Patient demographic form

TODAY'S DATE ____________

NAME ________________________ BIRTHDAY ____________ AGE __________
PLEASE USE FULL NAME (NO NICKNAMES)

ADDRESS ________________________ HOME PHONE # (____) ____________

________________________ ZIP ________ CELL PHONE # (____) ____________

E-MAIL ADDRESS ________________________ Circle: SINGLE MARRIED WIDOW DIV SEP

OCCUPATION ________________ HOW WERE YOU REFERRED HERE ? ____________

BUSINESS NAME AND ADDRESS ________________________

________________________ PHONE # (____) ____________

IF MARRIED, HUSBAND'S NAME ________________ OCCUPATION ____________

HIS BUSINESS NAME & ADDRESS ________________________

________________________ PHONE # (____) ____________

NAME AND ADDRESS OF CLOSEST RELATIVE ________________________
(except husband)

____

relationship to you ________________ PHONE # (____) ____________

PRIMARY INSURANCE POLICY INFORMATION

Company - ________________ Policy # - ________________

Group # - ____________ Policyholder's name: ____________ DOB: ________

SECONDARY INSURANCE POLICY INFORMATION (Please print "NONE" if you are covered by only one policy)

Company - ________________ Policy # - ________________

Group # - ____________ Policyholder's name: ____________ DOB: ________

YOUR SOCIAL SECURITY # ________________ DRIVER's LICENSE # ________________

GUARANTEE OF PAYMENT

I fully understand that I am directly responsible for payment to Pelaez & Apollon,&Karsenti MDs, LLC. for all medical and surgical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay for all collection costs, including reasonable attorney's fees and costs, in the event that it becomes necessary to file suit to effect payment or to engage the services of a collection agency.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purposes of processing any insurance claims.

ASSIGNMENT OF INSURANCE BENEFITS

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to Pelaez & Apollon,Karsenti MDs, LLC. for medical or surgical treatment received by me. In this circumstance I understand that I am financially responsible for any charges not covered by insurance.

MALPRACTICE INSURANCE

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. We, the physicians in this office, have decided not to carry malpractice insurance. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

[version 7-3-2003]

____
signature

DO NOT WRITE IN THIS BOX

Current as of : ______ ______ ______ ______ ______ ______ ______ ______ ______

HIPPA CONFIDENTIAL
COMMUNICATION REQUEST FORM

Miami MDs for Women
Obstetrics and Gynecology

Pelaez, Apollon & Karsenti, MDs LLC
Annette K. Pelaez, M.D., F.A.C.O.G.
K. Magalie Apollon, M.D., F.A.C.O.G.
Rebecca F. Karsenti, M.D., F.A.C.O.G.

Confidential Communications Request Form

Date: ______________________

I, ______________________________, request confidential communication of my health information when my health information is disclosed on my behalf.

- I have received the HIPAA Notice of Privacy Practices.

Please use the following address or manner in disclosing my health information to me.
Please list any and all people that we are allowed to release your medical information to.

(For example: Wife/name, husband/name, daughter-son/name.)
Please be as specific as possible.

____

____

____

- No One____

Printed name: ____________________________

Date of birth: ____________________________

Patient signature: ________________________

Effective date: ___________________________

7400 Southwest 87th Avenue • Suite 120 B • Miami, Florida 33173 • Phone: 305-630-4100 • Fax: 305-275-6450

HIPPA NOTIFICATION OF PRIVACY

HIPAA Notice of Privacy Practices

Effective Date: November 3, 2009

Pelaez, Apollon, & Karsenti MDs. LLC
Dr. Annette K. Pelaez , Dr. K. Magalie Apollon, Dr. Rebecca F. Karsenti

If you have any questions about this notice, please contact: Privacy Officer, Drs., Pelaez, Apollon, & Karsenti 8900 SW 117th Avenue, Suite 202-B, Miami, Florida 33186.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR OBLIGATIONS: We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to: Privacy Officer, Drs. Pelaez, Apollon,& Karsenti 8900 SW 117th Avenue, Suite 202-B, Miami, Florida 33186.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to: Privacy Officer, Drs. Pelaez, Apollon, & Karsenti 8900 SW 117th Avenue, Suite 202-B, Miami, Florida 33186

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to: Privacy Officer, Drs. Pelaez, Apollon, & Karsenti 8900 SW 117th Avenue, Suite 202-B, Miami, Florida 33186

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Privacy Officer, Drs. Pelaez, Apollon & Karsenti 8900 SW 117th Avenue, Suite 202-B, Miami, Florida 33186. *We are not required to agree to your request.* If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to: Privacy Officer, Drs. Pelaez, Apollon & Karsenti 8900 SW 117th Avenue, Suite 202-B, Miami, Florida 33186. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice contact Privacy Officer, Drs. Pelaez, Apollon, & Karsenti 8900 SW 117th Avenue, Suite 202-B, Miami, Florida 33186.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact: Privacy Officer, Drs. Pelaez, Apollon, & Karsenti 8900 SW 117th Avenue, Suite 202-B, Miami, Florida 33186. All complaints must be made in writing. You will not be penalized for filing a complaint.

E-mail Consent & Acknowledgment Form

The LLC and its Staff Members shall be referred to throughout this consent form as "Provider".

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
h. E-mail can be used to introduce viruses into the computer system.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
e. It is the patient's responsibility to follow-up and/or schedule an appointment.

E-mail Consent & Acknowledgment Form

3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS:

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.
b. Inform Provider of changes in his/her e-mail address.
c. Confirm that he/she has received and read the e-mail from the Provider.
d. Put the patient's name in the body of the e-mail.
e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).
f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
g. Withdraw consent only by e-mail or written communication to Provider.

4. TERMINATION OF THE E-MAIL RELATIONSHIP

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (Print) : ______________________________

Patient Signature : ______________________________ Date : ______________

Patient Email: ____