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:*		
Religion:		**Language Best Served:** *Idioma De Preferencia:*		

How Did You Hear About Us: ☐ **Friend** ☐ **Physician** ☐ **Patient Pop** ☐ **Family** ☐ **Hospital** ☐ **Other** ☐ **Internet** ☐ **None**

Como Supo De Nosotros: ☐ *Amigo* ☐ *Doctor* ☐ **Zocdoc** ☐ *Familia* ☐ *Hospital* ☐ *Otro* ☐ *Ninguno*

Employment Status: *Estatus Laboral*	**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: *Compañia 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: *Compañia 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 Responsible*

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*			
Patient Signature: *Firma Del Paciente:*		**Date:** *Fecha:*	

FMLA / DISABILITY FORM NOTIFICATION OR RECORD RELEASE

I acknowledge that there is a $20.00 fees for any disability, FMLA or any other paperwork that needs to be completed by your physician. As a patient, you are required to provide the paperwork from your employer and complete our request for completion of any disability form (s). This fee is not paid by your insurance company or include in your office visit. Please allow 7-10 business days for your paperwork to be completed.

Reconozco que hay una tarifa de $ 20.00 por cualquier formulario de discapacidad, FMLA o cualquier otra documentación que deba completar su médico. Como paciente, debe presentar los documentos de su empleador y completar nuestra solicitud para poder finalizar su formulario. Esta tarifa no la paga su compañía de seguros ni se incluye en su visita al consultorio. Por favor, espere de 7 a 10 días hábiles para que se complete su documentación.

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.

Todos los honorarios por servicio deben de ser pagados al recibir el servicio. Aceptamos cierta tarjetas de credito. Su seguro medico es un contrato entre usted y su compañía de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar 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 payer, 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 responsable por todos los cargos no cubiertos bajo mi seguro medico.

_____ _____

Patients / Guarantor's Signature Date

CANCELLATION & MISSED APPOINTMENT POLICY

Your appointments are very important to Jose Rivas Dominguez, MD, LLC. They are reserved especially for you. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least 24 hour notice for cancellations or rescheduling of appointments.

Please understand that when you forget, cancel, or change your appointment without giving enough notice, we miss the opportunity to fill that appointment time, and clients on our wait list miss the opportunity to receive services.

Any appointment missed, late cancelled, or changed without 24 hour notice will result in a $20.00 charge.

As a courtesy, your appointments are confirmed electronically the day before your scheduled appointment by text messaging or automatic voice calling software because we know how easy it is to forget an appointment you booked months ago. Below are the options listed to cancel your appointment without a charge.

- Confirming your appointment from the text message sent the day prior to your appointment. Please press 1 to confirm your appointment, press 2 to be connected to our office to reschedule or cancel, press 3 to hear the message again.
- Calling the office number 954-510-5454 and speak to a staff member.
- Emailing your cancellation with a 24hr notice to: agonzalezpardo@femwell.com

Please understand that it is your responsibility to remember your appointment dates and times in order to prevent any missed appointments which result in a cancellation fee. Not receiving an electronic notification of your appointments from us the day before is not sufficient reason to miss an appointment if the original confirmation notification was received timely.

Emergency absences will be considered on an individual basis by Jose Rivas Dominguez, MD LLC. You may request not to be charged for the late cancelled session in writing within 7 days if you feel such action is warranted. Jose Rivas Dominguez, MD LLC. will make the decision to honor your request on a case-by-case basis and will respond back to you in writing within 7 days.

It is mutually understood that if a cancellation is due to circumstances beyond any of our control, such as power outage, unfortunate incidence, or weather that requires you or us to have to cancel or be closed during regular business hours, we will reschedule your existing appointment and no discount or charges will apply.

I acknowledge that I have read the above disclaimer and agree with such policy.

Patient or Guarantor's Signature:_____

Date:_____

POLÍTICA DE CANCELACIÓN Y CITA PÉRDIDA

Sus citas son muy importantes para Jose Rivas Domínguez, MD, LLC.
Están reservados especialmente para ti. Entendemos que a veces los ajustes de horario son necesarios. Por lo tanto, solicitamos respetuosamente al menos 24 horas de anticipación para cancelaciones o reprogramaciones de citas.

Por favor, comprende que cunando olvida, cancela o cambia su cita sin avisar con suficiente antelación, perdemos la oportunidad de completar esa cita y los clientes en nuestra lista de espera pierden la oportunidad de recibir servicios.

Cualquier cita perdida, cancelada tardíamente o cambiada sin previo aviso de 24 horas resultara en un cargo de $20.00.

Como cortesía, sus citas se confirman electrónicamente el día antes de su cita programada mediante mensajes de texto o programa de llamadas de voz automáticas porque sabemos lo fácil que es olvidar una cita que reservo hace meses. A continuación se detallan las opciones para cancelar su cita sin cargo.

• Confirmar su cita desde el mensaje de texto enviado el día anterior a su cita. Presione 1 para confirmar su cita, presione 2 para conectarse a nuestra oficina para reprogramar o cancelar, presione 3 para escuchar el mensaje nuevamente.
• Llamar al número de la oficina 954-510-5454 y hablar con un miembro del personal.

• Enviar por correo electrónico su cancelación con 24 horas de aviso a: agonzalezpardo@femwell.com

Por favor, comprenda que es su responsabilidad recordar las fechas y horas de su cita para evitar cualquier cita perdida que resulte en una tarifa de cancelación. No recibir una notificación electrónica de sus citas de nosotros el día anterior no es razón suficiente para perder una cita si la notificación de confirmación original se recibió a tiempo.

Las ausencias de emergencia serán consideradas individualmente por Jose Rivas Domínguez, MD LLC. Puede solicitar que no se le cobre por la sesión cancelada tarde por escrito dentro de los 7 días si considera que tal acción está justificada. Jose Rivas Domínguez, MD LLC. tomaría la decisión de cumplir con su solicitud caso por caso y le responderemos por escrito dentro de los 7 días.

Se entiende mutuamente que si una cancelación se debe a circunstancias ajenas a nuestro control, como un corte de energía, una incidencia desafortunada o un clima que requiere que usted o nosotros tengamos que cancelar o cerrar durante el horario comercial habitual, reprogramaremos su actual cita y no se aplicarán descuentos ni cargos.

Reconozco que he leído el descargo de responsabilidad anterior y estoy de acuerdo con dicha política.

Firma del paciente o garante:_____
Fecha:_____

JOSE RIVAS DOMINGUEZ, M.D., LLC.

OBSTETRICS • GYNECOLOGY • INFERTILITY

Welcome to Jose Rivas Dominguez, M.D., LLC. for those of you who have been to our practice before, we appreciate your support and confidence you have in our practice. For those of you who are a new patient to our office, we will strive to meet your expectations.

Please be advised that I only deliver and work out of the following hospitals: Memorial Hospital Miramar.

If you seek care at any other hospitals, I will be unable to care for you while you are in the hospital.

Please note that other physicians will have On-Call coverage with other OB/GYN physicians, Dr. Victor H. Cantero, _____
They will also be available in case of any unforeseen emergency, vacation, seminar, etc.

Once again, we welcome you to our practice. Please do not hesitate to ask any questions or voice any concerns.

_____	_____
Patient's Name (Please Print)	Patient's Signature
_____	_____
Witness	Date

1951 SW 172 Avenue, Suite 301 • Miramar, FL 33029 • Phone : (954) -510-5454 • Fax : (954) -589-0960

JOSE RIVAS DOMINGUEZ, M.D., LLC.
OBSTETRICS • GYNECOLOGY • INFERTILITY

PATIENT FINANCIAL RESPONSIBILITY FORM

PATIENT NAME: _____ **DOB:** _____

Thank you for choosing Dr. Jose Rivas Dominguez, 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 your 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 Dr. Jose Rivas Dominguez, 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) - 589-0960

Jose Rivas Dominguez, MD, LLC
1951 SW 172nd Ave, Suite 301, Miramar, FL 33029
954-510-5454

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I – Authorization

I,_____, give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II - Health Information

I would like to give the above healthcare organization permission to:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information:
- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Disclose Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other: _____

Form of Disclosure:

☐ Electronic copy or access via a web-based portal
☐ Hard copy

Section III – Reason for Disclosure

Please detail the reason(s) why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

_____

_____

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

Jose Rivas Dominguez, MD, LLC
1951 SW 172nd Ave, Suite 301, Miramar, FL 33029
954-510-5454

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s):

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s)listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

☐ From _____ to _____

Or

☐ All past, present, and future periods

Or

☐ The date of the signature in section VI until the following event: _____

_____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

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

Jose Rivas Dominguez, MD, LLC
1951 SW 172nd Ave, Suite 301, Miramar, FL 33029
954-510-5454

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section VI – Signature

_____ _____

Print Patient Name Date

_____

Signature

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form: _____

_____

_____

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

Jose Rivas Dominguez, MD, LLC
1951 SW 172nd Ave, Suite 301, Miramar, FL 33029
954-510-5454

AUTORIZACIÓN PARA REVELAR INFORMACIÓN DE SALUD PROTEGIDA

Por favor complete todas las secciones de este formulario de liberación de HIPAA. Si alguna sección se deja en blanco, este formulario no será válido y no será posible que su información de salud se comparta según lo solicitado.

Sección I - Autorización

Yo, _____, doy mi permiso para _____ compartir la información que figura en la Sección II de este documento con la (s) persona (s) u organización (s) que he especificado en la Sección IV de este documento.

Sección II - Información de Salud

Me gustaría dar permiso a la organización de salud anterior para:

☐ Revelar mi registro de salud completo, que incluye, entre otros, diagnóstico, resultados de pruebas de laboratorio, tratamiento y registros de facturación para todas las condiciones.

O

☐ Revelar mi historial médico completo, excepto por la siguiente información:

- ☐ Registros de salud mental
- ☐ Enfermedades transmisibles que incluyen, pero no se limitan a, VIH y SIDA
- ☐ Revelar registros de tratamiento de abuso de alcohol / drogas
- ☐ Información genética
- ☐ Otro: _____

_____

_____

Forma de revelación de información:

☐ Copia electrónica o acceso a través de un portal en el internet.
☐ Copia en papel.

Sección III - Motivo por el cual se está revelando la información

Por favor detalle las razones por las que se comparte la información. Si está iniciando la solicitud de compartir información y no desea enumerar las razones para compartirla, escriba "solicitud propia".

_____

_____

_____

_____

Este documento será retenido por la organización proveedora por siete años.

Jose Rivas Dominguez, MD, LLC
1951 SW 172nd Ave, Suite 301, Miramar, FL 33029
954-510-5454

AUTORIZACIÓN PARA REVELAR INFORMACIÓN DE SALUD PROTEGIDA

Sección IV - Quién puede recibir mi información de salud

Doy mi autorización para que la información de salud que se detalla en la sección II de este documento se comparta con la (s) siguiente (s) persona (s) u organización (es):

Nombre: _____

Organización: _____

Dirección: _____

Entiendo que la (s) persona (s) / organización (es) enumerada (s) arriba puede no estar cubierta por las reglas estatales / federales que rigen la privacidad y seguridad de los datos y se le puede permitir compartir más la información que se les proporciona.

Section V – Duración de esta Autorización

Esta autorización para compartir mi información de salud es válida:

☐ Desde _____ hasta _____

O

☐ Todos los períodos pasados, presentes y futuros.

O

☐ La fecha de la firma en la sección VI hasta el siguiente evento.: _____

_____

Entiendo que puedo revocar esta autorización para compartir mis datos de salud en cualquier momento y puedo hacerlo mediante el envío de una solicitud por escrito a:

Nombre: _____

Organización: _____

Dirección: _____

Entiendo que:

- En el caso de que mi información ya haya sido compartida para cuando se revoque mi autorización, puede ser demasiado tarde para cancelar el permiso para compartir mis datos de salud.
- Entiendo que no necesito dar ningún otro permiso para que la información detallada en la Sección II se comparta con la (s) persona (s) u organización (s) enumerada (s) en la Sección IV.
- Entiendo que no firmar o enviar esta autorización o la cancelación de esta autorización no me impedirá recibir ningún tratamiento o beneficios a los que tengo derecho, siempre que esta información no sea necesaria para determinar si soy elegible para recibir esos tratamientos. o beneficios o para pagar los servicios que recibo.

Este documento será retenido por la organización proveedora por siete años.

Jose Rivas Dominguez, MD, LLC
1951 SW 172nd Ave, Suite 301, Miramar, FL 33029
954-510-5454

AUTORIZACIÓN PARA REVELAR INFORMACIÓN DE SALUD PROTEGIDA

Sección VI - Firma

_____ _____

Nombre del Paciente (Escriba) Fecha

_____

Firma

Si una persona con autoridad legal está completando este formulario para actuar en nombre de una persona, como un padre o tutor legal de un menor o un agente de atención médica, complete la siguiente información:

Nombre de la persona que completa este formulario: _____

Firma de la persona que completa este formulario: _____

Describa a continuación cómo esta persona tiene autoridad legal para firmar esto: _____

_____

_____

Este documento será retenido por la organización proveedora por siete años.

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 _____

JOSE RIVAS DOMINGUEZ, MD, LLC
1951 SW 172 Ave, Suite 301, Miramar, FL, 33029
Telephone: (954) 510-5454 ~ Fax: (954) 589-0960

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ 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.

CONSENT, PERMISSION AND RELEASE
FOR USE OF PHOTO, VIDEO AND/OR AUDIO

I hereby give consent and permission to Victor H. Cantero M.D , LLC to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of (print name) _____, age (if minor) _____.

Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by Victor H. Cantero M.D, LLC and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing.

I acknowledge that Victor H. Cantero M.D, LLC is the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that it has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video and/or audio may be used indefinitely by television, radio, newspapers, magazines, newsletters, brochures, Internet, intranet, or in other media once released.

Victor H. Cantero M.D, LLC has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold Victor H. Cantero M.D, LLC, its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production.

I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name: _____

Address: _____

Telephone: _____ Email address: _____

Signature: _____ Date: _____

Name of Parent/Legal Custodian (under age 18): _____

Signature of Parent/Legal Custodian (under age 18): _____

Witness Name: _____

Witness Signature: _____ Date: _____

I am revoking this consent. I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold Victor H. Cantero M.D, LLC responsible for instances of these violations.

Signature: _____ Date: _____