CENTRAL FLORIDA KIDNEY SPECIALISTS

PATIENT INFORMATION - INFORMACIÓN DEL PACIENTE

PATIENT NAME NOMBRE DEL PACIENTE			BIRTHDATE FECHA DE NACIMIENTO	BIRTH SEX SEXO AL NACER
ADDRESS DIRECCIÓN	CITY CIUDAD	STATE ESTADO	ZIP CODE ZIP CODE	SOCIAL SECURITY NUMBER NUMERO DE SEGURO SOCIAL	MARITAL STATUS ESTADO CIVIL ☐ SINGLE ☐ SOLTERO(A) ☐ MARRIED ☐ CASADO(A) ☐ DIVORCED ☐ DIVORCIADO(A) ☐ WIDOWED ☐ VIUDA(A)
HOME PHONE TELEFONO DE CASA	CELL PHONE TELEFONO CELULAR	REFERRING PHYSICIAN MEDICO REFERIDO	EMPLOYER PATRÓN	ADDRESS DIRECCIÓN
EMPLOYER PHONE TELEFONO DE PATRÓN	ARE YOU RETIRED ESTÁ USTED RETIRADO ☐ YES ☐ NO	DATE OF RETIREMENT FECHA DE RETIRO	ARE YOU DISABLED ESTÁ USTED INCAPACITADO ☐ YES ☐ NO	DATE OF DISABILITY FECHA DE INCAPACIDAD	DO YOU HAVE INSURANCE TIENE USTED SEGURO ☐ YES ☐ NO
SPOUSE / GUARDIAN NOMBRE DEL ESPOSO(A) / NOMBRE DEL CUSTIDIO		EMPLOYER PATRÓN		EMPLOYER PHONE TELEFONO DEL PATRÓN
EMERGENCY CONTACT CONTACTO DE EMERGENCIA		ADDRESS DIRECCIÓN		PHONE TELEFONO

FOR REPORT PURPOSES ONLY: RACE _____ **ETHNICITY** _____ **LANGUAGE** _____

PRIMARY INSURANCE INFORMATION - INFORMACIÓN PRIMARIA DEL SEGURO

NAME OF INSURANCE COMPANY NOMBRE DE COMPAÑIA DE SEGURO		ADDRESS DIRECCIÓN	PHONE TELEFONO
EFFECTIVE DATE FECHA VIGENTE	PATIENT'S INS. ID # SEGURO DEL PACIENTE ID #	GROUP NAME NOMBRE DEL GRUPO	GROUP NUMBER NUMERO DEGRUPO
NAME OF SUBSCRIBER NOMBRE DEL SUSCRIPTOR	SOCIAL SECURITY NUMBER OF SUBSCRIBER NÚMERO DE SEGURO SOCIAL DEL SUSCRIPTOR	BIRTHDATE OF SUBSCRIBER FECHA DE NACIMIENTO DEL SUSCRIPTOR	RELATIONSHIP OF SUBSCRIBER TO PATIENT RELACIÓN DEL SUSCRIPTOR AL PACIENTE

SECONDARY INSURANCE INFORMATION - INFORMACIÓN DE SEGURO SECUNDARIO

NAME OF INSURANCE COMPANY NOMBRE DE COMPAÑIA DE SEGURO		ADDRESS DIRECCIÓN	PHONE TELEFONO
EFFECTIVE DATE FECHA VIGENTE	PATIENT'S INS. ID # SEGURO DEL PACIENTE ID #	GROUP NAME NOMBRE DEL GRUPO	GROUP NUMBER NUMERO DEGRUPO
NAME OF SUBSCRIBER NOMBRE DEL SUSCRIPTOR	SOCIAL SECURITY NUMBER OF SUBSCRIBER NÚMERO DE SEGURO SOCIAL DEL SUSCRIPTOR	BIRTHDATE OF SUBSCRIBER FECHA DE NACIMIENTO DEL SUSCRIPTOR	RELATIONSHIP OF SUBSCRIBER TO PATIENT RELACIÓN DEL SUSCRIPTOR AL PACIENTE

LIFETIME AUTHORIZATION FOR INSURANCE ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE - AUTORIZATION POR VIDA PARA ASIGNACION DE BENEFICIOS Y LIBERACION DE INFORMACION:

I hereby give consent to **Central Florida Kidney Specialists (CFKS)** to provide any treatment they deem necessary to the patient named above.

I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested in order to obtain authorization for future treatment and to process claims. I authorize the release of any medical or other information necessary to process my insurance claims and assign payment of benefits directly to the physicians, nurse practitioners, or physician assistants at **CFKS** for services rendered. This assignment applies to Medicare, other health insurance companies, government programs, and commercial payors. I understand that I am financially responsible for any charges not covered by my insurance. A copy of this authorization is as valid as the original.

Payment is requested at the time of service for self-pay patients. If needed, a manager can assist you if arrangements need to be made. We will be glad to assist with insurance forms. Your policy and coverage are a contract between you and your insurance company. You are responsible for all payments.

All necessary lab work will be billed separately by an independent laboratory. Please notify the nurse of any special laboratory requirements.

By signing this agreement, you consent for **CFKS** to contact you by telephone using an automated dialing system, by text message, email, social media, or by leaving messages directly on your voicemail. This consent may be revoked at any time through written notice or by responding through the communication method used by **CFKS**. You also consent to allow any partner, vendor, or affiliate of **CFKS** to contact you on our behalf.

I certify that the information I have provided is true and correct. I understand that it is a crime to knowingly provide false information or to omit important facts on this form.

Por este medio doy mi consentimiento a **CFKS** a proveer cualquier tratamiento que se considere necesario para el paciento nombrado arriba.

Authorizo a cualquier compañia de seguro, empleador, hospital, medico, dentist ó compañía farmaceútica liberar cualquier información solicitada pata obtener autorización para futuros tratamientos y procesar las reclamaciones. Autorizo la liberación de la información necesaria para presentar una reclamación a la compañía de seguro médico y asigno beneficios que de otro modo se pagarían a mí, al proveedor medico ó grupo indicado en la reclamación. Entiendo que soy financieramente responsable por cualquier balance no cubierto por mi compañía de seguros. Una copia de firma es tan válida como el original.

Se solicita el pago en el momento del servicio para pacientes sin cobertura médica. Si es necesario, un gerente le puedo asistir a hacer arreglos de pago. Será un placer ayudarles con los formularios de seguro. Su póliza de seguro y cobertura médica son contratos entre paciente y la compañía de seguros que usted ha seleccionado. Usted es responsable de todos los pagos.

Yo autorizo el pago directo a los proveedores médicos de **CFKS** a recibir la cantidad adeudada por "Medicare", programa de salud gubernamenta "Medicaid", cualquier otra compania de seguro de salud comercial.

Todos los cargos por estudios de laboratorios ordernados por el proveedor seráan facturados independientemente. Por favor notifique a la enfermera de cualquier requisito especial de laboratorio.

Al firmar este acuerdo, yo autorizo a que **CFKS** me contacte por teléfono utilizando un Sistema automático, por mensajes de texto, correo electrónico, redes sociales ó dejando mensajes directamente en su buzón. Este consentimiento puede ser revocado en cualquier momento a través de un aviso por escrito o respondiendo a través del método de comunicación utilizado por **CFKS**. Tambien consiente a permitir que cualquier proveedor, socio ó afiliado a **CFKS** se comunique con usted en nuestro nombre.

Entiendo que es un delito proporcionar intencionalment información falsa o omitir hechos importantes en este formulario.

Signature / Firma _____ **Date / Fecha** _____

CENTRAL FLORIDA KIDNEY SPECIALISTS

Name/Nombre_____DOB/Fecha de Nacimiento_____
Civil Status / Estado Civil (circle one / circule uno): *Single / Soltero(a)* *Partnered / Convivo* *Married / Casado(a)* *Divorced / Divorciado(a)* *Widowed / Viudo(a)*
Are you retired? /Está usted retirado? Yes/Sí___ No___ Do You work?/Usted Trabaja?_____
Primary Care Physician/Doctor de Cabezera: _____
List all the doctors who treat you/Escriba el nombre de todos los doctors que lo atienden:
_____

PERSONAL HEALTH HISTORY

Past Surgical History/Historial De Cirugias

Year/Año	Surgery Name/Nombre de la cirugía
	Heart Catheterization/Cateterización Del Corazón
	Open Heart/Cirugía De Corazon Abierto
	Appendix Surgery/Cirugía del Apendice
	Gallbladder/Vesícula
	Hysterectomy/Histerectomía
	Carotid Surgery/Cirugía De La Carotida
	Knee Replacement/Reemplazo De Rodillas
	Hip Replacement/Reemplazo De Caderas
	Eye Laser Surgery/Cirugía De Laser
	Kidney Stones Removal/ Remoción De Piedras En El Riñon
	Other_____ _____ _____

Past Medical History/Historial Medico

___High Blood Pressure/Presión Alta
___Strokes/Derrame Cerebral
___ Heart Attack/Ataque al Corazón
___Diabetes/Diabetes
___Insulin/Insulina___Pills/Pastillas
___High Cholesterol/Colesterol Elevado
___Angina/Dolor de Pecho
___Congestive Heart Failure/Insuficiencia Cardiaca
___Lung Disease/Enfermedades del Pulmon
___Prostate Problems/Problemas de la Prostata
___Thyroid Problems/Problemas de la Tiroide
___Seizures/Ataques Epilepticos
___Cancer of_____/Cancer de_____
___Depression/Depresión
___Kidney Stones/Piedras en el Riñon
___Arthritis/Artritis
___Asthma/Asma
___Gastrointestinal Problems/Problemas Gastrointestinal
___Other_____

Allergies to Medication/ Alergias a Medicamentos

Medication Name/Nombre del Medicamento	Reaction/Reacción
1	
2	
3	
4	
5	
6	

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Social History/Historial Social

1. Where were you born? /Donde nació usted? _____
2. Have you ever smoked? Usted Fuma? ___YES/SI___NO
- **If yes**, check one of the following: Everyday____Socially___Past Use___ When did you quit?_____
- **Si usted fuma**, marque uno de los siguientes: A diario?____Socialmente_____¿Cuándo dejó de fumar?
3. Do you consume alcoholic drinks? Usted consume bebidas alcoholicas? YES/SI__NO____
   If yes,how much? Cuánto? _____Type/Tipo_____Frequency/Frecuencia_____
4. Do you drink coffee? /Usted toma café? How many cups?/Cuántas tazas? _____
5. Have you had a blood transfusion? Ha tenido usted una transfusion de sangre? YES/SI__ No_
6. Do you use any illicit drugs? Utiliza drogas ilegales? YES/SI__NO_
   If yes, check one of the following: Present use? __Past use_____What type?____
   Si utiliza, marque una de las siguientes: Utiliza actualmente?__En el pasado?__ Qué tipo?_____

Family History/Historial Familiar

use an X to mark if applicable/marque con una X si aplica

Condition Condición	Father/ Padre	Paternal Grandfather/ Abuelo Paterno	Paternal Grandmother/ Abuela Paterna	Mother/ Madre	Maternal Grandfather/ Abuelo Materno	Maternal Grandmother/ Abuela Materna	Siblings/ Hermanos	Child/ Hijos
High Blood Pressure/ Presión Alta								
Diabetes								
Cardiac Problems Problemas Cardiacos								
Renal Dialysis Diálisis Renal								
Kidney Stones/ Piedras en el riñón								
Alzheimer's Disease								
Pulmonary Disease/ Problemas Pulmonares								
Cancer Type_____								
Other								

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Medication List/Lista de Medicamentos

Patient Name/Nombre de Paciente_____

Pharmacy/Farmacia_____Address/Dirección_____

Pharmacy Phone Number/Teléfono de la Farmacia_____

LIST YOUR MEDICATIONS INCLUDING PRESCRIBED DRUGS, OVER THE COUNTER MEDICATIONS, VITAMINS, AND INHALERS. ENUMERE SUS MEDICAMENTOS, INCLUYENDOS LOS MEDICAMENTOS RECETADOS, VITAMINAS E INHALADORES.		
Name of medications/Nombre del Medicamento	Strength/Dosis	Frequency/Frecuencia
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		

CENTRAL FLORIDA KIDNEY SPECIALISTS

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The patient hereby consents to the use or disclosure or his/her individually identifiable health information (protected health information) and patient medical record information by **CENTRAL FLORIDA KIDNEY SPECIALISTS, Inc.** (the practice) in order to carry out treatment, payment or health care operations. The patient should review the Practice's Notice of Privacy Practices for more complete description of the potential uses and disclosures of such information and the patient has the right to review such Notice priority signing this Consent Form.

The practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the practice does change the terms of its Notice of Privacy Practices, patient may obtain copy of revised Notice.

Patient retains the right to request that the practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment or health care operations. The practice is not required to agree to such requested restrictions; however, if the practice does agree to patients requested restriction(s), such restrictions are then binding on the practice.

Patient acknowledges and agrees that the practice may disclose patients protected health information and patient medical record information to the following individuals who are either the patients family members, legal representatives, guardian, health care surrogates or have power of attorney on behalf of the patient: **(patient must fill out) NAME / RELATIONSHIP:** _____

_____

The patient agrees that the Practice may disclose the following types of information contained in the patients' medical records (please initial, do not check, the appropriate categories listed below):

Restrictions

____ HIV/AIDS Information_____

____Substance Abuse Information_____

____Sexually Transmitted Disease Information_____

____Mental Health Information _____

_____If patient is under the age of eighteen (18), Pregnancy Information_____

Patient agrees and consents to the practice releasing information to patient in the following alternative manners (please initial, do not check the appropriate spaces below):

____ Via e-mail to the Patients designated e-mail address which is: _____

____ Via Regular Mail with any envelopes being marked personal and confidential and addressed to patient.

____ Via Telephone, if patient contacts the practice and provides the appropriate information (including the patients name, social security number and date of birth).

At all times, patient retains the right to revoke this consent. Such revocation must be submitted to the practice in writing. The revocation shall be affective except to the extent that the practice has already taken action in reliance on the consent. If you revoke this consent, Central Florida Kidney Specialists, Inc. will only continue to treat you on an emergency basis and in the case for 30 days.

The practice may refuse to treat patient if he/she (or an authorized representative) does not sign this consent form. If patient (or authorized representative) sign this consent and then revokes it, the practice has the right to refuse to provide further treatment to patient as the time of revocation (except to the extent that the practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I MAY RECEIVE A COPY OF THIS CONSENT AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYNG CONSENT TO THE ABOVE STATED TERMS.

Date: _____ Time: _____AM/PM

_____ _____

Signature of patient / Authorized Representative* Print Name

*Please explain representatives relationship to patient and include a description of representatives authority to act on behalf of the patient. Please attach proof of guardianship with a court document.

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Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting us in writing.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name

(Print) _____

(Signature) _____

Date: _____

Witness: _____