



# **DAMAR MEDICAL CENTER, INC**

## **New Patient Consent for the Use and Disclosure of Health Information. For Treatment, Payment or Health Operations**

I, \_\_\_\_\_ understand that as part of my health care Damar Medical Center, inc. Originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purpose, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Damar Medical Center, Inc. Is not required to agree to the restrictions request. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the code of Federal Regulations.

I further understand that Damar Medical Center, Inc. Reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

Should Damar Medical Center, Inc send a copy of my revised notice to the address I've provided (whether U.S. Mail or, if I agree, email)

I wish to have the following restrictions OR authorization to the use or disclosure of my health information:

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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

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Patient's Signature

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Date

**DAMAR MEDICAL CENTER, INC**

**Authorization for Release of Information for Purposes  
Requested by Physician's Office From Another Covered Entity**

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ATTN: \_\_\_\_\_

**Name of Covered Entity**

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Social Security # \_\_\_\_\_

I authorize you to disclose the following protected health information.

(Specifically describe the information to be disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

TO: **DAMAR MEDICAL CENTER, INC**  
**Dario Altamirano, D.O**

**Fax (305) 820-1943**

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of Damar Medical Center Inc. in the following manner:

(Describe how protected health information will be used to carry out treatment, payment and/or health care operations purposes).

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Print Name of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient

**DAMAR MEDICAL CENTER, INC**

**HEALTH ASSESSMENT**

Name: \_\_\_\_\_ D.O.B \_\_\_\_\_  
Nombre: \_\_\_\_\_ Fecha de Nacimiento: \_\_\_\_\_

Ethnicity/Race/Language \_\_\_\_\_  
Pais de Origen /Raza/Lenguaje de Preferencia \_\_\_\_\_

Medical Problems  Yes  No | If yes, please list.  
Problemas medicos  Si  No | En caso afirmativo por favor escribalo.  
\_\_\_\_\_

Active Medication  Yes  No | If yes, please list.  
Medicacion que esta tomando  Si  No | En caso afirmativo por favor escribalo  
\_\_\_\_\_

Allergies  Yes  No | If yes, please list.  
Alergias  Si  No | En caso afirmativo por favor escribalo.  
\_\_\_\_\_

**Past Medical History / Antecedentes Médicos**  
\_\_\_\_\_  
\_\_\_\_\_

**Surgical History / Antecedentes Quirurgicos**  
\_\_\_\_\_  
\_\_\_\_\_

**Family History/ Historia Familiar**  
\_\_\_\_\_  
\_\_\_\_\_

**Social History/ Historia Social**  
Alcohol use  Yes  No      Tabaco use  Yes  No      Drug use  Yes  No  
Consume Alcohol  Si  No      Fuma  Si  No      Usa Droga  Si  No  
Have you ever been Transfused?  Yes  No  
Ha sido alguna vez Transfundido?  Yes  No

**Procedures / Procedimientos**  
Mammography  Yes  No      Date \_\_\_/\_\_\_/\_\_\_      Pap Smear  Yes  No      Date \_\_\_/\_\_\_/\_\_\_  
Colonoscopy  Yes  No      Date \_\_\_/\_\_\_/\_\_\_  
Bone Density  Yes  No      Date \_\_\_/\_\_\_/\_\_\_      Eye Exam  Yes  No      Date \_\_\_/\_\_\_/\_\_\_

Note: \_\_\_\_\_  
\_\_\_\_\_

Signature (Firma) \_\_\_\_\_ Date \_\_\_\_\_

# **DAMAR MEDICAL CENTER, INC**

## **Missed Appointment Policy**

We are glad you have chosen us to provide your medical care. If you missed your appointments you compromise your care. Annual office visits are required for continuity of care and necessary evaluation of medical care. We want you to be aware of our office policy regarding missed appointments.

A missed appointment is when you fail to show for a schedule appointment without a phone call or prior notification. We strive to be on time for your schedule appointment, as well as respect your time and needs, we ask that you give us the courtesy of a call when you are unable to keep your appointment.

### **Routine Office Visits**

We require 24 hour notice for all routine office visits otherwise a \$20 missed appointment fee will be charged.

1. First missed follow up appointment: We will call and offer to reschedule your appointment. You will be charged a missed appointment fee of \$20
2. Second missed follow up appointment: You will receive written notification of your missed appointment and be charged a fee of \$20
3. Third missed follow up appointment: You will be charged an additional missed appointment fee of \$20. This may also result in a discharge from the practice.

### **Credit Card on File**

I understand that although my insurance may be billed, I am financially responsible for all services and missed appointment fees. I understand that payment in full is due within 30 days of the date of service or from the missed appointment date, and that in the event of my nonpayment and/or a delinquent account my balance, including any fees I am responsible for paying the balance in full before being seen by the Doctor. If I have left a credit card on file, Damar Medical Center INC. will run the balance on my credit card.

**Card Holder Name:** \_\_\_\_\_

**CC#** \_\_\_\_\_ **EXP** \_\_\_\_\_ **CSC** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_