HISTORIA MÉDICA Y INFORMACION PERSONAL DEL PACIENTE

NOMBRE: _____ APELLIDO: _____ NUMER DE SEGURO SOCIAL: _____
FECHA DE NACIMIENTO: _____ DIRECCION: _____
CIUDAD: _____ESTADO: _____ CODIGO POSTAL: _____ NUMERO(S) DE TELFONO: _____
CENTRO DE TRABAJO: _____ NUMERO DE TELFONO: _____
NOMBRE Y APELLIDO DEL FAMILIAR MAS CERCANO: _____ PARENTESCO: _____
DIRRECION: _____ CIUDAD: _____ ESTADO: _____ TELEFONO: _____
FECHA DEL ULTIMO EXAMEN MEDICO: _____ NOMBRE DEL DOCTOR: _____

EQUIPO MEDICO

USA USTED: BASTON □ EQUIPO DE OXIGENO □ CATETER □ ANDADOR □ SILLA DE RUEDAS □ NEBULIZADOR □

USA ESPEJUELOS: SI □ NO □ USA AUDIFONOS: SI □ NO □

HABITOS SOCIALES

ALCOHOL: SI □ NO □ CIGARRO: SI □ NO □ DROGAS: SI □ NO □ OTROS: _____ RELIGION: _____

ETNICIDAD: □ Hispano o Latino □ No Hispano o Latino □ Prefieren no revelar

RAZA:

□ Indio Americano o Nativo de Alaska □ Asiático □ Negro o afro- □ Blanco Americano
□ Nativo de Hawái u otra isla del Pacífico □ Hispano □ Otra Raza □ Prefieren no revelar

ESTADO CIVIL:

□ CASADO(A) □ VIUDO(A) □ SOLTERO(A) □ DIVORCIADO(A) □ SEPARADO(A) □ VIVE SOLO(A):

VACUNAS

PNEUMOCOCO: □ RUBEOLA: □ TETANO: □ INFLUENZA: □ DIFTERIA: □ OTRAS: _____

HISTORIA FAMILIAR

FAMILIAR	VIVO(A)	FALLECIDO(A)	EDAD	CAUSA DE MUERTE
MADRE				
PADRE				
HERMANO(S)				
HERMANA(S)				

INDIQUE SI UESTED O ALGUIEN DE SU FAMILIA HA PADECIDO DE LAS SIGUIENTES ENFERMEDADES. DE NO ESTAR SEGURO DEJE EL ESPACIO EN BLANCO.

	PACIENTE	NO	FAMILIAR		PACIENTE	NO	FAMILIAR
ABUSO DE ALCOHOL	□	□	□	HEPATITIS	□	□	□
ALLERGIAS (A OTRA COSA QUE NO SEA MEDICINA)	□	□	□	HYPERTENSION	□	□	□
ANEMIA	□	□	□	POLIPOS INTESTINALES	□	□	□
ARTRITIS	□	□	□	ICTERICIA	□	□	□
ASMA	□	□	□	LEUCEMIA	□	□	□
TENDENCIA A SANGRAR	□	□	□	SARAMPION	□	□	□
CANCER	□	□	□	MIGRANA	□	□	□
VARICELA	□	□	□	PAPERAS	□	□	□
COLITIS	□	□	□	CRISIS NERVIOSA	□	□	□
CARDIOPATIA CONGENITAL	□	□	□	TRATAMIENTO DE RADIACION	□	□	□
DEPRESION	□	□	□	FIEBRE REUMATICA	□	□	□
DIABETES	□	□	□	ENFERMEDADES DE TRANSMISION SEXUAL	□	□	□
DIALISIS	□	□	□	ANEMIA DE CELULAS FALCIFORMES	□	□	□
ENFISEMA	□	□	□	ENFERMEDAD DE LA VESICULA BILIAR	□	□	□
EPILEPSIA	□	□	□	SUICIDIO	□	□	□
FREQUENTES INFECCIONES URINARIAS	□	□	□	ENFERMEDADES DE LA TIROIDE	□	□	□
FREQUENTES INFECCIONES PULMONARIAS	□	□	□	TUBERCULOSIS	□	□	□
BOCIO	□	□	□	ULCERA ESTOMACAL	□	□	□
GOTA	□	□	□	INFARTO CEREBRAL	□	□	□
FIEBRE DE HENO	□	□	□	TOS FERINA	□	□	□
INFARTO CARDIACO	□	□	□	OTRA	□	□	□

OPERACIONES – LISTE LAS OPERACIONES QUE USTED HA TENIDO Y APPROXIME EL ANO.

_____

_____

_____

LESIONES DE GRACEDAD – LISTA LAS LESIONES/ACCIDENTES QUE USTED HA TENIDO Y INDIQUE EL ANO. (EXLUYA LO QUE YA HA MENCIONADO).

_____

_____

_____

HOSPITALIZACIONES – QUE USTED HAYA TENIDO, ESPECIALMENTE EL ESTE ULTIMO ANO. EXCLUYA AQUELLAS DEBIDO A OPERACIONES.

_____

_____

_____

MEDICAMENTOS: - INDIQUE SI USTED TOMA ALGUNAS DE LAS SIGUIENTES MEDICINAS.

	MEDICAMENTO(S) *(LISTE LOS MEDICAMENTOS QUE ESTA TOMANDO)*	**DOSIS**	**FREQUENCIA**
□ MEDICINA PARA EL ASMA			
□ ASPIRINA, BUFFERIN, ANACNI, TYLENOL O PRODUCTOS SIMILARES			
□ MEDICINAS PARA LA PRESION			
□ CORTISONA, PREDNISONA			
□ MEDICINA CONTRA LA TOS			
□ MEDICINAS PARA EL CORAZON/DIGITALIS			
□ HORMONAS			
□ INSULINA O MEDICINAS PARA LA DIABETES			
□ LAXANTES			
□ MOTRIL, ADVIL, IBUPROFENO			
□ MEDICINAS PARA DORMIR, TRANQUILISANTES			
□ MEDICAMENTOS PARA LA TIROIDE			
□ MEDINCAS PARA EL ESTOMAGO/DIGESTION			
□ MEDICINAS PARA ADELGAZAR			
□ ANTICOAGULANTES O COUMADIN			
□ DILANTIN			
□ DIURETICOS			
□ ANTIBIOTICOS			
□ FENOBARBITAL/BARBITURICOS			
□ VITAMINAS			
□ OTRO TIPO DE MEDICAMENTO POR RECETA O POR LA LIBRE			

¿ES USTED ALERGICO A ALGUN MEDICAMENTO? SI □ NO □

SI LO ES, FAVOR DE LISTAR LAS MEDICINAS A LAS CUALES ES ALERGICO.

_____

_____

_____

_____

FAVOR DE TRAER TODAS LAS MEDICINAS QUE USTED ESTE TOMANDO CADA VEZ QUE VENGA A LA CONSULTA.

HERSHMAN
MEDICAL CENTER

AVISO DE PRÁCTICAS DE PRIVACIDAD

ACUSE DE RECIBO

de Fecha 14 de Abril 2003

Yo, _____, reconozco y acepto que he recibido una copia del Aviso de prácticas de privacidad de **Hershman Medical Center**.

_____ _____
Firma del Paciente Fecha

_____ _____
Representante Legal del Paciente (Si Procede) Fecha

_____ _____
Escriba el nombre del Representante Legal Fecha

PARA USO CLÍNICO SÓLO:

Los médicos Hershman hecho los siguientes esfuerzos de buena fe para obtener el individuo antes mencionado, están escrito acuse de recibo de las Prácticas de Confidencialidad:

El paciente recibió una descripción escrita de sus derechos con respecto a su información médica en los esfuerzos para educar a la nueva política y los procedimientos establecidos por los Reglamentos de privacidad de HIPAA. La firma del paciente en este formulario de notificación de acuse de recibo indica que el paciente ha recibido la revelación completa de Hershman Medical Center, P.A.

11479 S.W. 40 Street, Miami, FL 33165
Tel: 305-221-7235, Fax: 305-220-1847

AUTHORIZACION DE RESULTADOS Y CONDICION MÉDICA

Yo, _____ autorizo a los doctores de Hershman Medical Center, P.A. a darle fotocopia de mi expediente médico, incluyendo resultados de exámenes y laboratorios, al igual que discutir mi condición médica con las personas indicadas en esta forma:

1. _____ relación al paciente_____
2. _____ relación al paciente_____
3. _____ relación al paciente_____
4. _____ relación al paciente_____

Firma del Paciente _____ Fecha _____

Testigo _____

11479 S.W. 40 Street, Miami, FL 33165
Tel: 305-221-7235, Fax: 305-220-1847

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

This notice describes how health information about you or your child (herein after referred to as "you" or "your") may be used and disclosed and how you can access this information. Please review it carefully.

If you have any questions about this notice, please contact our

Privacy Officer at
11479 SW 40th St.,
Miami, FL. 33165
(305) 221-7235

OUR COMMITMENT TO YOUR PRIVACY

We understand that the information about you and your health is very personal and we are committed to protecting the privacy of this information. Each time you visit Drs. Hershman & Hershman we create a record of the care and services you receive. This record is necessary to provide you with high quality care and to ensure we are in compliance with certain legal requirements. The notice applies to all of your health information in our custody.

This notice will describe the ways in whi9ch we may use and disclose your medical information. We reserve the right to change the terms of this notice at any time. Any revisions to this notice will be applicable to all the medical information we already have about you. As well as any of your medical information that we may receive, create or maintain in the future. We will post a copy of our current notice in prominent locations in your practice location. A copy of the current notice in effect will be available from the practice receptionist.

HOW WE MAY USE AND DICLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use your health information within Drs. Hershman & Hershman and disclose your health information to persons and entities outside of Drs. Hershman & Hershman. Each description is of a category of uses or disclosures. We have not listed every use or disclosure within the categories, but all permitted uses and disclosures will fall within one of the following categories.

Treatment: We may use health information about you to provide you with medical treatment and services. We may disclose health information about you to doctors, nurses, technicians, medical students, interns, or other personnel who are involved in taking care of you during your visit with us.

Payment: We may use or disclose health information about you so the treatment and services you receive at Drs. Hershman & Hershman may be billed to and payment collected from you, an insurance company or a third party. This may also include the disclosure of health information to obtain prior authorization for procedures from your insurance plan.

Healthcare Operations: We may use and disclose health information about you for healthcare operations, including quality assurance activities, granting medical staff credentials to physicians, administrative activities, including Drs. Hershman & Hershman financial and business planning and development, customer service activities, including investigation of complaints, your health insurance plan and certain marketing activities, etc. These uses and disclosures are necessary for Drs. Hershman & Hershman to ensure all of our patients receive quality care.

Appointment Reminders: We may use your health information to contact you as a reminder that you have an appointment for treatment or medical care.

Health Related Products or Services: We may notify you of health-related products and services that may be of interest to you.

Family Members and Friends: We may disclose your health information to individuals, such as family members and friends, who are involved in your care of who help pay for your care. We may make such disclosures when: (a) we have your verbal agreement to do so, (b) we make such disclosures and you do not object, or (c) we can infer from the circumstances that you would not object to such disclosures. For example, if family members are in the exam room with you, we will assume that you agree to our disclosure of your information in their presence.

We may also disclose your health information to family members or friends in instances when you are unable to agree or object to such disclosures, provided that we feel it is in your best interests to make such disclosures and the disclosures relate to that family member or friend's involvement in your care. For example, if you present to our clinic with an emergency medical condition we may share information with a family member or friend who calls us to request a prescription refill for you.

SPECIAL SITUATIONS THAT DO NOT REQUIRE YOUR AUTHORIZATION

The following disclosures of your health information are permitted by law without any oral or written permission from you:

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procedurement or organ, eye or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release health information about you as required by military command authorities.

Worker's Compensation: We may release health information about you for worker's compensation or similar programs if you have a work related injury. These programs provide benefits for your work-related injuries.

Averting a Serious Threat to Health or Safety: We may use and/or disclose health information about you when necessary to prevent a serious threat to your health and/or safety and/or safety of another person or the public. These disclosures would be made only to someone able to help prevent the threat.

Public Health Activities: We may disclose health information about you for public health activities. These generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report child abuse or neglect
- To report reactions to medications, problems with products or other adverse events
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse (including child abuse), neglect or domestic violence. We will only make this disclosure if you agree or when required as authorized by law.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the healthcare system, government programs and compliance with civil rights law.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a course or administrative order. We may disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement: We may disclose health information if asked to do so by law enforcement officials for the following reasons:

- In response to a court order, subpoena, warrant, summons or similar process.
- To identify or locate a suspect, fugitive, material witness or missing person.
- About the victim of a crime if, under certain circumstances, we are unable to obtain
- About a death we believe may be the result of a criminal conduct.
- About criminal conduct at our facility
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Home Directors: We may disclose health information to a coroner or medical examiner. This may be necessary to identify a decreased person or determine the cause of death of a person. We may also release health information about patients at our facility to funeral home directions as necessary to carry out of their duties.

National Security and Intelligence Activities: We may disclose health information about you to authorized federal officials for intelligence,

counterintelligence and other national security activities authorized by law.

Inmates: If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose health information about you to the correctional institution or the law enforcement official. This is necessary for the correctional institution to provide you with healthcare, to protect your health and safety of others, or for the safety and security of the correctional institution.

Legal Requirements: We will disclose health information about you without your permission when required to do so by federal, state or local law.

WITH YOUR SPECIFIC WRITTEN "AUTHORIZATION"

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission (called "authorization"). If you authorize us to use or disclose health information about your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Drs. Hershman & Hershman entity that created it, the information belongs to you. You have certain rights with respect to your information as described below. If you wish to exercise your rights, you may complete preprinted forms at registration or you may write directly to the Privacy Officer.

1. **Right to request a restriction on certain uses and disclosures of your information.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone, such as family member or friend who is involved in your care or in the payment of your care. For example, you could ask that we not disclose information regarding a particular treatment that you received. We are not required to agree with your request. If we do not agree, that agreement must be in writing and signed by you and us.

2. **Right to request confidential communications.** You have the right to request that we communicate with you about medical matters in a certain manner or a certain location. For example, you may request that we limit our communications with you to contact work or home. Your request must be in writing, as described above, and must specify the manner in which or the location at which you wish to be contacted. All reasonable requests will be accommodated.

3. **Right to inspect and/or request a copy of your health record**. You have the right to inspect and/or receive a copy of any medical information maintained about your care. Typically, this will include your medical and billing records but does not include psychotherapy notes.

   In order to inspect and/or receive a copy of your medical information, you must submit your request in writing to your Privacy Officer, and we may charge a reasonable fee for this service based on our cost of complying.

   In very limited circumstances, we may deny your request to inspect and/or receive a copy of your information. However, if you request is denied, in some cases you may request that the denial be reviewed. Such reviews are performed by an independent licensed healthcare professional chosen by the Privacy Officer. We will comply with the outcome of the review.

4. **Right to request an amendment to your health record.** If you believe the information we maintain about you is incorrect or incomplete, you may request that we amend the information. In order to request an amendment, you must submit a written request, as described above, indicating the specific information you wish to be amended and providing the reason supporting the request. Failure to put your request in writing or provide supporting reasoning is likely to result in a denial of your request.

   We may also deny your request if you ask us to amend information that:
   - Is accurate and complete.
   - Is not part of information which you would be permitted to inspect or receive a copy
   - Is not part of the medical information maintained by (Physicians or Practice)
   - Was not created by us, unless the individual organizations that created the information are no longer available to make the amendment

5. **Right to obtain an accounting of disclosures of your health information**. You have the right to request an accounting or disclosures which is a list of certain disclosures of your medical information made by Drs. Hershman & Hershman other than disclosures allowed or required by law or authorized by you. The request for this accounting must be submitted in writing as described above. Your request must include the time period for which you are requesting an accounting, which may not exceed six years and not include dates prior to April 14, 2003. Fees may be imposed as allowed by law.

6. **Right to obtain a copy of Notices of Privacy Practices upon request.** We will post a copy of the current notice in our facility. A copy of the current notice in effect will be available at the reception area of each facility.

COMPLAINTS OR CONCERNS

You may contact the Privacy Officer if you have a question about this privacy notice or your privacy rights. You should also contact the Privacy Officer if you have a complaint or concern that your rights have been violated.

DRS. HERSHMAN & HERSHMAN
11479 SW 40th ST.
MIAMI, FL. 33165

You may also write to the Security of Health and Human Services.

Fecha: _____

Declaración de divulgación de responsabilidad financiera del paciente

Su firma abajo constituye un acuerdo obligatorio entre Hershman Medical Center (HMC – el proveedor de servicios médicos) y usted, el paciente, que recibe los servicios médicos, o como representante de un menor de edad, menor de 18 años de edad. Usted acepta la responsabilidad financiera por el (los) pago (s) de todas las cuentas médicas incurridas en la visita de hoy.

Todos los cargos por servicios médicos prestados se deben pagar al momento de la visita.

SEGURO MÉDICO: Tenemos contratos con muchas compañías de seguros, y les enviaremos una factura por los servicios prestamos a usted. Como parte responsable, usted es responsable si su compañía de seguros se niega a pagar por alguna razón.
La persona que firma en representación del paciente como parte responsable debe:

- Informar a HMC la dirección y número de teléfono actual del paciente y la parte responsable.
- Presentar todas las tarjetas de seguros actuales.
- Verificar si la información es actualizada firmando nuestra hoja de datos.
- Pagar cualquier copago requerido al momento de la visita.

Política de cheque devuelto
Si realiza el pago de una cuenta con un cheque, y el cheque es devuelvo por insuficiencia de fondos (NSF), cuenta cerrada (AC), o refiérase al emisor del cheque (RTM), el paciente o la parte responsable del paciente será responsable por la cantidad del cheque original además de un cargo de servicios de $35,00. Una vez recibida una notificación de cheque devuelto, HMC enviará una carta de notificación a la parte responsable acerca del cheque devuelto.

Incumplimiento de pago de cuenta
En caso de que procedimientos de cobranzas u otra acción legal sean necesarios para el cobro de una cuenta vencida, el paciente o la parte responsable del paciente, comprende que HMC tiene el derecho de revelar a una agencia de cobranzas externa toda la información relevante sobre la cuenta y personal necesaria para el cobro del pago por los servicios prestados. El paciente o la parte responsable del paciente, comprende que es responsable por todos los costos de cobranzas, incluyendo, sin limitación, los intereses adeudados al 18% APR, todos los costos de corte y honorarios de abogado, y una tarifa de cobranza se añadirá al saldo pendiente de pago.

Con su firma a continuación, usted acepta la responsabilidad financiera total como un paciente que recibe servicios médicos o como la parte responsable por un(s) paciente(s) menor(s). Su firma verifica que leyó la declaración de divulgación arriba indicada, comprende sus responsabilidades y acepta estos términos.

Paciente Nombre (Por favor escriba en letra imprenta) _____

Firma del paciente _____ Fecha _____

Nombre de la Parte Responsable (Por favor escriba en letra imprenta) _____

Firma de la Parte Responsable _____ Fecha _____