PEMBROKE PINES
PRIMARY CARE

Patient's Name: _____ DOB: _____ / _____ / _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Gender: ❍ Male ❍ Female Ethnicity ❍ Hispanic or Latino ❍ Not Hispanic or Latino

Race ❍ Black or African American ❍ White ❍ Asian ❍ American Indian or Alaska Native

Primary Language Spoken: _____ Translator Needed: ❍ Yes ❍ No

Social Security #: _____ Referred by: _____

Home Phone: _____ Cellular Phone: _____

Work Phone: _____ Email: _____ Apt: _____

Second Address (If Applicable): _____ State: _____ Zip: _____

Second Address Phone: _____

Marital Status: ❍ Single ❍ Married ❍ Widowed ❍ Divorced Spouse Name: _____

Religion: _____

Employer/School: _____ Occupation: _____

City: _____ State: _____ Zip: _____

Allergies: _____

Pharmacy: _____ Pharmacy Phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ (Work) _____ (Cell) _____

Person completing form, if not the patient: Legal guardian ❍ Yes (Please provide documentation) ❍ No

Name: _____ Relationship: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ (Work) _____ (Cell) _____

PLEASE RETURN TO YOUR PHYSICIAN

PATIENT HEALTH RISK ASSESSMENT

PEMBROKE PINES
PRIMARY CARE

It is our pleasure to welcome you to our practice. Please complete the assessment below. This is an important part of your initial evaluation and will help your doctor focus on areas that may require immediate or additional attention, improve your healthcare experience and add value to your health plan.

Patient Name: _____ ID #: _____

Date of Birth: ____/ ____/ ____ Gender: ◯ Male ◯ Female Primary Language: _____

HISTORY	Self	Parent	Sibling		Self	Parent	Sibling
Anemia	☐	☐	☐	Hay Fever	☐	☐	☐
Alcoholism	☐	☐	☐	Heart Attack	☐	☐	☐
Arthritis	☐	☐	☐	Other Heart Disease	☐	☐	☐
Asthma	☐	☐	☐	Hepatitis	☐	☐	☐
Bleeding tendency	☐	☐	☐	High Blood Pressure	☐	☐	☐
Cancer	☐	☐	☐	Intestinal Polyps	☐	☐	☐
Chemo/Radiation	☐	☐	☐	Jaundice	☐	☐	☐
Colitis	☐	☐	☐	Joint Replacement	☐	☐	☐
COPD	☐	☐	☐	Kidney Disease	☐	☐	☐
CHF	☐	☐	☐	Mental Illness	☐	☐	☐
Depression	☐	☐	☐	Migraine Headaches	☐	☐	☐
Diabetes	☐	☐	☐	Organ Transplant	☐	☐	☐
Dialysis	☐	☐	☐	Rheumatic Fever	☐	☐	☐
Epilepsy	☐	☐	☐	Sexually Transmitted Disease	☐	☐	☐
Emphysema	☐	☐	☐	Sickle Cell Anemia	☐	☐	☐
Kidney/Bladder Infection	☐	☐	☐	Stomach Ulcers	☐	☐	☐
Lung Infection	☐	☐	☐	Stroke	☐	☐	☐
Goiter	☐	☐	☐	Thyroid Disease	☐	☐	☐
Gout	☐	☐	☐	Tuberculosis	☐	☐	☐

PERSONAL

1. Have you ever smoked? ◯ Yes ◯ No If yes, number of cigarettes/day: _____

Have you used chewing tobacco? ◯ Yes ◯ No If yes, number of years: _____

Do you smoke cigars? ◯ Yes ◯ No

Do you smoke a pipe? ◯ Yes ◯ No

Are you a smoker now? ◯ Yes ◯ No If you were, when did you quit? _____

Are you serious about quitting? ◯ Yes ◯ No

2. Check if you regularly drink: ☐ Hard liquor (1-3 oz per day) ☐ Over 3 oz per day ☐ Beer/Wine (one per day) ☐ More than one per day

3. Check if you have ever used: ☐ Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐ Speed ☐ Other

PLEASE RETURN TO YOUR PHYSICIAN

ADVANCE DIRECTIVES

To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives. This is a written or oral statement about how you want medical decisions made should you not be able to make them yourself. The best time to do this is when you are healthy and well. **The three main types are: 1. A Living Will, 2. A Health Care Surrogate Designation** and **3. A Durable Power of Attorney.**

Which document(s) do you have? _____

(Please provide a copy of the document(s) to your Primary Care physician.)

COMMENTS

Patient: _____

Physician: _____

*** OFFICE USE ONLY ***

Old records requested: ◯ Yes ◯ No If yes, date requested: _____/_____/_____

Doctor: _____ Hospital: _____

Address: _____ Address: _____

Reviewed EOL with patient: ◯ Yes ◯ No Date: _____/_____/_____

Received: ☐ Living Will Date: _____/_____/_____

☐ Designation of Health Care Surrogate Date: _____/_____/_____

☐ Durable Power of Attorney Date: _____/_____/_____

Physician Review: _____ Date: _____/_____/_____

PLEASE RETURN TO YOUR PHYSICIAN

PEMBROKE PINES
PRIMARY CARE

PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment each visit.

3. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be not covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the apporopriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible Party **Date**

PEMBROKE PINES
PRIMARY CARE

Aurelio Torres, MD PA

Pembroke Pines Office:
601 NW 179th Ave. Suite 104
Pembroke Pines, FL 33029
Ph: (954) 442-0784
Fax: (954) 442-0786

Hialeah Office:
3000 West 12th Ave.
Hialeah, FL 33012
Ph: (305) 512-9002
Fax: (305) 512-9003

Request for Release of Medical Records

To: _____

_____

Office Phone: _____ Office Fax: _____

In order for us to full evaluate this patient's health and make an informed decision, the patient has approved our request for copies of all relevant medical records in your office.

I hereby authorize release of my complete medical history to Aurelio Torres MD PA DBA Pembroke Pines Primary Care

These records are to include psychiatric, substance abuse, and HIV testing/AIDS related complex information.

Please complete all sections below:

Date of Birth: _____ Today's Date: _____

_____
Patient's Name (Printed)

_____ _____
Patient's Signature Witness

Please Fax Records to: 305-512-9003 • 954-442-0786

PEMBROKE PINES
PRIMARY CARE

Aurelio Torres, MD PA

Authorization and Assignment

I hereby authorize my insurance carrier, attorney or any third-party payer to pay Aurelio Torres MD PA DBA Pembroke Pines Primary Care all charges submitted for services incurred by me. I understand I will be responsible for any and all charges not paid by my insurance company. I authorize Aurelio Torres MD PA DBA Pembroke Pines Primary Care to release information concerning my medical condition to my insurance company, employer, hospital, physician or attorney for the purpose of processing a claim. I assign payment directly to the physicians at Aurelio Torres MD PA DBA Pembroke Pines Primary Care which may be due from the Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or part medical services which I have received. The authorization and assignment shall be valid until I notify Aurelio Torres MD PA DBA Pembroke Pines Primary Care in writing of the cancellation. A photocopy of this authorization shall be valid as the original copy.

_____ _____

Signature Date

_____ _____

Signature (WITNESS) Date

PEMBROKE PINES
PRIMARY CARE

Consent for Treatment

______________________________ ______________________________
Patient Name Date of Birth

I hereby give my consent to Pembroke Pines Primary Care to provide diagnostic treatment and services as deemed necessary for myself, or the above-named patient of whom I am the parent or legal guardian.

______________________________ ______________________________ ______________________________
Printed Name Signature Date

- -

Do you have a Living Will/Durable Power of Attorney?

_____ Yes/Location: ____

_____ No/Would you like to discuss your options at today's visit? _______Yes ________ No

- -

Privacy Notice Acknowledgement

I understand that all personal health information (PHI) describing history, symptoms, diagnoses, treatment, test results, and plans for treatment can be used for the purpose of:

- Planning care and treatment;
- A means of communication among the professionals who contribute to care;
- Applying a diagnosis to a bill;
- A means by which third-party payer can verify that services billed were actually provided;
- Routine healthcare operations assessing service delivery and quality of care.

I understand and have been given a Privacy Notice that provides a more complete description of information uses and disclosures of personal health information (PHI) including my rights as defined in the HIPAA Privacy Rule.

______________________________ ______________________________ ______________________________
Patient/Legal Guardian Signature Date