐_____

(*If this form authorizes the use/disclosure of mental health records it may not be used to authorize the use/disclosure of any other health information. A separate authorization is needed for any other use/disclosure.) **NOTE:** You must obtain initial HIV antibody testing information from your physician. This form may not be used for marketing or research purposes.

4. Confined to records regarding admission and treatment on or about: _____

5. The disclosure of the health information described herein is being made for the reasons below:
☐ At request of Individual ☐ Sharing with other HCP as needed ☐ other: _____

6. I understand the I have a right to revoke this authorization at any time, and that if I revoke this authorization, I must send a written request to: *REISS, KANG, JAYANETTI & PEREDA, M.D., P.A, 6200 Sunset Drive, Suite 505, South Miami, FL 33143* Attn: Privacy Officer. I understand that the revocation will not apply to the information that has already been released in reliance of this authorization and to my insurance company when the law provided my insurer with the right to contest a claim under my policy.

7. This Authorization will expire _____ (* If left blank, this authorization will expire one (1) year form date on which it was signed)

8. I understand that this authorization is voluntary. I understand that once the health information described herein is disclosed, it maybe re- disclosed by the recipient and may no longer be protected by the federal privacy law; however under federal and state laws respectively, the recipient may be prohibited from re- disclosing substance abuse and HIV/AIDS information without specific written consent of the person to whom it pertains; or as otherwise permitted by such laws, I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, enrollment for benefits.

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this offices Notice of Privacy Practices/ *Yo he recibido una copia del Aviso de privacidad de esta Practica.*

Name: _____ Date: _____

Signature: _____

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Consentimineto de utilizar y divulger informacion Medica

Please inform us as to whom we may disclose health information, Please write their name and relationship to the patient.

Porfavor informenos a quien podemos divuglar su informacion Medica.

1. **_____**
2. **_____**
3. **_____** **Or No one** ☐
4. **_____**
5. **_____**

For Physician Office Use Only

T*Solamente para el uso de consulta Medica*

T**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:**T
Nosotros intentamos obtener un reconocimiento escrito que recibio nuestro aviso de privacidad de la pricatica, pero no pudo ser obtenido por:

☐ T**Individual refused to sign/**T Individuo se nego a firmar

☐ T**An emergency situation prevented us from obtaining the acknowledgement/** TUna emergencia no impidio obtener reconocimiento

☐ T**Communication barries prohibited obtaining the acknowledgement/**T Barreras de comunicacion prohibieron obtener reconocimiento

Assignment of Benefits Form

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed below for any equipment or services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable to related equipment or services to the organization, Health care financing administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to Health care financing administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

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(305) 668-1650

Name of person signing: _____

Relationship to Insured: _____

Signature: _____ Date: _____

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South Miami, FL 33143
(305) 668-1660

Date: _____

Patient Name: _____ DOB: _____

We are switching to Electronic Health Records (E.M.R) and as part of government guidelines we are required to ask the questions below:

Estamos cambiando a un sistema de records medico electronicos (R.M.E) y comoparte de los requisitos guvernamentales es necesario hacerles las siguientes preguntas:

Height/*Estatura***: _____ Weight/***Peso***: _____Do you Smoke? ☐ Yes ☐ No**

Preferred Language/*Primer Idioma***: _____**

ALLERGIES:
_____

_____

Please list Medications below

Medication	**Dosage**	**Route**	**Frequency**
