**E. LOPEZ DEL CASTILLO, M.D, LLC**

**9220 SW 72ND St. Suite #102 Miami, FL 33173**

**Office 305 275-1700**

**PATIENT INFORMATION**

Name:___________________________________________________________ Date of Birth:_____________ Age:______

Place of Birth: ___________________________ Marital Status: _______________ Social Security #:_______________________

Address: ___________________________________________________________ Home Phone: _________________________

City: ______________________ State: ____________ Zip Code: _____________ Alternative Phone:_____________________

E-mail Address: _____________________________

Occupation: ___________________________________ Name of Employer:__________________________________________

Primary Language Spoken: ____________________ How did you hear about us?_____________________________________

**HEALTH INSURANCE INFORMATION**

Name of Primary Insurance: ________________________________________ Policy#: ________________________________

Name of Secondary Insurance: ______________________________________ Policy#: ________________________________

Name of Subscriber: _______________________________ Date of Birth:____________ Relationship:_____________________

**EMERGENCY CONTACT INFORMATION**

Name of Relative: _____________________________________ Relationship: ________________ Phone: _________________

**PLEASE READ AND SIGN THE FOLLOWING:**

1. Payment or services is expected at time of visit.

2. If Insurance is filed, I authorize benefits to be paid directly to **E. LOPEZ DEL CASTILLO, M.D, LLC**

3. I am responsible for the balance on my account, regardless, of insurance coverage. My failure to: pay off outstanding balances may result in collection procedures.

4. I authorize **E. LOPEZ DEL CASTILLO, M.D, LLC** to release any information requested in regards to the processing of my medical claims.

Patient's Signature: ________________________________________ Date: _____________________

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Name( First) :________________ Last: __________________________________________________________DOB: ________

Today's date: _____________

**MEDICAL HISTORY**

**REASON FOR YOUR VISIT:** ________________________________________________________________________________

________________________________________________________________________________________________________

**PAST MEDICAL HISTORY :**

- ☐ None
- ☐ Hypertension
- ☐ Diabetes
- ☐ Heart attack
- ☐ Heart disease
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Asthma
- ☐ High blood cholesterol
- ☐ Cancer
  Type of Cancer: ______________________
- ☐ Arthritis
- ☐ Depression
- ☐ Anxiety
- ☐ Coagulation disorders
- ☐ Epilepsy
- ☐ Sleep apnea
- ☐ High blood triglycerides

Others:________________________________________________________________________________________
________________________________________________________________________________________________

**ALLERGIES AND TYPE OF REACTIONS:**

☐ No allergies

Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ Food if yes, please list______________________________
Allergies to medication:
________________________________________________________________________________________________
________________________________________________________________________________________________
__________________________________________

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Name(First) :________________ Last: __________________________________________________________DOB: ________

Today's date: _____________

**SURGERIES (TYPE AND YEAR)**

______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________

**VACCINES:**

______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________

**CURRENT MEDICATIONS:**

______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________
______________________________________________________________________________________________________

Pharmacy's name and address: ____________________________________________________________

Phone: _____________________

Patient's signature: ____________________________________________ Date:_______________

Physician's signature: __________________________________________ Date: _______________

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Name( First) :________________ Last: ____________________________________________________________DOB: ________

Today's date: _____________

**SOCIAL HISTORY**

Do you smoke? ☐ Yes ☐ No

If yes, how much? _______________________________________________________________________________________

For how long ? __________________________________________________________________________________________

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 |
|---|---|---|---|---|---|---|
| Hypertension | | | | | | |
| Diabetes | | | | | | |
| Cancer ( list type) | | | | | | |
| Heart attack | | | | | | |
| Heart disease | | | | | | |
| Stroke | | | | | | |
| Asthma | | | | | | |
| Thyroid Disease | | | | | | |
| High blood cholesterol | | | | | | |
| High blood triglycerides | | | | | | |
| Mental illness ( list type) | | | | | | |
| Coagulation disorders | | | | | | |
| Glaucoma | | | | | | |
| Other | | | | | | |

Patient's signature: ______________________________________________ Date:_______________

Physician's signature: ____________________________________________ Date: _______________

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**FINANCIAL POLICY**

We appreciate the confidence that you have expressed in selecting **E. LOPEZ DEL CASTILLO, 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.**
I WILL PAY TODAY AND FUTURE CHARGES BY CASH, CHECK, OR CREDIT CARD.

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.

**LATE/MISSED APPOINMENT POLICY:**

We appreciate a 24 hour notice on cancellations. This allows the office time to fill the empty appointment slot with someone else that needs to be seen. We will try to accommodate any sick patient who arrives late with the next available open appointment.

**POLIZA DE LLEGADAS TARDES Y AUSENCIA SIN PREVIO AVISO:**

Agradecemos un aviso de 24 horas sobre cancelaciones. Esto le da tiempo a la oficina para llenar el espacio de citas vacío con otra persona que necesita ser vista. Intentaremos acomodar a cualquier paciente enfermo que llegue tarde con la próxima cita abierta disponible.

**WALK-IN POLICY**

We see all patients by appointments and offer same day appointment scheduling. Unless deemed urgent, patients who arrive without an appointment will be given the next available open appointment.

**REFERRAL POLICY**

Many insurance companies require authorization through your PCP before seeing a specialist. This process can take up to 5 business days to complete. If your PCP believes you should see a specialist, call the specialist, confirm the doctor is on your insurance plan, and make an appointment. Call our office back with the name of the specialist, the appointment date, and time. Allow 3-5 business days for the completion of your referral.

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**PRESCRIPTION REFILL POLICY**

Prescription refill requests should be phoned in during regular office hours. Provide all pertinent information including the patient's name, date of birth, medication name, dose, pharmacy name, pharmacy address and phone number. Allow up to 3 business days for us to prepare the prescription. Certain chronic and recurrent conditions may require a visit for re-evaluation before a refill is provided. We do not call in or refill antibiotics or oral steroids without having seen the patient first.

Thank you for understanding our policies. Please let us know if you have any questions.

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

Patient's Name:_______________________________________________________________________________________

Patient's Signature: ____________________________________ Date:_______________

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**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 it 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 Personal Health 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.

| ______________________________ | ______________________________ | ______________ |
|---|---|---|
| Patient's Name | Patient or Legal Representative Signature | Date |

And I also acknowledge that I have been provided with the "Notice Of Privacy Practices"

**Compliance Assurance Notification for our patients.**

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 input regarding any service problem so that we may remedy the situation promptly.

**Patient Request for Confidential Communications of Protected Health Information.**

The Health Insurance Portability Act of 1996 ("HIPAA") provides you the right to request that **E. LOPEZ DEL CASTILLO, M.D, LLC** 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. **E. LOPEZ DEL CASTILLO, M.D, LLC** must accommodate your request If it is reasonable. **E. LOPEZ DEL CASTILLO, M.D, LLC** 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: **E. LOPEZ DEL CASTILLO, M.D, LLC** 9220 SW 72ND St. Suite #102 Miami, FL 33173 Office 305 275-1700.

**E. LOPEZ DEL CASTILLO, M.D, LLC**

**9220 SW 72ND St. Suite #102 Miami, FL 33173**

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| Patient Name:_____________________________________________ Telephone#:____________________________________ |
|---|
| Address: ______________________________________ City:________ State:_____ Zip code: ________ |

Describe the alternative means of communication you are requesting:

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

I am requesting that **E. LOPEZ DEL CASTILLO, M.D, LLC** communicates 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.

___________________________________________ Date Signed ____ / ____ / _______

Signature of Patient or Legal Representative
*May be requested to show proof of representative status

| **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 our consent to communicate with you by email regarding your Protected Health Information (PHI).** |
|---|

EDUARDO LOPEZ DEL CASTILLO, M.D. offers patients the opportunity to communicate by e-mail. Transmitting patient information by email 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 here in. 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: ___________________________________________________________

__________________________________________ Date Signed:_____/______/_______

Signature of Patient or Legal Representative
*May be requested to show proof of representative status

Office Use: Received:___/___/ ____ Completed:___/___/ ____ Initials: _____

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**CONSENT FORM FOR 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 Eduardo Lopez del Castillo, M.D, 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 Eduardo Lopez del Castillo, M.D, LLC may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers 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 Eduardo Lopez del Castillo, M.D, 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.

Patient's Name: ____________________________________________Patient's DOB:______________________

Signature of Patient or Guardian: _________________________________ Date: _________________________

Relationship to Patient: ________________________________________________________________________

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**Office 305 275-1700**

**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 **E. LOPEZ DEL CASTILLO, M.D, 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's Name (Print) Date

__________________________________

Signature