15735 NW 57 AVE
MIAMI LAKES, FL 33014
PH:786-953-5506 FAX: 786-953-5627

Name/ Nombre y Apellido:_____ _____ Sex/Sexo:____ Age/Edad:_____

DOB/Fecha de Nacimiento:_____ SSN/Social Security:_____-_____-_____

Address/Direccion:_____ City/Ciudad:_____

State/Estado: _____ Zip code/ Codigo postal:_____

Race/Raza:_____ Ethnicity/Origen _____ Smoking/Fumas:___ YES ____NO

Language/Lenguaje:_____

Home phone number/Telefono de casa: (_____)_____-_____

Alternate phone number/ Telefono alternativo:(_____) _____-_____

Email/Correo electronico :_____

Emergency Contact name/ contacto de emergencia nombre:_____

Emergency contact phone: (_____) _____-_____

Referred by/ Referido por:_____

I certify that the above information is true and correct to the best of my knowledge. I will not hold my doctor membership of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Yo certifico que la informacion escrita esta correcta, igualmente certifico que llenando esta aplicacion no hare al medico o a ningun miembro de sus empleados responsables por cualquier error cometido por mi.

Signature/Firma del paciente_____ Date/Fecha _____

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HIPPA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.
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 operation. We are not required to agree to this restriction, but if we do, we shall honor that 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. You have the right to revoke this consent, In Writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent the practice provides this form to comply with the Health Insurance Portability/and Accountability Act of 1993 (HIPAA).

That patient understands that:

- ✓ Protected health Information may be disclosed or used for treatment, payment, or healthcare.
  operations,
- ✓ The Practice has a Notice of Privacy Practices, and that the patient has the opportunity to review this.
  notice.
- ✓ The Practice reserves the right to change the Notice of Privacy Practices,
- ✓ The patient has the right to restrict the uses of their information, but the Practice does not have to agree to the restrictions.
- ✓ The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- ✓ The practice may condition receipt of treatment upon the execution of this consent.

This consent was signed by:

_____ _____
Printed Name- Patient or Representative Date

_____
Signature

Relationship to Patent if other than patient):
_____

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Financial Policies & Assignment of Benefits

Financial Policies:

We will need to discuss our fees prior to the beginning of your treatment. Payment of fees for services rendered is expected at the time services are provided. We file insurance as a courtesy to our patients.
However, we do require co-payments to be paid at the time of the service. We accept cash and checks; Refund checks are subject to a $35.00 fee.
Since our profession is based on an appointment schedule, our policy is to charge for missed appointments, unless your appointment is cancelled within 24-48 hours in advance.

Insurance Assignment and Release

I, the undersigned, have insurance coverage and assigned directly to Stay in Step, Spinal Cord Injury Recovery Center., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of his signature on all my insurance submissions. I am responsible for any fees that Stay in Step, Spinal Cord Injury Recovery Center, incurs for the full collections of payments.

_____ _____
Signature of Patient/ Guardian Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me of on my behalf to Stay in Step, Spinal Cord Injury Recovery Center, for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based on the charge determination of the Medicare carrier.

_____ _____
Signature of Patient/ Guardian Date

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Release of Medical Records

The following individual has asked us to request that his or her medical records be released and forwarded to our office:

_____
Patient Name:

_____ _____
Date of Birth: Social Security Number.

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

Thank you for expediting this request. Please send these records to our office address shown above or fax them to (786)953-5627

I hereby authorize the release of all necessary medical records to Dreams Medical Center and wish for them to be forwarded as soon as possible.

_____ _____
Patients Signature Date:
(Or parent if patient is a minor)

_____
Address:

_____ _____ _____
State: Zip: City.

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SOCIAL MEDIA CONSENT/RELEASE FORM

I hereby authorize Dreams Medical Center to use my photo and/or information related to my experiences at Dreams Medical Center. I understand this information may be used in publications, including electronic publications, audiovisual publications, promotional literature, advertising, community presentations, media and/or other similar ways.

My consent is freely given as a public service to Dreams Medical Center without expecting payment. I release Dreams Medical Center and their respective employees, officers, and agents from any and all liability which may arise from the use of such news media stories, promotional materials, written articles, video and/or photographs.

I prefer that:

___My complete name be used.

___My first name only be used.

___No name be used.

I understand that I can revoke this release at any time in writing and that the use of any of my photos or other information authorized by this release will immediately cease.

Please print or type:

_____
Name.

_____
Address:

_____ _____ _____
City State Zip;

(_____)_____-_____
Phone

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AUTORIZACIÓN PARA LA LIBERACIÓN DE REGISTROS MÉDICOS A UN FAMILIAR

Información del Paciente:

Nombre Completo: _____

Fecha de Nacimiento: _____

Número de Teléfono: _____

Familiar Autorizado:

Yo, _____, autorizo a Dreams Medical Center a liberar mis registros médicos al siguiente familiar:

Nombre Completo: _____

Relación con el Paciente: _____

Número de Teléfono: _____

Alcance de la Autorización:

Esta autorización permite la liberación de la siguiente información médica:

☐ Todo el expediente médico

☐ Registros específicos (especifique): _____

Términos y Condiciones:

Entiendo que puedo revocar esta autorización en cualquier momento mediante un aviso por escrito a Dreams Medical Center.

Entiendo que esta autorización no expira a menos que se indique lo contrario a continuación:

Fecha de Expiración (si aplica): _____

Entiendo que, una vez liberada, mi información médica puede no estar protegida bajo las reglas de privacidad de HIPAA.

Firmas:

Firma del Paciente: _____ Fecha: _____

Nombre del Testigo: _____

Firma del Testigo: _____ Fecha: _____

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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS TO A FAMILY MEMBER

Patient Information:

Full Name: _____

Date of Birth: _____

Phone Number: _____

Authorized Family Member:

I, _____, authorize Dreams Medical Center to release my medical records to the following family member:

Full Name: _____

Relationship to Patient: _____

Phone Number: _____

Scope of Authorization:

This authorization allows the release of the following medical information:

☐ Entire medical record

☐ Specific records (specify): _____

Terms and Conditions:

I understand that I may revoke this authorization at any time by providing written notice to Dreams Medical Center.

I understand that this authorization does not expire unless otherwise stated below:

Expiration Date (if applicable): _____

I understand that once released, my medical information may not be protected under HIPAA privacy rules.

Signatures:

Patient Signature: _____ Date: _____

Witness Name: _____

Witness Signature: _____ Date: _____

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HIV AND PREP PROGRAM

Patient Eligibility Questionnaire

Patient Information

- **Patient Name:** _____
- **Date of Birth (DOB):** _____
- **Address:** _____
- **City:** _____ **State:** _____ **Zip:** _____
- **Phone:** _____
- **Alternate Phone:** _____
- **Email:** _____
- **Emergency Contact:** _____

Certain medications weaken the immune system and compromise the body's ability to fight infections. We have partnered with the American Sexual Health Association (ASHA), which specializes in educational services supporting comprehensive preventive care for the transmission of infections such as Tuberculosis, Hepatitis A, B & C, Human Immunodeficiency Virus (HIV), Gonococcal Infection, Acquired Immune Deficiency Syndrome (AIDS), Monkeypox, Syphilis, and other Sexually Transmitted Infections (STIs) that could compromise your treatment and overall health.

We are committed to promoting the overall health, well-being, and sexual health of individuals through a range of services, including STI testing, education, prevention, and regular screenings. These questions aim to provide a comprehensive and personalized approach to care.

Eligibility Questions

1. Have you been sick or been exposed to anyone who has been sick in the past 48 hours?
   Yes [ ] No [ ]
2. Have you been exposed to Syphilis, Gonorrhea, Chlamydia, HIV, or Hepatitis C through social activities, blood transfusions, or needle usage in the recent past?
   Yes [ ] No [ ]
3. Do you have a rash on the palms of your hands or legs that has been present for longer than a month?
   Yes [ ] No [ ]

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4. Do you feel like you could be at risk for HIV, Hepatitis C, or any other infections that could further compromise your immune system?
   Yes [ ] No [ ]
5. Is there any information you feel is important to your care that you want to share today?
   Yes [ ] No [ ] If yes, please provide details:
   _____

Consent and Acknowledgment

American Sexual Health Association (ASHA) and ID Care will continue to monitor your risk of infection throughout your care. ASHA believes that everyone has the right to information and services that will help them be sexually healthy. In that aim, ASHA provides information and resources that are reliable, science-based, and stigma-free. Please find these educational opportunities at www.ashasexualhealth.org.

Patient Signature: _____ **Date:** _____

Clinical Representative: _____

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HIV AND PREP PROGRAM

Cuestionario de Elegibilidad del Paciente

Información del Paciente

- **Nombre del Paciente:** _____
- **Fecha de Nacimiento (DOB):** _____
- **Dirección:** _____
- **Ciudad:** _____ **Estado:** _____ **Código Postal:** _____
- **Teléfono:** _____
- **Teléfono Alternativo:** _____
- **Correo Electrónico:** _____
- **Contacto de Emergencia:** _____

Ciertos medicamentos debilitan el sistema inmunológico y comprometen la capacidad del cuerpo para combatir infecciones. Nos hemos asociado con la Asociación Americana de Salud Sexual (ASHA), que se especializa en servicios educativos que apoyan la atención preventiva integral para la transmisión de infecciones como Tuberculosis, Hepatitis A, B y C, Virus de Inmunodeficiencia Humana (VIH), Infección Gonocócica, Síndrome de Inmunodeficiencia Adquirida (SIDA), Viruela del Mono, Sífilis y otras Infecciones de Transmisión Sexual (ITS) que podrían comprometer su tratamiento y su salud en general.

Estamos comprometidos con la promoción de la salud en general, el bienestar y la salud sexual de los individuos a través de una variedad de servicios, que incluyen pruebas de ITS, educación, prevención y exámenes regulares. Estas preguntas tienen como objetivo proporcionar un enfoque integral y personalizado a la atención.

Preguntas de Elegibilidad

1. ¿Ha estado enfermo o ha estado expuesto a alguien que haya estado enfermo en las últimas 48 horas?
   Sí [ ] No [ ]
2. ¿Ha estado expuesto a Sífilis, Gonorrea, Clamidia, VIH o Hepatitis C a través de actividades sociales, transfusiones de sangre o uso de agujas en el pasado reciente?
   Sí [ ] No [ ]

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3. ¿Tiene una erupción en las palmas de sus manos o piernas que ha estado presente por más de un mes?
   Sí [ ] No [ ]
4. ¿Siente que podría estar en riesgo de contraer VIH, Hepatitis C u otras infecciones que podrían comprometer aún más su sistema inmunológico?
   Sí [ ] No [ ]
5. ¿Hay alguna información que considere importante para su atención que desee compartir hoy?
   Sí [ ] No [ ] Si la respuesta es sí, por favor proporcione detalles:
   _____

Consentimiento y Reconocimiento

La Asociación Americana de Salud Sexual (ASHA) y ID Care continuarán monitoreando su riesgo de infección durante su tratamiento. ASHA cree que todas las personas tienen derecho a información y servicios que les ayuden a mantener una salud sexual óptima. Con ese objetivo, ASHA proporciona información y recursos que son confiables, basados en la ciencia y libres de estigmas. Puede encontrar estas oportunidades educativas en www.ashasexualhealth.org.

Firma del Paciente: _____ **Fecha:** _____

Representante Clínico: _____

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Telehealth Services Informed Consent

Name: _____

Date of Birth (DOB): _____

Date: _____

Definition of Telehealth

Telehealth involves the use of electronic communications to enable professionals to connect with individuals using interactive video and audio technology. Telehealth may include services such as psychological care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transmission of medical and clinical data.

Telehealth Services – Informed Consent

I understand that I have the following rights with respect to telehealth:

1. **Confidentiality**: I understand that privacy and confidentiality laws apply to telehealth services. No information obtained during my telehealth sessions will be disclosed to third parties, including researchers, without my written consent.
2. **Use of Technology**: My healthcare provider has explained how videoconferencing technology will be used. I understand that I will not be in the same room as my provider during the session.
3. **Technology Risks**: I understand that there are potential risks to using telehealth technology, including interruptions, unauthorized access, and technical difficulties. Either I or my provider can discontinue the session if the technology is deemed inadequate.
4. **Right to Withdraw**: I understand that I have the right to withhold or withdraw my consent to telehealth services at any time, without affecting my right to future care or treatment.
5. **Sharing of Information**: I understand that my personal medical information may be electronically communicated to other medical practitioners, who may be located in different regions or states.

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6. **No Guarantees**: I understand that no specific results or benefits from telehealth services are guaranteed.
7. **Participation of Others**: I understand that other individuals may be involved in the session for purposes such as technical support, scheduling, or billing. I will be informed of their presence and have the right to:
    - Request that any non-medical personnel leave the room.
    - Terminate the telehealth session at any time. These individuals are required to maintain confidentiality of the information discussed.
8. **Emergency Situations**: I understand that telehealth is not appropriate for all situations, especially emergencies or crises. In such cases, I will call 911 or seek immediate help from a nearby hospital or crisis center.

Consent to the Use of Telehealth

By signing this form, I certify that:

- I have read, or had this form read and/or explained to me.
- I fully understand the contents, including the risks and benefits of telehealth services.
- I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.

Client Signature: _____

Date: _____