Date: *Fecha*	**Patient Registration** *Registracion del Paciente*	

PATIENT INFORMATION – *Informacion del Paciente*

Social Security #: *Numero de Seguro Social*		**Address:** *Direccion del Hogar*		
First Name: *Primer Nombre*	**Middle:** *Segundo Nombre*	**City:** *Ciudad*	**State:** *Estado*	**Zip:** *Codigo Postal*
Last Name: *Apellido*		**Email Address:**		
Sex: *Sexo*	**Date of Birth:** *Fecha de Nacimiento*	**Home Phone:** *Telefono del Hogar*		
Marital Status: *Estado Civil*		**Cell Phone:** *Telefono Cellular*		
Race/Ethnicity: *Raza/Etnia*		**Referred by:** *Recomendado Por*		
Employment Status:	**Employer:** *Empleador*	**Work Phone:** *Telefono de Trabajo*		

INSURANCE INFORMATION – *Informacion del Seguro*

Please provide your insurance card to the receptionist – *Por favor entregue su tarjeta de seguro a la recepsionista*

Insurance company: *Compañía de Seguro*		
Insured / Card Holder's Name: *Nombre del Asegurado*		**Relationship:** *Relacion*
Policy #: *Numero de Poliza*	**Group #:** *Numero de Grupo*	**Phone #:** *Telefono*

SECONDARY INSURANCE INFORMATION – *Informacion del Seguro Secundario*

Please provide your insurance card to the receptionist – *Por favor entregue su tarjeta de seguro a la recepsionista*

Insurance company: *Compañía de Seguro*		
Insured / Card Holder's Name: *Nombre del Asegurado*		**Relationship:** *Relacion*
Policy #: *Numero de Poliza*	**Group #:** *Numero de Grupo*	**Phone #:** *Telefono*

EMERGENCY CONTACT – *En emergencias, contactar a:*

Social Security #: *Numero de Seguro Social*		**Sex:** *Sexo*	**Relationship:** *Relacion*
First Name: *Primer Nombre*	**Middle:** *Segundo Nombre*	**Last Name:** *Apellido*	
Home Phone #: *Telefono del Hogar*	**Work Phone:** *Telefono de Trabajo*		

PHARMACY - *Farmacia*

Pharmacy: *Farmacia*	**Pharmacy Phone #:** *Numero de telefono de la farmacia*
Pharmacy Address: *Direccion de la farmacia*	

SPOUSE/GUARANTOR/RESPONSIBLE PARTY – *Esposo / Persona Responsable*

Social Security #: *Numero de Seguro Social*	**Sex:** *Sexo*	**Date of Birth:** *Fecha de Nacimiento*	
Relationship: *Relacion*	**Employer:** *Empleo*		
First Name: *Primer Nombre*	**Address:** *Dirrecion*		
Last Name: *Apellido*	**City:** *Ciudad*	**State:** *Estado*	**Zip:** *Codigo Postal*
Address: *Direccion del Hogar*			

Signature: ***Firma***	**Date:** ***Fecha***

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todoes los honorarios per servicio deben de ser pagados al recibir el servicio. Aceptamos cierta tarjetas de credito. Su seguro medico es un contrato entr usted y su compañía de seguro. Pagos por nuestros servicios dependen de los terminus de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal paracobrar esta deuda, usted es responsable de los gastos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgements up to the minimum amounts pursuant to S.458.320 (5)(g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is pursuant to Florida Law.

Hemos elegido no llevar seguro de negligencia medica o no demostrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (la ley 5) (g). Florida impone penas contra los medicos de los no-asegurado que no pueden satisfacer los juicios adversos que se presentan de demandas de la negligencia medica. Este aviso esta conforme a la ley de la Florida.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by the physician. I understand that I am financially responsible to the physician for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a el medico todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compañía de seguro para procesar mi reclamacion. Yo entiendo que soy responsible por todos los cargos no cubiertos bajo mi seguro medico.

_____ _____

Patients / Guarantor's Signature Date

VICTOR H. CANTERO, M.D., LLC..

OBSTETRICS • GYNECOLOGY • INFERTILITY

PATIENT FINANCIAL RESPONSIBILITY FORM

PATIENT NAME: _____ **DOB:** _____

Thank you for choosing Victor H. Cantero, M.D. LLC., as your health provider. We are honored by your choice and are committed to providing you with the highest quality health care.
We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

- The patient (or patient's guardian, if minor) is ultimately responsible for the payment for her treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated.
- We will verify your insurance prior to you appointment. **If you are coming in for a well woman appointment, and are seen on the same day for a problem, if your insurance bills for a copay, you will then be responsible for that copay.** Your insurance may require a copay that you will be responsible to pay on the day of the service.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatments not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, and most major credit cards at our office.
- Patients may incur, and are responsible for the payment of additional charges at the discretion of Victor H. Cantero, M.D. These charges may include (but are not limited to):
    - Any costs associated with screening and/or diagnostic testing ordered by physician.
    - Any costs associated with turning unpaid accounts over to our collection agency.

I have read the policy regarding my financial responsibility to the Practice, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits; or, if applicable any amount due after payment has been made by my insurance carrier.

_____

Signature of Patient or Guardian Date

1951 SW 172 Avenue, Suite 301 • Miramar,, FL 33029 • Phone: (954)-510-5454 • Fax: (954)-510-5455

VICTOR H. CANTERO, M.D., LLC.
OBSTETRICS • GYNECOLOGY • INFERTILITY

Notice of Privacy Practice

For

Victor H. Cantero, M.D., LLC

1951 NW 172 Avenue, Suite 301 • Miramar, FL 33029 • Phone: (954)-510-5454 • Fax: (954)-510-5455

VICTOR H. CANTERO, M.D., LLC.
OBSTETRICS • GYNECOLOGY • INFERTILITY

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

INTRODUCTION

At Victor H. Cantero, M.D., LLC, we are committed to treating and using protected health information about you responsibly. This notice of health information Practices described the personal information we collect and how and when we use to disclose that information it also describes your rights as relate to your protected health information. This notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit Victor H. Cantero, M.D., LLC, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health of medical records, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A source of data for our planning and marketing
- A toll with which we can asses and continually work to improve the care we render and the outcomes we achieve

Understanding what and how your record and health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may asses your health information, and make informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Jose H. Santos M.D., LLC, the information belongs to you. You have the right to:

- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain and accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communication of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

OUR RESPONSIBILITIES

Victor H. Cantero, M.D., LLC, is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by terms of notice
- Notify you if we are unable to agree to a request restriction
- Accommodate reasonable request you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new previsions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions or would like additional information, you may contact the practice's Privacy Officer.

If you believe your privacy rights have been violated you can file a complaint with the Practice's Officer or with the *Office for Civil Rights, U.S. Department of Health and Human Services*. There will be no relation for filing a complaint with either the Privacy Officer or the Office of Civil Rights. The address for the OCR is listed below:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Room 509F, HHH Building
Washington, D.C. 20201

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

We will use your health information for treatment.

For example: information obtained by a nurse, physician, or other member of your health care team will be reordered in your record and used to determine the course of treatment that should work best for you. Members of your health care team will then record the actions they took and their observations.

We will also provide your physician or subsequent healthcare provider with copes of various reports that should assist him or her in treating you once you are discharge from his hospital.

We will use your health information for payment.

For example: a bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies needed.

We will use your health information for regular health operations.

For example: members of the medical staff, the risk or quality improvement manager or members of the quality improvement team may use information in you r health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Business associates: there are some services provided in our organization through contacts with business associates. Examples include: physician services in the emergency department and radiology, certain laboratory test and a copy service we used when making copies of your health record. When these services are contracted, we may disclose information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associates to appropriately safeguard your information.

Directory: unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliations for the directory purposes. This information may be provided to members of the clergy except for religious affiliations, to other people who ask for you by name.

Notification: we may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: health professionals, using their best judgment may disclose to a family member, other related close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: we may disclose information to researchers when their research has been approved by an institution review board that has reviewed the research proposal and establish protocols to ensure the privacy of your health information.

Funeral directors: we may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organization or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Fundraising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): we may disclose to the FDA health information relative to adverse events with respect to food supplement, product and product defects or post marketing surveillance information to enable product recalls, repair, or replacement.

Workers compensation: We may disclose health information to be extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: as required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and potentially endangering one or more patients, workers or the public.

VICTOR H. CANTERO, M.D., LLC.

OBSTETRICS • GYNECOLOGY • INFERTILITY

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, this facility originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that this facility, is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that this facility, reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should this facility, change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to other entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I authorize this facility to discuss my treatment, payment and healthcare operation with:

_____

_____

_____

I fully understand and accept / decline the terms of this consent.

_____
Patient's Signature

_____
Witness

_____
Date

FOR OFFICE USE ONLY

[ ] Consent received by_____ On _____.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.

1951 NW 172 Avenue, Suite 301 • Miramar, FL 33029 • Phone: (954)-510-5454 • Fax: (954)-510-5455

Notice of Privacy Acknowledgement

Victor H. Cantero, MD, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

E-mail Consent Form

Patient Name _____ Date _____

Patient E-mail address _____ Patient phone number _____

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 patients 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 patients 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.

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.

E-mail Consent Form

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.

Patient Name (print) _____

Patient Signature _____ Date _____

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 _____

Victor H. Cantero, MD, LLC
1951 SW 172 Ave, Suite 301, Miramar, FL, 33029,
Telephone: (954) 510-5454 ~ Fax: (954) 510-5455

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ ID Number: _____

Date of Birth: _____

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:	Persons/organizations receiving the information:
Specific description of information (including dates):	**Purpose of requested use or disclosure:**

The patient or the patient's representative must read and initial the following statements:

		Initials
1.	I understand that this authorization will expire on ___/___/___ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

This document will be retained by the providing organization for six years.