Kendall Family Medical Center

What to expect during your visit al Kendall Family Medical Center

- The first visit to Kendall Family Medical Center requires a comprehensive evaluation that will take about one and a half hours. Your visit may take longer if you have a complex health situation.

- Things that would be helpful to bring include your photo identification card, insurance card, medication list and any prior records if available.

- Once you have checked in, you will be greeted by a Medical Assistant or Physician Assistant who will begin your work up. During this time the medical assistant will weigh you and check all your vital signs and he/she will ask you questions about your medical history, current medications, refills and problems prior to being seen by the physician.

- After all your information is completed you will be ready to meet your physician, who will have all of your test results available. The process completed at your visit prior to seeing the physician allows him to review your records, reach a diagnosis, and discuss a plan of treatment on that visit.

- At check-out please ask for a copy of today's visit.

Should you have any questions during your visit, you may speak to any of the Medical Assistant or clinical staff available. Thank you for choosing Dr. Hector Delgado DO PA as your primary care physician.

Kendall Family Medical Center

KENDALL FAMILY MEDICAL CENTER

9220 SW 72 ND STREET * SUITE 202 * MIAMI, FL 33173

(305)279-0111

WITH MY CONSENT **HECTOR M DELGADO DO PA** MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT ME TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (TPO). PLEASE REFER TO

HECTOR M DELGADO DO PA NOTICE OF PRIVACY PRACTICES

FOR A COMPLETE DESCRIPTION OF SUCH USES AND DISCLOSURES.

I HAVE THE RIGHT TO REVIEW THESE POLICIES PRIOR TO SIGNING THIS CONSENT. HECTOR M DELGADO DO PA RESERVES THE RIGHT TO REVISE ITS NOTICE OF PRIVACY PRACTICES AT ANYTIME. A REVISED NOTICE MAY BE OBTAINED BY FORWARDING A WRITTEN REQUEST TO PRIVACY OFFICER AT (HECTOR M DELGADO DO PA)

WITH MY CONSENT, HECTOR M DELGADO DO PA MAY CALL MY HOME AND OR OTHER DESIGNATED LOCATIONS AND LEAVE A MESSAGE ON VOICE MAIL OR IN PERSON IN REFERENCE TO ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUT TPO SUCH AS APPOINTMENT REMINDERS, INSURANCE ITEMS, AND ANY CALLS PERTAINING TO MY CLINICAL CARE INCLUDING LABORATORY RESULTS AMONG OTHERS.
WITH MY CONSENT HECTOR M DELGADO DO PA MAY MAIL, EMAIL AND COMMUNICATE TO MY HOME OR OTHER DESIGNATED LOCATION THAT MAY ASSIST THE PRACTICE IN CARRYING OUT TPO, SUCH AS REMINDER CARDS, RESULT CARDS AND PATIENT STATEMENTS AS LONG AS THEY ARE MARKED PERSONAL AND CONFIDENTIAL.

I HAVE THE RIGHT TO REQUEST THAT HECTOR M DELGADO DO PA RESTRICT HOW IT USES OR DISCLOSES MY PHI TO CARRY OUT TPO. HOWEVER THE PRACTICE IS NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF IT DOES IT IS BOUND BY THIS AGREEMENT.
BY SIGNING THIS FORM, I CONSENT TO HECTOR M DELGADO DO PA USE AND DISCLOSURE OF MY PHI TO CARRY OUT TPO.

I MAY REVOKE MY CONSENT IN WRITING EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ALREADY MADE DISCLOSURES IN RELIANCE UPON MY PRIOR CONSENT.
IF I DO NOT SIGN THIS CONSENT, HECTOR M DELGADO DO PA MAY DICLINE TO PROVIDE TREATMENT TO ME.

_____	_____
PRINT PATIENT NAME	SIGNATURE

_____	_____	_____
PRINT LEGAL GUARDIAN	RELATIONSHIP	SIGNATURE
_____		___/___/___
WITNESS		DATE

Kendall Family Medical Center

PATIENT INSURANCE INFORMATION
HECTOR M DELGADO DO PA
FELLOW ACOFP

HECTOR M. DELGADO DO. PA will bill your insurance carrier if proper coverage verification is received. Please complete the required insurance information and acknowledgement fields below, as well as the Insurance and Financial Policies page attached. Please include **a front & back copy of your primary insurance card to the front desk**.

First Name (Nombre): _____ Last Name(Apellido)_____ D.O.B ___/___/____
(fecha nacimiento)

SSN: _____ **e-mail (required):** _____
(All information is private, will not be sold. And gives you the ability to sign in the Office Portal)

Address(Direccion): _____ Status: ___M ____S____W____O
(Estado Civil) _____

City(Ciudad) _____ State(Estado): _____ Zipcode (Codigo Postal)_____

Phone(telefono) #: _____ Additional Phone#: (Celular)_____

Name of Employer: _____ Work Phone #: _____

Emergency Contact: _____ Relation: _____Phone #:_____
(Contacto Emergencia)

Insured Name ***(required if different than patient)*** _____

Relationship to Patient: _____ D.O.B _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone #: _____ Additional Phone#: _____

Name of Insurance Company (Nombre de Seguro Medico): _____

Member ID #: _____ Group # _____ Phone#: _____

Claims Address: _____

City: _____ State: _____ Zip: _____

PATIENT RESPONSIBILITY ADKNOWLEDEMENT & ASSIGMENT AUTHORIZATION:

1. I understand that I am financially responsible for all charges not paid by my insurance, with payment expected from me **within 30 days of statement notification**. I understand that non-compliance with payment terms can immediately result in my forfeiture of any all insurance billing extended to me.
2. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to my doctor. A photo static copy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

Patient Signature: _____ **Date:** _____

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INSURANCE AND FINANCIAL POLICIES

1) Insurance: ____ Initial

Some providers participate or contract with certain insurance companies. Knowing your insurance coverage is your responsibility – please contact them with questions about your coverage before your visit. In some cases, care agreed to be medically indicated by the physician and the patient **may not be covered** by insurance (for example: laboratory work up, annual exams, pre-existing conditions) and you will be required to pay for these services. Please check with your insurance company to find out if there are any exclusions in your individual policy. **It is important to understand that a verbal confirmation of coverage over the phone from the insurance company does not guarantee payment by them.** As is not uncommon for an insurance company to misquote a policy, we recommend reviewing your policy to confirm that the information we received is correct. It is the patient's responsibility to follow up if a claim is not paid. **Please be aware that you are responsible for the balance of your claim as decreed by your insurance company.**

2) Co-payments and Deductibles: ____ Initial

By signing this agreement you agree to pay your co-payment, co-insurance and /or deductible and any fees that your insurance company does not cover. Co-payment or co-insurance is an arrangement between you and your insurance company. Failure on our part to collect co-payment, co-insurance and deductibles from patients could be considered fraud. Please be informed about your co-payment, co-insurance and deductible.

3) Proof of Insurance: ____ Initial

All patients with insurance coverage must complete the patient intake forms and provide a current valid insurance card. This card will be copied a stored with your patient chart. If insurance coverage changes or expires, please provide a current card as soon as it is issued.

4) If you do not have insurance, payment in full is expected at the time of services rendered ____ Initial

5) Non-payment: ____ Initial

If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with billing department. Please be aware that if a balance remains unpaid, your account may be referred to a collection agency and charged a processing fee of $75.00 and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis. It is your responsibility for all fees incurred to obtain payment. There is a $35.00 fee for returned checks to cover bank fees.

6) Late Cancellations/Missed Appointments: ____ Initial

As a courtesy to other patients requiring services, we request that you provide notice of cancellation 24 hours in advance of your appointment. Patients who do not give 24 hours' notice for a missed appointment will be charged a fee of $35.00. After two missed appointments, you will be charge for the entire time reserved for you on the schedule. Exceptions are made for emergency / serious cases.

Authorization

- I have read the above 2 pages of information and agree regardless of my insurance status to be responsible for the balance of my account. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any changes to my insurance coverage.
- I authorize the release of any medical or other information necessary to process any claims.
- I authorize payment of medical benefits to my physician / provider Dr. Hector M. Delgado DO PA

Name (print) _____ **Signature:** _____ **Date:** _____

Witness: _____

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Hector M. Delgado, D.O.

PATIENT PORTAL

REGISTER OTHER MEMBER:

I, _____ with my signature represents that I grant permission to the following Family Member, Legal Guardian, Power Of Attorney to access my health information via the secure patient portal system.

Registers Name: _____ Email address: _____

_____ _____

Patient Signature Date Witness Date

PATIENT DECLINE/REFUSAL

I, _____ with my signature represents that I was offered electronic access to my health information at the office of my Primary Care Physician, **Hector M. Delgado, D.O.** and I have declined/refused access.

PLEASE CHECK (V) ONE OF THE FOLLOWING;

□ I do not have a private email address

□ I do not have access to a personal computer

□ I do not have a trustworthy Family Member (Patient Advocate) and or Legal Guardian that I would give permission to access my health care information.

_____ _____

Patient Signature Date Witness Date