Barbara Martinez M.D.
17900 NW 5th Street, Suite 205
Pembroke Pines, FL 33029
Ph (954) 367-3157 Fax: (954) 374-9038

PATIENT INFORMATION

Name: Nombre ____________ Date of Birth: Fecha de Nacimiento ____________ Age: Edad: ____________

Place of Birth: Lugar de Nacimiento: ____________ Marital Status: Estado Civil: ____________ Social Security #: Numero Seguro Social ____________

Address: Direccion: ____________ Home Phone: Telefono del Hogar: ____________

City: Ciudad: ____________ State: Estado: ____________ Zip Code: Codigo Postal ____________ Alternate Ph: Telefono Alternativo ____________

E-mail Address: Direccion correo electronico: ____________

Occupation: Ocupacion: ____________ Name of Employer: Nombre del Lugar de Empleo: ____________

Primary Language Spoken: Primer Idioma: ____________ How Did you hear about us?: Como se entero de nosotros: ____________

Health Insurance Information/ Informacion de su Seguro Medico

Name of Primary Insurance: Nombre del Seguro Primario: ____________ Policy #: Numero de Poliza: ____________

Name of Secundary Insurance: Nombre del Seguro Secundario: ____________ Policy #: Numero de Poliza: ____________

Name of Subscriber: Nombre del Asegurado ____________ Date of Birth: Fecha de Nacimiento: ____________ Relationship: Parentesco ____________

Emergency Contact Information/ Informacion de su Contacto de Emergencia

Name of Relative: Nombre del Familiar ____________ Relationship: Parentesco ____________ Phone: Telephone ____________

Please read and sign the following/ Por favor de leer y firmar lo siguiente:

1. Payment for services is expected at time of visit.
*Pago por el servicio brindado es requerido al momento de la visita
2. If insurance is filed, I authorize benefits to be paid directly to Tenet Florida Physician Services.
* Al proveer mi seguro, Yo permito que mis beneficios sean pagados directamente a Barbara Rosa Martinez MD LLC
3. I am responsible for the balance on my account, regardless, of insurance coverage. My failure to pay off outstanding balances may resul in collection procedures
* Yo soy responsible por cualquier balance en mi cuenta, a pesar de, cual sea mi prima de seguro. Mi falta de pagar cualquier cuenta pendiente puede dar lugar a procedimiento de coleccion.
4. I authorize Dr. Barbara Rosa Martinez to release any information requested in regards to the processing of my medical claims
* Yo permito a Dr Barbara Rosa Martinez a proveer cualquier informacion requerida para el proceso de mis reclamos medicos

Patient Signature: Firma del Paciente: ____________ Date: Fecha: ____________

Barbara Martinez, MD – 17900 NW 5th Street – Suite 205- Pembroke Pines, Fl 33029 – Tel 954-367-3157 Fax 954-374-9038

Name (First):_______________ MI____Last:_______________ DOB:__________ Today's Date:__________

MEDICAL HISTORY

Reason for your visit____

____

PAST MEDICAL HISTORY

- ☐ None
- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Attack
- ☐ HIV
- ☐ Heart Diseases
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Hemorrhoids
- ☐ Cancer
  Type of cancer ____________________
- ☐ Breast Cancer
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Coagulation disorders
- ☐ Epilepsy

Others____

____

ALLERGIES AND TYPE OF REACTIONS

☐ **No allergies**

Allergies: ☐ LATEX ☐ IODINE/IODO ☐ TAPE

Allergies to medication

____

____

____

____

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Name (First):______________________ MI____Last:_______________ DOB:___________ Today's Date:___________

SURGERIES(TYPE AND YEAR)

____

____

____

____

____

VACCINES:

____

____

____

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____

____

MEDICATIONS PRESENTLY TAKEN:

____

____

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____

Pharmacy Name: ____________________________ Phone: ____________________________

Physician Signature _______________________ Date ___________

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Name (First):______________ MI____Last:____________ DOB:__________ Today's Date:__________

SOCIAL HISTORY

Do you smoke?: ☐ YES ☐ NO

How much? ____

Do you drink alcohol? ☐ YES ☐ NO If yes, ☐ daily ☐ occasionally

Do you use drugs? ☐ YES ☐ NO

If yes, please list:____

FAMILY HISTORY

Please check any family members who have the following health problems

	Father	Mother	Brother	Sister	Grandparent	other
Breast Cancer						
Glaucoma						
Cancer (list type)						
Heart attach						
Angina						
Stroke						
High blood pressure						
High cholesterol						
Alcoholism						
Drug abuse						
Depression						
Mental Illness						
Diabetes						
Other						

Patient signature: ______________________________ Date: ____________________

Physician Signature ______________________ Date ____________

Barbara Rosa Martinez M.D LLC
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Financial Policy

We appreciate the confidence thet you have expressed in selecting Barbara Rosa Martinez M.D LLC for your healthcare needs and we look forward to working with you. If you have any questions about our services, fees or other aspects of your care please feel free to discuss your concerns with us.

A payment for your office visit is required at the time of service for:
1. Patients without insurance.
2. Patients with private insurance.
3. Patients who are not covered by one of our contracted insurance plans.
4. Patients who do not provide us with contracted insurance information.
   (We must have a copy of your current insurance card on file.)

ALL MONIES OWED BY THE PATIENT: CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICES ARE PAYABLE AT THE TIME OF SERVICE.

Any service that is rendered by this office that is not a covered benefit of your insurance policy is your responsibility to pay.

Our staff will assist you in dealing with your insurance company, but it is your responsibility to know and understand your own insurance policy. It is our sincere hope that this policy will be helpful and reduce any confusion or misunderstanding at a later date.

24 HOURS ADVANCE NOTICE IS REQUIRED FOR CANCELLATIONS. CALL 954-367-3157
A FEE OF $25.00 MAY BE CHARGED FOR FAILURE TO TIMELY CANCEL AN APPOINTMENT. I WILL PAY TODAY AND FUTURE CHARGES BY CASH, CHECK, OR CREDIT CARD.

I understand the above policy and acknowledge that I am financially responsible for services rendered.

Patient's Name: ______________________________

Patient's Signature: ____________________________________ Date: ____________________

PRIMEHEALTH PHYSICIANS

17900 NW 5th Street, Suite No. 205 Pembroke Pines, FL 33029

Releasing Information / Patients Rights and
Acknowledgement of Receipt of Notice of Privacy Practices

The Department of Health and Human Services Has established a "Privacy Rule" to help insure that personal health care information is protected for privacy and is only to be used or shared in the minimum necessary fashion. Healthcare providers are to obtain their patient's consent for uses and disclosure of health information about the patient to carry out treatment, payment, or health care operations. By signing this consent, you understand that your physician may need to provide necessary medical information to other appropriate physicians, pharmacies, hospitals, insurance companies, laboratories, and billing agencies. Refusing to consent to the use or disclosure of your personal health information prohibits the doctor from billing for their services; scheduling your care at a hospital; or calling in a prescription to a pharmacy; or medical need. Under this law we have the right to refuse to treat you should you choose to refuse to disclose your PersonalHealth Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke any actions that have already been taken which relied on this or a previously signed consent.
If you have any objections to this form, please ask to speak with our Office Manager.

El departamento de Servicios Humanos y de Salud ha establecido una Regla de Privacidad con miras de asegurar que se proteja la privacidad de la informacion sobre la atencion personal de la salud y que se use o se comparta solamente la minima informacion que sea necesaria con el fin de proporcionarles una norma a revelaciones de informacion acerca de la salud de usted para fines de tratamientos, pagos, y operaciones de cuidado de la salud. El negarse a dar su consentimiento al uso o revelacion de informacion personal sobre su salud le prohibe al medico facturar sus servicios, programar la atencion que se le vaya a dar a usted en el hospital, llamar a una farmacia para que le despachen una receta asi como satisfacer otras necesidades medicas. En virtud de esta ley, tenemos el derecho de negarnos a dar tratamiento si usted decide negarse a revelar Informacion Personal sobre la Salud (PHI Personal Health Information por sus siglas en ingles). Si usted decide dar su consentimiento mediante este documento, en algun momento futuro usted tambien podra revocar dicho consentimiento por escrito. No se dara a conocer ninguna otra informacion a partir de la fecha en que usted le presente dicha revocacion al doctor.
Si tiene alguma pregunta acerca del presente formulario, pida hablar con nuestro gerente de oficina.

Patient Consent for use and disclosure of Protected Health Information as required and/or permitted by law.
Consentimiento del Paciente para usar y compartir Informacion Personal sobre la Salud como lo permitad y/o requiera la ley.

________________________	______________________________	________________
Patient's Name / Nombre del Paciente	Patient or Legal Representative Signature Firma del Paciente o Representante Legal	Date / Fecha

And I also acknowledge that I have been provided with the "Notice Of Privacy Practices"
Y tambien confirmo haber recibido la "Noticia De las Practicas de Privacidad"

Compliance Assurance Notification for Our Patient's

The misuse of PHI has been identified as a national problem causing inconvenience, aggravation, and money.We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government regulations regarding HIPAA with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing service for our patients. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your imput regarding any service problem so that we may remedy the situation promptly.

El mal uso de la PHI ha sido identificado como un problema nacional que causa molestias, exasperacion y gasto de dinero. Queremos que sepa que todos nuestros empleados, gerentes y doctores continuamente reciben entrenamiento para que sepan comprender y cumplir las reglas y regulaciones gubernamentales con respecto a HIPAA dandole especial enfasis a la Regla de Privacidad. Nos esforzamos por alcanzar las mas elevadas normas de etica e integridad en la prestacion de servicios a nuestros pacientes. Nuestra politica es el determinar adecuadamente los usos apropiados de la Informacion Personal sobre la Salud en conformidad con las reglas, leyes y regulaciones gubernamentales. Queremos asegurar que nuestra practica nunca contribuya de manera alguna al creciente problema de la revelacion inapropiada de dicha informacion. Como parte de este plan, hemos implementado un Programa de Cumplimiento que creemos nos ayudara a impedir cualquier uso inapropiado de PHI. Tambien sabemos que no somos perfectos, a causa de ello, nuestra politica es escuchar a nuestros empleados y pacientes sin intecion alguna de sancionarlos ni penalizarlos si ellos son de la opinion que un evento compromete nuestra politica de Integridad de algun modo. Mas aun, acogemos las ideas que usted tenga acerca de qualquier problema que tenga el servicio para poder resolver esa situacion prontamente.
Gracias por ser nuestro valioso paciente.

Patient Request for Confidential Communications of Protected Health Information

The Health Insurance Portability Act of 1996 ("HIPAA") provides you the right to request that **PRIMEHEALTH PHYSICIANS., (PHP)** communicate with you about your health information at an alternative address or phone number, or by an alternative means (for example, by email) that is more confidential for you. **PHP** must accommodate your request if it is reasonable. **PHP** may require you to specify an alternative address or other method of contact before providing the requested accommodation. If your request is accepted, the Medical Center will make every attempt to communicate with you in the manner you have requested. Your election will remain in effect until you have instructed us in writing to change the manner of communication.

To request confidential communications, please complete the form below and send to:
PRIMEHEALTH PHYSICIANS. **17900 NW 5th Street, Suite No. 205 Pembroke Pines, FL 33029**

Patient Name: ______________________________ Telephone #: ____________________
(Print)
Address: ______________________________ City: ______________ State: ______ Zip: ______________

Describe the alternative means of communication you are requesting:

____

____

I am requesting that **PRIMEHEALTH PHYSICIANS.,** communicate with me by an alternative means or at an alternative address or phone number that is more confidential for me. I understand that the Medical Center will not accommodate unreasonable requests.

____
Signature of Patient or Legal Representative *May be requested to show proof of representative status
Date Signed ______/______/______

REMINDER: If the alternative address selected by patient is an e-mail, then E-Mail Consent Form MUST be completed.

E-Mail Consent Form

Purpose: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information (PHI).

PRIMEHEALTH PHYSICIANS., (PHP) offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before granting consent to use e-mail for these purposes. **PHP** will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, **PHP** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

Patient's Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of e-mail between **PHP** and me and consent to the conditions outlined herein. Any questions I may have had were answered. I agree and consent that **PHP** may communicate with me regarding my protected health information by e-mail.

My Consented E-Mail Address is : ______________________________

____

____
Signature of Patient or Legal Representative * May be requested to show proof of representative status
Date Signed: ______/______/______

Office Use: Received: ____/____/____ Completed: ____/____/____ Initials: __________

Barbara R. Martinez, M.D.
17900 N.W. 5th Street, Suite 205
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Starting June 1st, 2016, there is a charge for not showing up for scheduled appointments. $25.00 per appointments cancelled without a 24 hour notice. Repeated cancellations or missed appointment will result in loss of future appointment privileges.

OTHER CHARGES INCLUDE:

$20.00 to have the blood drawn in the office.

$1.00 per page not exceeding $25.00 for Medical Records/Lab Results

$25.00 for Insurance Paperwork or Forms to be filled out.

Empezando el 1 de Junio del 2016, se aplicara un cargo por no asistir a su cita de $25.00 por visita que no se cancele con 24 horas de anticipation. Muchas cancelaciones repetitivas causara perder privilegios para sus futuras citas.

OTROS CARGOS INCLUYE:

$20.00 por hacer sus analisis de sangre en la oficina.

$1.00 por paginas que no exceda $25.00 por Historia Medica/resultados de laboratorios

$25.00 para llenar los papeles del seguro y formulatios.

Nombre del Paciente:
Patient's Name: ______________________ Date: ______________

Firma del Paciente:
Patient's Signature: ______________________

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication History Transaction** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens, therapeutic interventions, drug-drug and drug-allergy interactions, adverse drug reactions, and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at PrimeHealth Physicians, LLC as well as other health care providers involved in your care and may include sensitive information including, but not limited to medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

Consent

By signing this consent form you are agreeing that your provider at PrimeHealth Physicians, LLC may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have any effect on any action taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to PrimeHealth Physicians, LLC to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name: ______________________________ Patient DOB: ________________________

Signature of Patient or Guardian: ______________________________ Date: ________________

Relationship to Patient: ____

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of PrimeHealth Physicians, LLC Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

____
Patient Name (Type or Print)

____
Date

____
Signature