INTEGRATED Sleep Care

New Patient Encounter Form
(Información de la Primera Visita del Paciente)

Basic Information /Información Básica

First Name / Primer Nombre	Middle Name / Segundo nombre	Last Name / Apellido

Date of Birth / Fecha de Nacimiento: ____ ____ ____ (Month/Mes Day / Día Year / Año)

Gender / Sexo: Female/Mujer ☐ Male/Hombre ☐

SSN / Numero de Seguro Social : ____ ____ ____

Driver's License # / No. de Identificación: ____

Contacto Información / Información de Contacto

Home Phone / Teléfono de la Casa ____ ____ ____

Cell Phone / Teléfono celular: ____ ____ ____

Email / Correo electrónico: ____

Home Address / Dirección Personal

Street ____

City / Ciudad: ____ State/Estado ____ Zip ____

Demographic Information / Información Demográfica

☐ Hispanic / Hispano ☐ Non-Hispanic / No Latino

Preferred Language /Idioma preferido ____

Race/ Raza: ☐ Caucasian / Caucásico ☐ African American / Africano o Africoamericano

☐ Asian / Asiático ☐ Native American / Nativo Americano

☐ Other / Otro

Additional Patient Information / Información Adicional

Ocupation / Ocupación : ____

Marital Status/ Estado Civil: ____

How did you hear about our office / Como supo de nuestra practica? ____

Primary Care Physician / Medico Primario ____ ____ ____

DME Company / Compañía que le suministra el CPAP: ____

Pharmacy / Farmacia: ____ Phone: ____

Insurance Information / Informacion del Seguro

Uninsured Self Paid / Sin Seguro medico: Yes/ Si ☐ No ☐

Name of Insurance / Nombre de Seguro: ____

Member ID: ____ Group ID: ____

Name of the Insured Person / Nombre de la persona asegurada: ____

Insured SSN / Seguro social del asegurado: ____ Insured DOB ____

Emergency Contact Information / Persona a contactar en caso de emergencia

Name /Nombre: ____

Relationship / Relacion: ____

Cell / Celular: ____

Purpose of the Visit / Motivo de Consulta

____

Medical History and Year of Diagnosis / Historia Medica pasada y Año de Diagnostico

Surgeries Since Birth and Year of Procedure / Cirugia desde el Nacimiento y Año del Procedimiento

Medications / Medicinas	Dose / Dosis	How Often

Allergies / Alergias

Smoking History / Historia de Fumar

- ☐ Current Tabaco user / Fumador — For how many years / Cuantos años
- How many cigaretes per day / Cuantos cigarrillos al día
- ☐ Former Smoker / Ex fumador — For how many years / Cuantos años
- How many cigaretes per day / Cuantos cigarrillos al día
- Year you quit smoking / Año en el que dejo de fumar
- ☐ Never Smoked / Nunca ha fumado

Alcohol History / Historia de consumo de Alcohol

- ☐ Current Drinker / Consumidor de alcohol
- How many drinks per day / Cuantas bebidas por días
- ☐ Former drinker / Ex-consumidor de alcohol
- ☐ Never Consumed alcohol / No ha consumido alcohol

Drug History / Historia de consumo de drogas

- ☐ Current drug user / consumidor de drogas actual
- ☐ Former drug user / Exconsumidor de drogas
- ☐ Never Consumed drugs / No ha consumido drogas

Family Medical History / Historia de Enfermedades en su familia

- ☐ Nothing significant / Nada importante
- ☐ Unknown / Desconocida

Mother / Madre	
Father / Padre	
Siblings / Hermanos	

Preventive Care / Cuidado Preventivo (Most recent date / Indique la fecha mas reciente)

Flue shot / Vacuna del flu		Penumonia Shot/ Vacuna contra la neumonia	
PAP smear / Papanicolaou		Mammogram / Mamografía	
Colonoscopy / Colonoscopia		Cholesterol Test / Examen de colesterol	
HIV Test		Prostate Level exam / examen del nivel de la próstata	
Sleep Study / Estudio del sueño			

Review of Systems / Revisión de Síntomas Generales

Have you had any of the following in the last 2 weeks ? / Ha tenido alguno de estos sintomas en las ultimas dos semanas?

Symptoms / Sintomas	Yes/Si	No	Symptoms / Sintomas	Yes/Si	No
Fever / Fiebre			Fatigue / Fatiga		
Loss of Appetite / Perdida del apetito			Chills / Escalofríos		
Night Sweats / Sudoración nocturna			Weight Loss / Perdida de peso		
Eyes / Ojos					
Pain / Dolor =			Visual Loss / Perdida de la vision		
Blurred Vision / Vision Borrosa			Discharge / Secreciones		
Ear Nose and Throat / Oidos, Nariz y Garganta					
Hoarseness / Ronquera			Nose discharge / Secreciones nasales		
Nose Bleed / Sangrado por la nariz			Earache / Dolor de oído		
Ear discharge/ Secrecion por el oido			Sore Throat/ Dolor de garganta		
Hearing Loss / Perdida de la audición					
Cardiovascular					
Inability to sleep flat / No puede dormir plano			Leg Swelling / Hinchazón en las piernas		
Chest Pain / Dolor de pecho			Palpitations / Palpitaciones		
Respiratory / Respiratorio					
Shortness of Breath / Dificultad para respirar			Sputum production/ Secreción con tos		
Wheezing / Sibilancias o pitos al respirar			Cough / Tos		
Coughing blood / Tos con sangre					
Gastrointestinal					
Nausea			Abdominal Pain / Dolor abdominal		
Diarrhea / Diarrea			Incontinence / Incontinencia		
Difficulty Swallowing / Dificultad para tragar			Constipation / Estreñimiento		
Rectal bleeding / Sangrado rectal			Vomiting / Vomito		
Genitourinary					
Difficult Urination/Dificultad para orinar			Blood in the urine / Sangre en la orina		
Pain with Urination/Dolor al orinar			Incontinence / Incontinencia		
Make effort to Urinate/Esfuerzo para orinar			Vaginal Bleeding/Sangrado vaginal		
Vaginal discharge/Secreción vaginal					
Musculoskeletal					
Muscle pain / Dolor muscular			Neck Pain / Dolor en el cuello		
Joint pain / Dolor en las articulaciones			Swollen Joints / Inflamación en las articular		
Skin					
Bleeding / Sangrado			Bruising / Moretones		
Open wounds / Heridas abiertas			New moles/ Lunares nuevos		
Neurologic					
Loss of Consciousness/ Perdida del conocimiento			Numbness / Adormecimiento		
Depression / Depresión			Hallucinations / Alucinaciones		
Endocrine					
Very thristy / Mucha sed			Very hungry / Mucha Hambre		
Urinating a lot / Orinando mucho			Uncontrolled sugar / Azúcar descontrolada		
Headache / Dolores de Cabeza			Seizures /Convulsiones		

Signature / Firma _____ Date: _____

Print Name _____

INTEGRATED Sleep Care

Jose F. Ramirez, M.D., F.C.C.P.
Board Certified in Internal Medicine,
Pulmonary, Critical Care and Sleep Medicine.

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (Including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of any given right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restrictions. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____
Signature: Patient or Guardia Relationship to Patient

_____
Print Name

_____
Date

14601 SW 29th ST Suite 109, Miramar FL 33027
Phone: 954-289-6106 ~ Fax: 954-3376101
www.integratedsleepcare.com ~ info@integratedsleepcare.com

AUTHORIZATION FOR RELEASE OF RECORDS

TODAY'S DATE: Month / Mes _____ Day / Dia _____ Year / Año _____

PATIENT'S NAME / NOMBRE

_____

First Name / Primer Nombre Middle Name / Segundo nombre Last Name / Apellido

DATE OF BIRTH: Month / Mes _____ Day / Día _____ Year / Año _____

SSN # : _____

I, _____ , HEREBY AUTHORIZE _____

TO RELEASE ALL OF MY RECORDS, WHICH INCLUDES: MEDICAL HEALTH STATEMENTS, INITIAL EVALUATION NOTE, LAST FOLLOW-UP NOTE, PFT RESULTS, SLEEP STUDIES, PATHOLOGY REPORTS AND RADIOLOGY TEST TO:

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I understand and acknowledge that this may include treatment for physical and mental illness, alcohol / drug abuse, and or HIV / AIDS test results and diagnosis. Your health care (or payment for care) will not be affected whether or not your sign this authorization. Once your health care information is released, the disclosure of your health care information by the recipient may no longer be protected by law.This authorization and consent will expire one year from the date of authorization written below. You can also request a copy of this authorization. Additionally, you may revoke this authorization at any time by submitting a written request to this office. Your revocation will be honored except to the extent the action has been taken there on.

PATIENT OR LEGAL GUARDIAN *: _____

SIGNATURE : _____ **DATE** _____

PRINT NAME: _____

WITNESS: _____

PRINT NAME: _____

***** If other than the patient's signature, a copy of the legal paperwork verifying the patient's personal representative MUST accompany request (i.e. Court appointed guardian, durable power of attorney for health care). Exception: Parent signing for a patient under the age of eighteen. For a deceased patient a court order must accompany an authorization signed by the named individual.

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RECEIPT OF RIGHT TO REVIEW THE PRIVACY PRACTICE

I, _____have been given the right to receive and review a copy of the Integrated Sleep Care Inc, / Jose F Ramirez, M.D. privacy practice forms.

_____
Signature: Beneficiary / Legal Guardian

_____
Date

RECIBO DEL DERECHO A REVIZAR LA FORMA DE PRIVACIDAD DE LA PRACTICA

Yo, _____ confirmó que se me ha dado el derecho de recibir y revisar la forma de privacidad de la practica: Integrated Sleep Care Inc, / Jose F Ramirez M.D.

_____
Signature: Beneficiary / Legal Guardian

_____
Date

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FINANCIAL POLICIES

Payment of fees for the services rendered is expected at the time services are provided. We bill insurances directly. However, we do require co-pay, co-insurance and deductible to be paid at the time of the services. We accept personal checks, cash and credit cards. Return checks are subject to a $ 25 fee.

If you are unable to cancel a scheduled appointment within 24 hours you will be charged a $ 35.00 dollar no show fee.

Patient's Initials: _____

INSURANCE ASSIGMENT AND RELEASE

I,_____the undersigned, have insurance coverage and assign directly to Integrated Sleep Care, Inc. / Jose F Ramirez, M.D., 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 authorized the doctor(s) / medical company 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 Integrated Sleep care Inc. / Jose F Ramirez M.D., incurs for the full collection of payments.

INSURANCE PAYMENT AUTHORIZATION

I request that payments of medical benefits be made to me or on my behalf to Integrated Sleep Car Inc., / Jose F Ramirez, M.D., for any services furnished by that doctor / group. I authorize any holder of medical information about me to release it to the health care financial administration and his agents to determine benefits or the benefits payable to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim form 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: Beneficiary / Legal Guardian Relationship

_____ _____

Print Name Date

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