René F. Cruz, M.D.

Family Practice SPECIALISTS

PATIENT INFORMATION

DATE _____

Patient's Last Name _____ First Name _____ Middle Name _____

Suffix _____ Gender: q Male q Female Social Security Number _____ Date of Birth _____

Race _____ Ethnic Group: q Hispanic q Non-Hispanic q Unknown Preferred Language _____ Marital Status _____

Mailing Address _____ Country _____ Zip Code _____ City _____ State _____ County ___

Home Address _____ Country _____ Zip Code _____ City _____ State _____ County ___

Home Ph.(___) _____ Cell Ph. (___) _____ Work Ph. (___) _____ Ext ____ Email Address _____

Primary Care Physician _____ Referring Physician _____

Employment Status q Full-Time q Part-Time q Retired Retired Date _____

Employer _____ Occupation _____

WHO IS FINANCIALLY RESPONSIBLE FOR THE PATIENT (GUARANTOR)

Self _____ Spouse _____ Parent _____ Other _____ Gender _____

Last Name _____ First Name _____ Middle Name _____

SSN _____ Date of Birth _____ Home Ph.(___) _____ Cell Ph. (___) _____ Work Ph. (___) _____

Street Address _____ Country _____ Zip Code _____ City _____ State _____

Employment Status q Full-Time q Part-Time q Retired Retired Date _____

Employer Name _____

Policy Holder Information (if Different from Patient). If same as responsible, please check here q

Self _____ Spouse _____ Parent _____ Other _____ Gender _____

Last Name _____ First Name _____ Middle Name _____

SSN _____ Date of Birth _____ Home Ph.(___) _____ Cell Ph. (___) _____ Work Ph. (___) _____

Street Address _____ Country _____ Zip Code _____ City _____ State _____

Employment Status q Full-Time q Part-Time q Retired Retired Date _____

Employer Name _____

Emergency Contact (Parent / Guardian if patient is a minor)

Name _____ Relationship _____

Home Ph.(___) _____ Cell Ph. (___) _____ Work Ph. (___) _____

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE READY FOR THE RECEPTIONIST. PAYMENT FOR PROFESSIONAL SERVICES IS DUE AND PAYABLE WHEN SERVICE IS RENDERED.

CONSENT FOR EVALUATION OR TREATMENT

The undersigned hereby consents to evaluation or treatment the assigned healthcare provider may deem necessary to the patient name above.

PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE DATE

INSURANCE ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Family Practice Specialists. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

PATIENT SIGNATURE DATE

FOR MEDICARE PATIENTS ONLY
MEDICARE PART B SIGNATURE AUTHORIZATION – LIFETIME

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

PATIENT NAME PATIENT SIGNATURE

MEDICARE B # DATE

ADVANCE DIRECTIVE

I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my care givers to the extent permitted by law. Please check one of the following statements:

( ) I HAVE executed an Advance Directive.
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)

Please provide copies of Advance Directive/Living Will to the receptionist to be included in your medical record.

( ) I HAVE NOT executed an Advance Directive.
(Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.)

SIGNATURE DATE

René F. Cruz, M.D.
Family Practice
SPECIALISTS

Written Acknowledgement of Receipt
Of Family Practice Specialists' Notice of Patient Privacy Practices

By signing this Written Acknowledgement, I hereby expressly acknowledge my receipt of FPS's Notice of Patient Privacy Practices.

_____
Patient, or Legal Representative, Signature

_____
Printed Patient, or Legal Representative Name

_____
Relationship to Patient

_____
Date

Acknowledgement **NOT** obtained because:

_____Patient, or legal representative, declined to accept Notice of Patient Privacy Practices:

_____Patient received Notice of Patient Privacy Practices, but refused to sign Acknowledgement.

_____Other (briefly describe) _____

_____
Employee Signature

_____
Employee Printed Name

_____
Date

COMMUNICATION
USE AND DISCLOSURE AUTHORIZATION

Section A: Please complete the following information for all requests

1. Today's date: _____
2. Patient name: _____
3. Date of Birth: _____ 4. Patient #: _____
5. Address: _____

I hereby request the following regarding the use of my PERSONAL HEALTH INFORMATION:

1. You may leave the following messages on answering machines:
   - q Referral Information
   - q Prescription refill information
   - q Test results
   - q Other: _____
2. You may discuss information regarding my treatment and care with the following family members and/or friends:

   _____

   _____

   _____
3. You may contact me regarding my treatment and care at the following numbers:

   _____

   _____

   _____

_____ _____

Signature of Patient or Guardian Date

_____

Signature of Staff Person and Title

_____

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Family Practice

SPECIALISTS

IN EFFORT TO BETTER SERVE OUR PATIENTS, WE ARE REQUIRING A 24-HOUR ADVANCE NOTICE, IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT.

I understand the importance of keeping my scheduled appointment and agree to notify the office at leas 24-hours in advance, if I am unable to keep it. I also understand that if I do not give the required notice may be charged a fee of $50.00.

Patient _____ **Witness**

Date:_____