

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

Patient Name: \_\_\_\_\_  
*Nombre del Paciente*

Date: \_\_\_\_\_  
*Fecha*

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 como parte de los requisitos gubernamentales es necesario hacerles las siguientes preguntas:*

Height: \_\_\_\_\_  
*Estatura*

Weight: \_\_\_\_\_  
*Peso*

Do You Smoke: Yes or No  
*Fuma Si o No*

Preferred Language: \_\_\_\_\_  
*Primer Idioma*

Ethnicity (Circle One)  
*Etnicidad*

Non Hispanic

Hispanic  
*Latino*

Other: \_\_\_\_\_  
*Otro*

Race (Circle One)  
*Raza*

American Caucasian African American Hispanic American Indian Other: \_\_\_\_\_

Allergies/Alergias: \_\_\_\_\_

List of Medications: \_\_\_\_\_  
*Lista De Medicamentos*

**Patient Registration**  
*Registracion Del Paciente*

**Patient Information-Informacion del Paciente**

**Patient's Name:** \_\_\_\_\_  
*Nombre del Paciente*

**Date:** \_\_\_\_\_  
*Fecha*

**Home Address:** \_\_\_\_\_  
*Direccion del Paciente (Street/Calle) (City/Ciudad) (State/Estado) (Zip Code/Codigo Postal)*

**Home Phone:** \_\_\_\_\_  
*Telefono de Casa*

**Work Phone:** \_\_\_\_\_  
*Telefono del Trabajo*

**Cellular Phone:** \_\_\_\_\_  
*Celular*

**Alt. Phone:** \_\_\_\_\_  
*Telefono Alternativo*

**S.S.#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
*Numero de Seguro Social*

**Sex:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
*Sexo Edad*

**Marital Status:** S M D W  
*Estado Matrimonial S C D V*

**Birthdate:** \_\_\_\_\_  
*Fecha de Nacimiento*

**Employer:** \_\_\_\_\_  
*Empleador*

**Occupation:** \_\_\_\_\_  
*Ocupacion*

**Ethnicity:** \_\_\_\_\_  
*Etnicidad*

**Race:** \_\_\_\_\_  
*Raza*

**Prefered Language:** \_\_\_\_\_  
*Primer Idioma*

**ALLERGIES/ALERGIAS:** \_\_\_\_\_

**LIST OF MEDICATIONS:** \_\_\_\_\_  
*LISTA DE MEDICAMENTOS*

**REASON FOR VISIT:** \_\_\_\_\_  
*RAZON DE VISITA*

**E-mail Address:** \_\_\_\_\_  
*Correo Electronico*

**Referred By:** \_\_\_\_\_  
*Referido Por*

**Primary Care Physician:** \_\_\_\_\_  
*Doctor Primario*

**Referring Doctor Phone:** \_\_\_\_\_  
*Telefono del Doctor que lo refirio*

**Primary Care Physician Phone:** \_\_\_\_\_  
*Telefono del Doctor Primario*

**Emergency Contact- En Emergencias, Contactar a:**

**Name:** \_\_\_\_\_  
*Nombre*

**Relationship to Patient:** \_\_\_\_\_  
*Relacion al Paciente*

**Home Phone:** \_\_\_\_\_  
*Telefono del Hogar*

**Cellular Phone:** \_\_\_\_\_  
*Telefono de Celular*

**Spouse/Guarantor/Responsible Party-Esposo/Persona Responsable**

**Name:** \_\_\_\_\_  
*Nombre*

**Relationship:** \_\_\_\_\_  
*Relacion*

**Date of Birth:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*Fecha de Nacimiento*

**S.S. #** \_\_\_\_\_  
*Numero de Social Security*

**Home Phone:** \_\_\_\_\_  
*Telefono del Hogar*

**Cellular Phone:** \_\_\_\_\_  
*Telefono del Celular*

**INSURANCE INFORMATION**

*Informacion de Seguro*

**Primary Insurance:** \_\_\_\_\_  
*Seguro Primario*

**Phone:** \_\_\_\_\_  
*Telefono*

**Contract/Policy#:** \_\_\_\_\_  
*No. de Contrato/Identificacion*

**Group#:** \_\_\_\_\_  
*Grupo*

**Subscriber's Name:** \_\_\_\_\_  
*Nombre de Asegurado*

**DOB of Subscriber:** \_\_\_\_\_  
*Fecha de Nacimiento*

**Secondary Insurance:** \_\_\_\_\_  
*Seguro Secundario*

**Phone:** \_\_\_\_\_  
*Telefono*

**Contract/Policy#:** \_\_\_\_\_  
*No. de Contrato/Identificacion*

**Group#:** \_\_\_\_\_  
*Grupo*

**Subscriber's Name:** \_\_\_\_\_  
*Nombre de Asegurado*

**DOB of Subscriber:** \_\_\_\_\_  
*Fecha de Nacimiento*

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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**

\* **Signature:** \_\_\_\_\_

\* **Date:** \_\_\_\_\_

Bajo la ley de la Florida, Los medicos son generalmente requeridos de llevar un seguro medico para negligencia o de otra manera demostrar responsabilidad financiera para cubrir los reclamos potenciales contra negligencia medica. **SU MEDICO HA 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 fallan 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**

**Firma Del Paciente:** \_\_\_\_\_

**Fecha:** \_\_\_\_\_

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

Delivery Method:  Mail Pickup Date: \_\_\_\_\_  
Records will automatically be mailed 10 days after pick-up date, (initial) \_\_\_\_\_

I hereby authorize the use and/or disclosure of the below named individual's health information as described below.

- 1. I hereby authorize the following individual(s) or organization(s):  Baptist Hospital  South Miami Hospital  Doctors Hospital
- Homestead Hospital  Baptist outpatient Services  Ambulatory Surgery Center  Mariners Hospital
- Diagnostic Center  Urgent Care Center  Physician Practice
- Other (specify): \_\_\_\_\_ to make the disclosure of health information in the manner described herein.

\* Patient Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
(please print)

Address: \_\_\_\_\_ D.O.B \_\_\_\_\_ Social Security #: \_\_\_\_\_

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

Name of person/organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone # \_\_\_\_\_

3. Describe the health information you are authorizing to be used/disclosed:
- All records  Operative Record  Physician Orders  Mental Health\* (initial) \_\_\_\_\_
  - Pertinent Information  Pathology Report  Laboratory  HIV/AIDS (initial) \_\_\_\_\_
  - Emergency Record  Consultation  Pathology Slides  Substance Abuse (initial) \_\_\_\_\_
  - Discharge Summary  Progress Notes  Cath Lab cine / CD  Imaging Films \_\_\_\_\_
  - Imaging Studies Report: \_\_\_\_\_  Other: \_\_\_\_\_

(\*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 reason below:  At the request of the individual  Sharing with other health care providers as needed Other (describe): \_\_\_\_\_

6. I understand that 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, Burks, 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 information that has already been released in reliance of this Authorization and to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. This Authorization will expire (insert date or event) \_\_\_\_\_  
(if left blank, the Authorization will expire one (1) year from 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 federal privacy laws; 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 or eligibility for benefits.

\_\_\_\_\_  
\* Signature of Patient\*/ Personal Representative Relationship to Patient Date \*

\_\_\_\_\_  
Witness Date

\*The above individual is unable to consent because (check one):

- Minor  Incompetent  Other (explain): \_\_\_\_\_

Fees: In accordance with FS. 395.3025 Healthcare facilities and ambulatory surgery centers charge for medical record copy is: \$1.00 search fee for every year requested; \$1.00 per page for paper records; \$2.00 per page for non-paper records, plus sales tax and actual postage. In accordance with FS. 456.057 Healthcare practitioners and physicians' offices charge for medical record copy is: \$1.00 per page for the first 25 pages and .25 cents for any page after that.  
Informed of charge for copies. (Please initial) \_\_\_\_\_

You are entitled to a copy of this authorization after you sign it.

IAN M. REISS, M.D., F.A.C.S.  
STEVEN S. KANG, M.D., F.A.C.S.  
JAMES A. BURKS, JR., M.D., F.A.C.S.  
CHAM A. JAYANETTI, M.D., F.A.C.S.  
JUAN CARLOS PEREDA, M.D.  
6200 Sunset Drive • Suite 505  
South Miami, Florida 33143  
Ph: 305-668-1660 • Fax: 305-668-1650

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

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
*Reconocimiento De Recibo de Aviso de Privacidad de Practica*

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

\*Name: \_\_\_\_\_  
*Nombre*

\*Signature: \_\_\_\_\_  
*Firma*

\*Date: \_\_\_\_\_  
*Fecha*

**CONSENT TO USE AND DISCLOSE HEALTH INFORMATION**  
*Consentimiento de utilizar y divulgar informacion Medica*

\* Please inform us as to whom we may disclose your Health Information.  
*Porfavor informenos a quien podemos divulgar su informacion Medica.*

1. Spouse/Significant Other  
*Esposo (a)/Pareja*
2. Children/Step Children  
*Hijos/Hijastros*
3. Parents/In-laws  
*Padres/Suegros*
4. Siblings/Step Siblings  
*Hermanos/Hermanas*
5. All relatives/other family members  
*Cualquier Familiar*
6. An aide or helper  
*Asistente Oh Ayudante*
7. All the above  
*Todo los Anteriores*
8. No one/Nobody  
*Nadie*
9. Other (please specify) \_\_\_\_\_  
*Otro (porfavor especificar)*

\*Signature: \_\_\_\_\_  
*Firma*

**FOR PHYSICIAN OFFICE'S USE ONLY**  
*Solamente para el uso de consulta Medica*

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

- \_\_\_ Individual refused to sign  
*Individuo se nego a firmar*
- \_\_\_ An emergency situation prevented us from obtaining acknowledgment  
*Una emergencia nos impidio obtener reconocimiento*
- \_\_\_ Communication barriers prohibited obtaining the acknowledgment  
*Barreras de comunicacion prohibieron obtener reconocimiento*

**LIFETIME INSURANCE AUTHORIZATION**

Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment is correct. I authorize any medical or other information about me to be released to my insurance company or its intermediary carries, which includes any information needed for this claim, or any future claim. I also authorize payment of medical benefits to Reiss, Kang, Burks, Jayanetti & Pereda, M.D. P.A, or to any orf it's associates. I understand that I am financially responsible for payment of my medical services to Reiss, Kang, Burks, Jayanetti & Pereda, M.D. P.A, regardless of any insurance benefits I may have, and understand that it is my responsibility to collect any reimbursements from my insurance company. I understand that I will be responsible for any fee that might be incurred by Reiss, Kang, Burks, Jayanetti & Pereda , M.D. P.A, in their efforts to collect fees due to us, including fees from collection agencies, attorney's fees, and court fees.

Patient Name: \_\_\_\_\_  
\*(Print)

\*Patient Signature: \_\_\_\_\_

**AUTORIZACION POR VIDA DE SEGURO**

Certificacion y autorizacion del paciente para liberar informacion y pedida de pago. Yo certifico que la informacion dada por mi para pedir pago a mi seguro, sus provehedores intermediarios de los cuales incluyen cualquier informacion que sea necesaria para este reclamo o cualquier otro reclamo en el futuro. Yo tambien autorizo el pago de beneficios medicos a Reiss, Kang, Burks, Jayanetti & Pereda, M.D., P.A. o cualquier asociado. Yo entiendo que yo soy responsable financieramente por mis servicios medicos a Reiss, Kang, Burks, Jayanetti & Pereda, M.D., P.A, a pesar de cualquier beneficios de seguro que pueda tener; tambien entiendo que es mi responsabilidad colectar cualquier reembolso de mi compania de seguro. Yo entiendo que soy responsable de cualquier cargo que pueda ser efectuado por Reiss, Kang, Burks, Jayanetti & Pereda M.D., P.A. en sus efuerzos de colectar cargos debidos por mi, incluyendo cargos de agencias de recolecta, abogados, o de corte.

Nombre del Paciente: \_\_\_\_\_  
(Emprimir)

Firma del Paciente: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I request that payment of authorized insurance benefits be made on my behalf to Reiss, Kang, Burks, Jayanetti & Pereda, M.D. P.A, for services furnished to me by any associate of this office. I authorize any holder of medical information about me to release to \_\_\_\_\_ (your insurance company) any information needed to determine these benefits or the benefits payable for related services.

Patient Name: \_\_\_\_\_  
\*(Print)

Witness Name: \_\_\_\_\_  
(Print)

\*Patient's Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

**ASIGNACION DE BENEFICIOS**

Yo solicito que el pago de los servicios medicos que han sido autorizados se hagan en mi nombre a Reiss, Kang, Burks, Jayanetti & Pereda, M.D., P.A. para cualquier asociado de esta oficina. Yo autorizo a cualquier poseedor de informacion medica sobre mi para liberar a \_\_\_\_\_ ( Su compania de seguros) toda la informacion necesaria para determiner estos beneficios o los beneficios pagaderos para servicios relacionados.

Nombre del Paciente: \_\_\_\_\_  
(Emprimir)

Nombre de Testigo: \_\_\_\_\_  
(Emprimir)

Firma del Paciente: \_\_\_\_\_  
(Emprimir)

Fimra del Testigo: \_\_\_\_\_  
(Firma)

\*Date: \_\_\_\_\_  
(Fecha)