Essential Care Family Practice
Ricardo Aleman Chinea, MD

Patient Information

First Name:	Middle Name:	Last Name:	Gender: ☐Male ☐Female
Street Address:	City, State, Zip:	E-mail Address: *(Required)*	
Date of Birth: / /	Soc Sec #:	Marital Status: ☐Married ☐Single ☐Divorced ☐Partnered ☐Widowed	
Home Phone:	Cell Phone:	Work Phone:	
What is your *preferred* method of contact? ☐Home Phone ☐Cell ☐Work ☐E-Mail ☐Mail			
Employer: ☐Check here if Retired	Occupation:	Referred by or how did you hear about us:	
Emergency Contact:	Contact Phone:	Relationship to Patient: ☐Spouse/Partner ☐Child ☐Sibling ☐Parent ☐Friend	
Race: ☐White ☐Black or African American ☐Asian ☐Pacific Islander ☐American Indian ☐Other Race _____ ☐Unreported/Refused to Report			
Preferred Language:	Ethnicity: ☐ Hispanic ☐ Non- Hispanic ☐ Unreported/Refused to Report		
Pharmacy:	Address:	Telephone #	

Financially Responsible Party

First Name:	MI:	Last Name:	Soc Sec #:	Date of Birth: / /
Relationship of Financial Party to Patient: ☐Self ☐Spouse ☐Parent ☐Guardian ☐Other				
Address (if different from Patient):		Phone:		
Employed by:		Occupation:		
Business Address:		Business Phone:		
Insurance Company: Group #		Subscriber/Member #		

Additional Insurance

☐ **Check here if No additional Insurance and skip this section** Name Financially Responsible Party:	Soc Sec #:	Date of Birth: / /
Relationship of Financial Party to Patient: ☐Self ☐Spouse ☐Parent ☐Guardian ☐Other		
Address: (if different from Patient):	Phone:	
Employed by:	Occupation:	
Business Address:	Business Phone:	
Insurance Company: Group #	Subscriber/Member #	

If Patient is a Minor: By signing below, as parent, legal guardian or authorized party, I consent and authorize on behalf of the Patient, to the rendering of care and treatment, in including but not limited to medical, surgical, diagnostic, or other treatments/procedures considered necessary or advisable by employees and authorized Agents of Essential Care Family Practice, LLC.

By signing below, I acknowledge and agree to the terms above.

Patient/Guardian Signature:	**Date**:
Patient Name:	

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Consent for Treatment

General Consent for Treatment: I hereby consent and authorize to the rendering of care and treatment, including but not limited to medical, surgical, diagnostic, or other treatments/procedures ("Treatments") considered necessary or advisable by physicians, practitioners, their employees and authorized agents of Essential Care Family Practice, LLC, to provide any medications, treatment or therapy necessary to effectively assess and maintain my health and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

General Acknowledgments: I understand that the practice of medicine is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury and even death. No guarantees have been made to me with respect to the results for my examinations or treatments. I understand and agree that I may be observed and/or receive care from medical, nursing and other health care students in training at Essential Care Family Practice, LLC. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care as directed by Essential Care Family Practice, LLC.

Right to Refuse Treatments: In giving my general consent to treatment, I understand that I have the right to make informed decisions regarding all care and treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers.

I fully understand this agreement and consent will continue until canceled by me in writing.

Patient/Guardian Signature: **_____Patient Name:** **Date:**

COVID-19 Informed Consent

I understand I am giving this informed consent to Essential Care Family Practice, LLC (the "Practice") evidencing my educated decision to receive services at the Practice prior to any vaccine or known effective treatment to the CoronaVirus-COVID-19. I have been advised that the Practice has adopted recommended protocols for the prevention of COVID-19 at its facility and that I can request additional information prior to signing this consent, and at any time thereafter, as to the specific protocols in place regarding the Practice response to COVID-19.

I acknowledge my understanding that the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and may still be highly contagious. I understand the Practice will be treating patients other than myself at its facility, as well as employing personnel who may be asymptomatic or qualified as "recovered" in accordance with CDC guidelines. I understand that it is impossible to determine who has it and who does not, at any given time, even as testing becomes readily available. I understand it is my responsibility to notify the Practice if I am medically "high risk" for any reason.

I hereby agree to release the Practice, and its owners, members, officers, employees, contractors, agents, and representatives ("Practice Representatives"), and covenant not to commence or maintain any action or proceeding against the Practice and any Practice Representatives, for or from any and all claims, causes of action, liabilities, damages, fees (including attorney's fees and costs of defense) and demands whatsoever, in law or equity ("Claims"), which I (and my heirs, executors, administrators and assigns) shall or may have, or from any person or entity other than myself, for, upon, or by reason of my contracting COVID-19, including any claim resulting from my transmission of COVID-19 to any other person or thing. I hereby agree to indemnify and hold the Practice and Practice Representatives harmless from and against any and all Claims from or against any person or entity other than myself relating to my having or transmitting COVID-19.

By signing below, I acknowledge I have read this Informed Consent and I hereby agree to its terms and I assume the risk of potential COVID-19 exposure by receiving treatment at the Practice.

Patient/Guardian Signature: **_____Patient Name:** **Date:**

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Assignment of Benefits

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Known by all these present that: the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint Essential Care Family Practice, LLC ("Health Care Provider") and any of its duly authorized agents and employees as and to be the undersigned's tur and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and Essential Care Family Practice, LLC which checks, drafts or money orders are made payable for services which have been rendered by Essential Care Family Practice, LLC at the request of or with the knowledge and approval of the undersigned and/or maker of the check, draft or money order.

This assignment includes, but is not limited to, all rights to collect benefits directly from my insurance company ("Insurer") for services that I have received and all rights to proceed against my insurance company in any action including legal suit of for any reason by insurance company fails to make payments of benefits due to my assignee or me. This assignment also includes any rights to recover attorney's fees and costs for such action brought by the Health Care Provider as my assignee.

The undersigned by these presents gives and grants Essential Care Family Practice, LLC as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said check and concerned as well as any other document.

At any time after Insurer fails to render the applicable payment within thirty (30) days upon receipt of Health Care Provider's medical bills for any date of service, this agreement may be revoked. Health Care Provider's said revocation will be effective on the thirty-first day after Insurer has received Health Care Provider's medical bill(s) that Insurer has denied, withdrawn, reduced, or failed to pay in accordance with Florida Statute 627.736. Said revocation shall include any and all dates of service subsequent to the thirty-first day after Insurer has received Health Care Provider's medical bill(s) that Insurer has denied, withdrawn, reduced, or failed to pay in accordance with Florida Statue 627.736.

A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do and cause to be done by virtue of these presents.

I hereby authorize my contracted insurance company, previously identified, to pay and to mail directly to Essential Care Family Practice, LLC the medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby irrevocably assign to Essential Care Family Practice, LLC any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any services and charges provided by Essential Care Family Practice, LLC.

Patient/Guardian Signature: **_____Patient Name:** **Date:**

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Patient acknowledgement of receipt of Notice of Privacy Practices and Consent/Limited Authorization and Release Form (HIPAA Omnibus rule)

Patient Name: _____ **Date of Birth:** _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

☁ First Name Only ☁ Proper Surname ☁ Other

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes stepparents, grandparents and any care takers who can have access to this patient's records):

Name: Relationship:

Name: Relationship:

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, HEALTH, TREATMENT & BILLING INFORMATION VIA:

☁Cell Phone Confirmation	□ Home Phone Confirmation	□ Work Phone Confirmation
☁Text Message to my Cell Phone	□ Email Confirmation	□ Any of the Above

I hereby consent to Essential Care Family Practice, LLC using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at any time. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to the Practice.

By signing below, I consent to the Practice's use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information I stated above and including in-person, mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including results and other matters incident to my treatment TPO. I understand that I have the right to request that the Practice 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. I understand that 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, I understand that the Practice may decline to provide treatment to me.

You may refuse to sign this acknowledgment & authorization. If refusing, we *may not be allowed* to process your insurance claims.

I acknowledge and agree that I have received a copy of Essential Care Family Practice, LLC's Privacy Practices.

Patient/Guardian Signature: _____**Patient Name:** **Date:**

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Patient Contract

Welcome to Essential Care Family Practice, LLC We are committed to our patient's health and wellness. In return for our commitment to you, our patient, we require you to acknowledge and adhere to Essential Care Family Practice, LLC 's basic operating procedures, set forth in this Patient Contract, as follows:

- Essential Care Family Practice, LLC will offer you access to your own personal patient portal where you can obtain your records and contact the office. The portal is not for urgent issues. Messages sent through the portal will not be checked until the next business day. Please provide your email address for this function.

- In order to keep your records accurate and avoid potentially harmful drug interactions, we may need to verify your medications through an external database or with your pharmacist. This allows Essential Care Family Practice, LLC providers to know what medications other doctors have prescribed for you.

- I agree to arrive on time to my appointment. We recommend 15 minutes early for existing patients or 30 minutes for new patients. Essential Care Family Practice, LLC requires 24-hour notice if I am unable to keep my appointment. I understand that missed appointments with less than 24-hour notice may incur a fee of $50.

- Labs and diagnostic tests ordered prior to your visit or at your visit may require an additional follow-up appointment with your provider to discuss results. If you are unable to keep your scheduled appointment, you will be required to reschedule to discuss your results.

- I hereby authorize appropriate staff and providers to take digital pictures of my skin condition that will be solely used for the purpose of medical record documentation, location for treatment options, and plan of care.

- If available, I consent to Telemedicine visits, the use of electronic information and communication technologies by a healthcare provider used to deliver services to you when you are at a different location or site than the provider. I understand that I have the right to withhold or withdraw my consent to telemedicine without affecting my right to future care.

- I hereby consent that I will not use any recording device of voice or image on the premises of Essential Care Family Practice, LLC. This includes but, is not limited to, cameras, voice recorders, phones and Google glasses.

Patient/Guardian Signature: **_____Patient Name:** **Date:**

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Agreement of Financial Responsibility

- Proof of coverage and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s), coinsurance or deductible(s) which are payable at time of service, and then bill you for any remaining amount determined to be your responsibility by your insurance company. Any balance you owe that remains unpaid 90 days after you were billed will be transferred to a collection agency for recovery.
- I agree to pay my account at the time service is rendered or will make financial arrangements satisfactory to Essential Care Family Practice, LLC for payment. If my account is sent to collections, I agree to pay collection expenses, court fees and reasonable attorney fees as established by the court. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefit of any type under any policy of insurance insuring the patient, or any party liable to the patient, is hereby assigned to Essential Care Family Practice, LLC. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Essential Care Family Practice, LLC.
- A returned Check Fee of $25 will be added to your account balance in addition to the amount of the check returned for insufficient funds. This total must be paid by cash or credit card within 14 days.

- **Non-Covered Services:** I understand that Essential Care Family Practice, LLC contracts with health care plans which specifically state services which are “covered” by the health care plan. Accordingly, the undersigned accepts full financial responsibility for all services, which are determined by the health care service plans not to be covered. I agree to cooperate with Essential Care Family Practice, LLC to obtain necessary health care service authorizations. I understand that not all services provided are considered medically covered services by my health plan and payment will be due at the time of service. If we do not contract with your insurance company, we will prepare and submit your claim for you on an assigned basis. Please be aware that we are not contractually obligated to accept any adjustments from your insurance carrier. Any amounts determined to be "Patient Responsibility" and not collected at time of service will be billed to you and payment is due upon receipt of statement from our office.

- **Medicare Patients Only:** Essential Care Family Practice, LLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for any deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Essential Care Family Practice, LLC. If l receive payment, then I am responsible to provide payment and EOB to Essential Care Family Practice, LLC.

BY SIGNING BELOW, I AGREE TO THE FINANCIAL POLICIES OF THE PRACTICE SET FORTH HEREIN. A copy of this policy is available upon request.

Patient/Guardian Signature: _____ **Patient Name:** _ **Date:**

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Authorization to Release Medical Records

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

Patient Name: **Date of Birth:**

Address: **Last 4 of SS#:**

City: **State:** **Zip:** **Phone:**

- I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to this authorization. I understand that if I revoke this authorization I must do so in writing and present my written request to the Medical Records Department.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign and the facility of Essential Care Family Practice, LLC will not base treatment, payment, or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that I may inspect a copy of the information to be disclosed, as provided in 45 CFR 164.524 (with reasonable charge).
- I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient of the information and no longer protected by federal confidentiality laws or Essential Care Family Practice, LLC.

I Authorize (print name of party releasing the records): to release my health information to _____for the purpose of my healthcare and treatment.

Information to be Disclosed (please check all that apply): All Records _____ Lab _____ Pathology _____ Other

Purpose for Disclosure: Continuation of Care _____ Other

Special Instructions:_____ Faxed:_____ Pick-up:_____ EMR:_____ Mailed:

Unless otherwise revoked, this authorization will expire 36 months from the date of the signature listed below.

Patient/Guardian Signature: _____**Patient Name:** **Date:**