PREVENTION FIRST HEALTH PROGRAM

INTERNAL MEDICINE

PATIENT INFORMATION

ANTONIO FERNANDEZ, M.D., F.A.C.P.
JACOBO WAJNER, M.D.

4302 ALTON ROAD #900
MIAMI BEACH, FL 33140
PHONE: 305-532-9900
FAX: 305-534-4808

NAME:_____
Last First Middle Initial

LOCAL ADDRESS_____
Street Apartment #

_____
City State Zip Code

HOME PHONE (____)_____ CELLULAR (____)_____

WORK PHONE(____)_____ SOCIAL SECURITY #_____

MARITAL STATUS:__SINGLE __MARRIED __DIVORCED __WIDOWED

DAT E OF BIRTH_____ SEX: M F AGE:_____

EMPLOYER:_____ OCCUPATION_____

ADDRESS_____

NAME OF PRIMARY INSURANCE CO:_____

ID# OR POLICY_____ GROUP#_____

NAME OF SECONDARY INSURANCE CO:_____

ID# OR POLICY_____ GROUP#_____

SPOUSE OR NEAREST RELATIVE:_____

RELATIONSHIP:_____ PHONE# (___)_____

ADDRESS:_____

REFERRED BY:_____

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be Fully responsible for all lawful debts incurred by myself for services received from Federico R. Justiniani, M.D., P.A., Antonio Fernandez, M.D., Jacobo Wajner, M.D.

_____ _____
Patient Signature Date

PREVENTION FIRST HEALTH PROGRAM
INTERNAL MEDICINE

PATIENT INFORMATION

ANTONIO FERNANDEZ, M.D., F.A.C.P.
JACOBO WAJNER, M.D.

4302 ALTON ROAD #900
MIAMI BEACH, FL 33140
PHONE: 305-532-9900
FAX: 305-534-4808

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN MÉDICA

I hereby authorize the release of any pertinent medical information necessary to process this claim. I also request payment of my insurance benefits to be made directly to **COMPREHENSIVE PRIMARY CARE SPECIALISTS**. In addition, I realize I am responsible to pay non-covered services.

Por la presente autorizo a esta oficina para que divulgue a mi seguro médico la información médica necesaria para procesar mis cobros. También pido que se paguen mis beneficios médicos directamente a nombre de **COMPREHENSIVE PRIMARY CARE SPECIALISTS**. Así mismo añado que yo me hago cargo de pagar por los servicios que no estén cubiertos por mi seguro.

_____ _____

Patient's signature (Firma del paciente)

PRINT patient's name
(Nombre del paciente)

_____

Medicare number (Número de Medicare)

AUTHORIZATION TO RECEIVE SUPPLEMENTAL PAYMENT

AUTORIZACIÓN PARA RECIBIR PAGO SUPLEMENTARIO

If applicable, I hereby authorize my supplemental insurance (Medigap) to make payments paid directly to **COMPREHENSIVE PRIMARY CARE SPECIALISTS.**

Por la presente autorizo a mi seguro suplementario (Medigap) para que pague mis beneficios directamente a **COMPREHENSIVE PRIMARY CARE SPECIALISTS.**

_____

Patient's signature and date. (Firma del paciente y fecha)

HIPAA NOTICE OF PRIVACY PRACTICES

PREVENTION FIRST HEALTH PROGRAM
4302 Alton Road, Suite 900
Miami Beach, Fl 33140

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that, relates to your past, present or future physical or mental health or condition and related health care services.

1. Users and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that you relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law. Communicable Disease: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements:

Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected information, under federal law, you may not Inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary 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 our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer in person or by our Main Phone number

Print Name:_____ Signature:_____ Date:_____