CARDELLA M.D., LLC.
OB/GYN
UROGYNECOLOGY
7300 SW 93rd Ave Suite 200
Miami, Fl. 33173
Phone: 305 971-0510 Fax: 305 663-5929

Patient Information Form

Name: _____ SSN: ____/____/____ DOB: _____

Home Phone ( ) _____-_____ Cell Phone ( ) _____-_____ Fax: ( ) _____-_____

Religion: _____ Race_____ Age: _____ Marital Status: ___ Single ___ Married ___ Divorced ___ Widow

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Employer / School: _____ Tittle: _____ Work #: ( ) _____-_____

Spouse: _____ Age: _____ DOB: ____/____/____ SSN: _____-_____-_____

Employer / School: _____ Tittle: _____ Work #: ( ) _____-_____

Primary Language Spoken: _____ Phone ( ) _____-_____ Fax: ( ) _____-_____

Insurance Information

Primary Insurance: _____ Policy/Subscriber: _____

Address: _____ Date of Birth: _____

City, State, Zip: _____ Insured Policy ID: _____

Plan Phone: _____ Group Number: _____

Effective Dates: _____ Patient Relationship to Subscriber: _____

Secondary Insurance: _____ Policy/Subscriber: _____

Address: _____ Date of Birth: _____

City, State, Zip: _____ Insured Policy ID: _____

Plan Phone: _____ Group Number: _____

Effective Dates: _____ Patient Relationship to Subscriber: _____

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Informacion del Paciente

Nombre: _____ SSN: _____/_____/_____ DOB: _____

Telefono Casa ( ) _____-_____ Celular ( ) _____-_____ Fax: ( ) _____-_____

Religion: _____ Raza_____ Edad: _____ Estado Civil: ___ Solera ___ Casada ___ Divorciada ___ Viuda

Direccion: _____ Apt #: _____

Ciudad: _____ Estado: _____ Codigo Postal: _____ Email: _____

Empleador / Escuela: _____ Titulo: _____ Tel. Trabajo: ( ) _____-_____

Esposo/a: _____ Edad: _____ DOB: _____/_____/_____ SSN: _____-_____-_____

Empleador / Escuela: _____ Titulo: _____ Tel. Trabajo: ( ) _____-_____

Lenguage Nativo: _____ Referida por: _____

Doctor Primario: _____ Telefono: ( ) _____-_____ Fax: ( ) _____-_____

Informacion de Seguro

Seguro Primario:_____ Polisa/Acegurado: _____

Direccion: _____ DOB: _____

Ciudad, Estado, Zip: _____ Numero de Polisa: _____

Tel. Del Seguro: _____ Numero de Grupo: _____

Fecha Efectiva: _____ Relacion al Paciente: _____

Seguro Secundario: _____ Numero de Polisa del Paciente: _____

Direccion: _____ DOB: _____

Ciudad, Estado, Zip: _____ Polisa del Paciente: _____

Tel. Del Seguro: _____ Numero de Grupo: _____

Fecha Efectiva: _____ Relacion al Paciente: _____

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Miscellaneous Information

What is your preferred Pharmacy:

Pharm. Name: _____

Tel ( ) _____-_____

Emergency Contact

Emergency Contact:_____

Patient Relationship to contact? _____

Phone Number: _____

If Patient is a Minor, Please Complete the Following:

Father;s Name _____ Mother's Name _____

Home Phone ( ) _____-_____ Cell Phone ( ) _____-_____

AUTHORIZATION OF MINOR TREATMENT

By signing this statement, I authorize examination, diagnosis and treatment to the above mentioned minor. This authorization may include the release of records to insurance company and/or state/federal legal authorities.

_____
Parent or Legal Guardian Signature

_____ _____
Patient's Signature Date

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Information De Farmacia

Cual es el nombre de su Farmacia Preferida

Farmacia: _____

Tel. Farm. ( ) _____-_____

Contacto de Emergencia

Contacto de Emergencia: _____

Relacion del Contacto? _____

Numero de Tel. del contacto: _____

Si la Paciente es una Menor de edad, Por Favor complete lo siguiente:

Nombre del Padre _____ Nombre de la Madre _____

Tel. De la Casa ( ) _____-_____ Tel. Celular ( ) _____-_____

AUTORIZACION PARA TRATAMIENTO MEDICO DE UNA PACIENTE MENOR DE EDAD

Al firmar esta forma, yo autorizo la examinacion, diagnostico y tratamiento a la paciente menor de edad mencionada en esta forma. Esta autorisacion incluye el intercambio de sus documentos medicos a su aseguadora y/o a autoridades estatales y/o federales.

_____
Firma del Padre o Guardian Legal

_____
Firma del Paciente

_____
Fecha

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LAB RESULTS: Effective immediately you can now access your lab results through **Quest or LabCorp.** You will have to download the application to your phone. Please allow 5-7 business days for your results to upload. We will only be calling patients with **ABNORMAL** results. However, if you have any questions regarding your results, please feel free to contact our office at (305) 971-0510.

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FINANCIAL POLICY:

Thank you for choosing I Anthony Cardella, M.D., LLC. The following is a statement of our Financial Policy.

PAYMENT IS DUE AT THE TIME OF SERVICE
ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT

WE ACCEPT: CASH, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, AND PERSONAL CHECKS

PROOF OF INSURANCE: All patients must complete our patient information form. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We are in network with most major insurance carriers. However, it is the patient's responsibility to verify that we are a participating provider of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. As part of the contract with your insurance company, all co-payments, co-insurances and deductibles must be paid at time of service. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of services rendered.

NONCOVERED SERVICES: Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

RETURNED CHECKS: Any check returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) along with a $25.00 NSF fee from the office.

COLLECTION POLICY: Should your account become past due, the patient/debtor assumes all costs of collection, including but not limited to, collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

ADDITIONAL OFFICE FEES: Blood drawing, Injections, FMLA, WIC, Disability Forms are $15.00, Medical records $1 dollar per page, Cord Blood collection fee $250, No Show $20.00

I HAVE READ AND FULLY UNDERSTAND the Financial Policy and all my questions regarding this policy have been answered. I hereby agree to render payment in accordance with the terms and conditions set forth.

Patient Name: _____ Date: _____

Patient/Responsible Party Signature: _____