

PATIENT INFORMATION

PATIENT LAST NAME: _____ **NAME:** _____ **MIDDLE:** _____
 (APELLIDO) (NOMBRE) (INICIAL)

CURRENT ADDRESS: _____ **CITY:** _____ **ZIP:** _____
 (DIRECCION ACTUAL) (CIUDAD) (ZIPCODE)

DOB: ____/____/____ **AGE:** ____ **SS #** ____/____/____ **Sex:** F / M **MARITAL STATUS:** _____
 (FECHA DE NACIMIENTO) (SEGURO SOCIAL) SEXO (F/ M) (ESTADO CASADO, SOLTERO, VIUDO)

HOME PHONE: _____ **CELL PHONE:** _____ **EMAIL** _____
 (TELEFONO DE LA CASA) (TELEFONO MOBIL) (CORREO ELECTRONICO)

EMPLOYER: _____ **EMPLOYER PHONE:** _____
 (LUGAR DE TRABAJO) (TELEFONO DEL TRABAJO)

PRIMARY INSURANCE: _____ **MEMBER ID #** _____ **GROUP#** _____
 (NOMBRE SEGURO MEDICO) (NUMERO DE POLIZA) (NUMERO DE GRUPO)

SECONDARY INSURANCE: _____ **MEMBER ID #** _____ **GROUP #** _____
 (SEGURO MEDICO SECUNDARIO) (NUMERO DE POLIZA) (NUMERO DE GRUPO)

PERSONS TO CONTACT IN CASE OF EMERGENCY
 (PERSONAS A LLAMAR EN CASO DE EMERGENCIA)

NAME: _____ **PHONE:** _____ **RELATION:** _____
 (NOMBRE) (NUMERO DE TELEFONO) (PARENTESCO CON PACIENTE)

NAME: _____ **PHONE:** _____ **RELATION:** _____
 (NOMBRE) (NUMERO DE TELEFONO) (PARENTESCO CON PACIENTE)

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME, TO RELEASE TO MY INSURANCE CARRIER OR ITS INTERMEDIARIES ANY INFORMATION NEEDED FOR THIS OR RELATED CLAIM, I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO MYSELF OR TO THE PARTY THAT ACCEPTS ASSIGNMENT OF

Autorizó a cualquier sostenedor medico u otra información acerca de mí, para mi compañía de seguros o sus intermediarios cualquier información necesaria para REHC o que este o relacionada para ser utilizados en lugar del original y solicitar el pago de beneficios de seguro médico para mí, en la asignación de

PATIENT SIGNATURE: _____ **DATE:** _____
 (FIRMA DEL PACIENTE) (FECHA)

DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Information Portability and Accountability Act of 1996, you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your copy of this form and returning it to this office.

(Como es requerido por la portabilidad de la información de salud y el acto de rendición de cuentas de 1996, tiene derecho a designar a una o más personas para actuar en su nombre con respecto a la protección de información de salud que pertenece a usted. Completando esta forma están informándonos de designar a la persona nombrada con su firma.)

Patient Name: _____ D.O.B. _____ Date: _____
(Nombre del paciente) (Fecha de nacimiento) (Fecha)

Address: _____
(Dirección)

Telephone: _____
(Teléfono)

I request the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of my protected health information.

Name: _____
(Nombre)

Telephone: _____
(Teléfono)

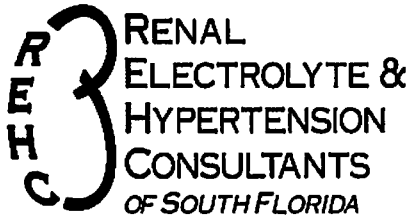
What relationship is this person to you? _____
(QUE PARENTESCO TIENE CON EL PACIENTE)

Patient's Signature _____
(FIRMA DEL PACIENTE)

I HEREBY REVOKE THIS DESIGNATION OF A PERSONAL REPRESENTATIVE,

Patient's Signature
(Firma del paciente)

Date:
(Fecha)



**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES
AND
CONSENT TO USE AND DISCLOSE HEALTH**

I acknowledge that I was provided with a copy of the REHC of South Florida Notice Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that REHC of South Florida continues to its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my Health Information for the purposes and the activities permitted under the federal privacy law.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be change at any time. I may obtain a revised copy by calling the REHC of South Florida Office at (954)463-0112.

I acknowledge that I have received a copy of the REHC of South Florida Notice of Privacy Practice.

Patient Name: _____ Date: _____

Signature of Patient: _____

Patient Legal Representative (if applicable) _____ Date: _____

Signature of Legal Representative: _____

FOR PHYSICIAN'S OFFICE USE ONLY

OFFICE STAFF MEMBER OBTAINING SIGNATURE

- Reason Signature and Date were not obtained
- Individual Refuse to Sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency prevented us obtaining acknowledgement
- Other

Other medical conditions: _____

Past Surgical History: YES / NO IF YES LIST PROCEDURES AND DATE: _____

Are you currently using TABACCO products? YES/NO If yes, quantity per day: _____

If you quit, how often did you use per day? _____ for how long: _____

Do you drink alcohol? YES/NO if yes, amount: _____ How often: _____

Patient Signature: _____ Date: _____

PERIPHERAL ARTERIAL DISEASE (PAD) RISK ASSESSMENT FORM

PERIPHERAL ARTERIAL DISEASE IS A COMMON AND OFTEN SILENT CONDITION THAT AFFECTS THE CIRCULATION TO THE LEGS AND FEET, INITIALLY CAUSING ACHING PAIN, CRAMPING AND FATIGUE. THE ARTERIES BECOME NARROWED AND WALKING MAY BECOME MORE DIFFICULT AND PAINFUL. THIS CONDITION CAN LEAD TO FOOT AND LEG WOUNDS OR ULCERS THAT DON'T HEAL OR ARE VERY SLOW TO HEAL, AND POTENTIALLY LEAD TO AMPUTATIONS IF LEFT UNTREATED.

THE BELOW ASSESSMENT WILL HELP TO IDENTIFY YOUR RISK FOR PERIPHERAL ARTERIAL DISEASE. PLEASE COMPLETE BOTH SECTIONS IN THEIR ENTIRETY.

PATIENT NAME: _____ DATE: ____/____/____

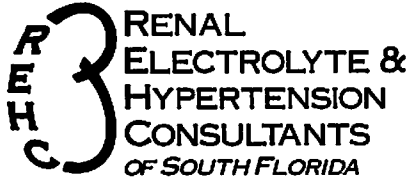
STREET ADDRESS: _____

CITY/ STATE/ZIP: _____ PHONE # _____

DAY OF BIRTH: _____ AGE: _____ EMAIL: _____

RISK FACTORS FOR PAD

- | | | |
|---|-----|----|
| 1. DO YOU HAVE DIABETES? | YES | NO |
| 2. ARE YOU CURRENT OR FORMER SMOKER? | YES | NO |
| 3. DO YOU HAVE LEG PAIN WITH EXERTION?(e.g while walking) | YES | NO |
| 4. HAVE YOU HAD ANY LOWER LEG, ANKLE OR FOOT WOUNDS THAT ARE/WERE SLOW TO HEAL? | YES | NO |



**TO: REHC OF SOUTH FLORIDA
ATTN: JEANNIE CAPHTOM
Privacy Officer
407 S.E 9th Street
Ft. Lauderdale, FL 33316
(954) 463-0112**

ATTN: _____

Authorization for Release of Information for Purposes Request by a Covered Entity from Another Covered Entity.

PATIENT NAME: _____ **D.O.B.** _____

I authorize you to disclose the following protected health information.

(specially describe the information to be disclosed, including, but not limited to, meaningful descriptors, such as date of service, type pf service provided, level of detail to be release, origin of information, etc.

All records, test results scan results, office notes, and any and all other information in my chart, including but not limited to: Further, you are hereby authorized to discuss my medical history with the covered entity named below and provide them with any information requested and or opinions they deem relevant.

This protect health information is being used or disclosed to carry out treatment, payment and/or health care operations in the following manner:

Patient will be seen for evaluation and treatment, including the following

Signature of the Patient: _____ **Date:** ____/____/____

Print name of Patient: _____

Se autoriza a discutir mi historial médico con REHC y proporcionar toda la información solicitada para ser utilizada para evaluación o tratamiento médico, pago o cuidado de salud.