



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last (Apellido) First (Nombre) Middle (Inicial) Month / Day / Year

Age (Edad): \_\_\_\_\_ Sex (Sexo): \_\_\_\_\_ Marital Status: \_\_\_\_\_ Social Security # (Seguro Social): \_\_\_\_\_

Address: \_\_\_\_\_  
(Direccion) City (Ciudad) State (Estado) Zip Code (Codigo Postal)

Home Phone (# de Casa): \_\_\_\_\_ Cell Phone (# de Celular): \_\_\_\_\_

Employer (Patrono): \_\_\_\_\_

Work Phone (# de Trabajo): \_\_\_\_\_ Position (Posicion): \_\_\_\_\_

In case of emergency, what person should be notified? \_\_\_\_\_ Relationship: \_\_\_\_\_  
(A quien llamar en caso de emergencia?) (Nombre) (Relacion)

Phone Number (# de telefono-Dia): \_\_\_\_\_ Evening (# de telefono-Noche): \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Name: \_\_\_\_\_ Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
(Seguro Primario) (# de Poliza) (# de Grupo)

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Asegurador) Last (Apellido) First (Nombre) Middle (Inicial) Month / Day / Year

Age (Edad): \_\_\_\_\_ Sex (Sexo): \_\_\_\_\_ Marital Status: \_\_\_\_\_ Social Security # (Seguro Social): \_\_\_\_\_

Address: \_\_\_\_\_  
(Direccion) City (Ciudad) State (Estado) Zip Code (Codigo Postal)

Home Phone (# de Casa): \_\_\_\_\_ Cell Phone (# de Celular): \_\_\_\_\_

Employer (Patrono): \_\_\_\_\_ Work Phone (# de Trabajo): \_\_\_\_\_ Job Position (Posicion): \_\_\_\_\_

Relationship to patient (Relacion):  Self (Yo)  Spouse (Esposo/a)  Child (Hijo/a)  Other (Otro)

Secondary Insurance Name: \_\_\_\_\_ Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
(Seguro Secundario) (# de Poliza) (# de Grupo)

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Asegurador) Last (Apellido) First (Nombre) Middle (Inicial) Month / Day / Year

Age (Edad): \_\_\_\_\_ Sex (Sexo): \_\_\_\_\_ Marital Status: \_\_\_\_\_ Social Security # (Seguro Social): \_\_\_\_\_

Address: \_\_\_\_\_  
(Direccion) City (Ciudad) State (Estado) Zip Code (Codigo Postal)

Home Phone (# de Casa): \_\_\_\_\_ Cell Phone (# de Celular): \_\_\_\_\_

Employer (Patrono): \_\_\_\_\_ Work Phone (# de Trabajo): \_\_\_\_\_ Job Position (Posicion): \_\_\_\_\_

Relationship to patient (Relacion):  Self (Yo)  Spouse (Esposo/a)  Child (Hijo/a)  Other (Otro)

**Please read the following and sign in the space provided**

I understand that all fees or charges are payable at the time the professional services are given. I authorize my insurance carrier to pay for these services and I agree to pay for charges not covered by insurance. I authorized **Primary HealthCare Associates, Inc.** to release any medical information upon the request of my Health Insurance Company.

Entiendo que de haber algun cargo se cobrara en el momento del dia de la cita. Yo autorizo a mi compañía de seguros para pagar por estos servicios y estoy de acuerdo en pagar los gastos no cubiertos por el seguro. Yo autorizo a **Primary HealthCare Associates, Inc.**, proveer cualquier información médica a petición de mi compañía de seguros de salud.

\_\_\_\_\_  
Signature of Patient (Firma)

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date (Fecha)



# Advance Directives Statement

Florida lawmakers have expressed concern about the number of people in this state who lack the capacity to make decisions about their health care. These people may not have family or a guardian who can make decisions for them. Therefore, a new law has been enacted which requires hospitals to ask the following questions:

(Los legisladores de Florida han expresado su preocupación por el número de habitantes de este estado que carecen de la capacidad necesaria para tomar decisiones acerca de su cuidado de la salud. Estas personas pueden no tener familia o un tutor que pueden tomar decisiones por ellos. Por lo tanto, se ha promulgado una nueva ley que requiere que los hospitales hagan las siguientes preguntas):

1. Do you have a Living Will? (Tienes un testamento de vida?)

Yes (Si)     No    If Yes, please provide us with a copy. (Si tienes un testamento, por favor traer copia.)

2. Do you have Durable Power of Attorney? (Tiene un poder legal duradero? Si tienes, por favor traer copia)

Yes (Si)     No    If Yes, please provide us with a copy (Si tienes, favor traer copia copia.)

3. Have you completed a legal document designating anyone (other than your family or a guardian) to make health care decisions for you, in the event you were incapacitated and could not make them yourself?

(Tiene algun documento legal asignando a alguien (a otra persona además de su familia) para tomar decisiones medicas por usted, en el caso de que usted se encuentre incapacitado para tomarlas?)

Yes (Si)     No    If Yes, who? (Si tiene, quién es?)

Name (Nombre): \_\_\_\_\_ Phone (Telefono): \_\_\_\_\_

4. Is this person aware of your choice? (Esta persona esta de acuerdo con su decision?)

Yes (Si)     No

\_\_\_\_\_  
Patient's Signature or Patient's Representative  
(Firma del paciente o representante del paciente)

\_\_\_\_\_  
Date  
(Fecha)

\_\_\_\_\_  
Printed Name of Patient's Representative  
(Escribir nombre del representante del paciente)

\_\_\_\_\_  
Relationship to Patient  
(Relación con paciente)

## What are Advance Directives?

A living will allows you to document your wishes concerning medical treatments at the end of life.

### **Before your living will can guide medical decision-making two physicians must certify:**

- You are unable to make medical decisions,
- You are in the medical condition specified in the state's living will law (such as "terminal illness" or "permanent unconsciousness"),
- Other requirements also may apply, depending upon the state.

A medical power of attorney (or healthcare proxy) allows you to appoint a person you trust as your healthcare agent (or surrogate decision maker), who is authorized to make medical decisions on your behalf.

### **Before a medical power of attorney goes into effect a person's physician must conclude that they are unable to make their own medical decisions. In addition:**

- If a person regains the ability to make decisions, the agent cannot continue to act on the person's behalf.
- Many states have additional requirements that apply only to decisions about life-sustaining medical treatments.
- For example, before your agent can refuse a life-sustaining treatment on your behalf, a second physician may have to confirm your doctor's assessment that you are incapable of making treatment decisions.

### **What Else Do I Need to Know?**

- Advance directives are legally valid throughout the United States. While you do not need a lawyer to fill out an advance directive, your advance directive becomes legally valid as soon as you sign them in front of the required witnesses. The laws governing advance directives vary from state to state, so it is important to complete and sign advance directives that comply with your state's law. Also, advance directives can have different titles in different states.
- Emergency medical technicians cannot honor living wills or medical powers of attorney. Once emergency personnel have been called, they must do what is necessary to stabilize a person for transfer to a hospital, both from accident sites and from a home or other facility. After a physician fully evaluates the person's condition and determines the underlying conditions, advance directives can be implemented.
- One state's advance directive does not always work in another state. Some states do honor advance directives from another state; others will honor out-of-state advance directives as long as they are similar to the state's own law; and some states do not have an answer to this question. The best solution is if you spend a significant amount of time in more than one state, you should complete the advance directives for all the states you spend a significant amount of time in.
- Advance directives do not expire. An advance directive remains in effect until you change it. If you complete a new advance directive, it invalidates the previous one.
- You should review your advance directives periodically to ensure that they still reflect your wishes. If you want to change anything in an advance directive once you have completed it, you should complete a whole new document.

### **For more information please visit:**

<https://floridahealthfinderstore.blob.core.windows.net/documents/reports-guides/documents/HealthCareAdvanceDirectives-English.pdf>



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**ACUSE DE RECIBO DEL AVISO DE PRÁCTICAS DE PRIVACIDAD**

Notice to Patient (Aviso al Paciente):

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

(Le proveemos una copia de nuestro Aviso de Prácticas de Privacidad, donde podemos usar y/o divulgar su información médica. Favor de firmar este formulario donde a firma que recibo esta Comunicado. Usted puede negarse a firmar este formulario, si lo desea.)

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.  
(Yo reconozco que he recibido una copia de la notificación de Prácticas de Privacidad.)

\_\_\_\_\_  
*Please print your name here (Nombre)*

\_\_\_\_\_  
*Signature (Firma)*

\_\_\_\_\_  
*Date (Fecha)*

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (*Please provide specific details*)

\_\_\_\_\_  
**Employee signature**

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



**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION.**

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.  
(YO AUTORIZO EL USO O DIVULGACIÓN DE INFORMACIÓN DE SALUD ACERCA DE MÍ COMO SE DESCRIBE A CONTINUACIÓN)

Patient Name (Nombre del Paciente): \_\_\_\_\_

Date of Birth (Fecha de Nacimiento): \_\_\_\_\_ Patient's SSN (# Seguro Social): \_\_\_\_\_

A. Person(s) or Organization(s) authorized to provide the information (Las personas o las organizaciones autorizadas a suministrar la información): **PRIMARY HEALTHCARE ASSOCIATES, INC.**

B. Person(s) or Organization(s) authorized to receive the information (Personas o organizaciones autorizada a recibir la información):

C. Specific description of the information that may be used or disclosed (including date(s)) (Descripción específica de la información que puede ser usada o revelada):

D. Specific description of how the information will be used (Descripción específica de la forma en que la información se utilizará):

- 1) I understand that this authorization will **expire** on *(Entiendo que esta autorización caducará en)* \_\_\_\_\_.
- 2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying **PRIMARY HEALTHCARE ASSOCIATES, INC.** in writing. *(Entiendo que puedo revocar esta autorización en cualquier momento mediante notificación a PRIMARY HEALTHCARE ASSOCIATES, INC. por escrito.)*
- 3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable). *(Entiendo que se me puede negarse a firmar esta autorización y que mi negativa no afectará mi capacidad de obtener tratamiento, pago o mi elegibilidad para beneficios (si procede)).*
- 4) I may **inspect or copy** any information used or disclosed under this agreement. *(Puedo verificar o copiar cualquier información utilizada o divulgada bajo este contrato.)*
- 5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations. *(Entiendo que si la persona o la organización que recibe la información no es un proveedor de servicios de salud o plan de normas federales de privacidad, la información descrita anteriormente puede ser redisclosed por lo que ya no estaría protegido por este reglamento.)*

\_\_\_\_\_  
Patient's Signature or Patient's Representative  
(Firma del paciente o representante del paciente)

\_\_\_\_\_  
Date  
(Fecha)

\_\_\_\_\_  
Printed Name of Patient's Representative  
(Escribir nombre del representante del paciente)

\_\_\_\_\_  
Relationship to Patient  
(Relación con paciente)

**NOTE:**

You have the right to know specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information.").

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information (e.g., the names of your health care provider(s)).

You have the right to know who is going to use it and what it is going to be used for. (e.g., John Smith, PhD / Research)

**YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM \*USTED TIENE EL DERECHO DE RECIBIR UNA COPIA DE ESTE FORMULARIO**

**HIPAA Authorization for Release of Information**

*This form does not constitute legal advice and covers only federal, not state, laws.*