HIPAA NOTICE OF PRIVACY PRACTICE-PATIENT QUESTIONNAIRE

1) PLEASE LIST THE NAME (S) OF A FAMILY MEMBER (S) OR PERSON (S), IF ANY, WHOM WE MAY DISCUSS YOUR DIAGNOSIS AND MEDICAL CONDITION (INCLUDING TREATMENT, PAYMENT AND HEALTHCARE OPERATION). **THIS IS OPTIONAL. YOU MAY LEAVE IT BLANK.**

NAME: ______________________ PHONE NUMBER: ______________________
NAME: ______________________ PHONE NUMBER: ______________________

2) PLEASE LIST THE FAMILY MEMBER OR SIGNIFICANT OTHER, **IF ANY**, WHOM WE MAY INFORM ABOUT YOUR MEDICAL CONDITION IN CASE OF AN **EMERGENCY ONLY.**

NAME: ______________________ PHONE NUMBER: ______________________
NAME: ______________________ PHONE NUMBER: ______________________

3) I UNDERSTAND THAT UNLESS OTHERWISE SPECIFIED, ALL MY CORRESPONDENCE INCLUDING POSTCARD REMINDER CARDS, LAB RESULTS AND BILLING STATEMENTS FROM THIS OFFICE WILL BE MAILED TO MY HOME ADDRESS AND **MAY NOT** BE MARKED "CONFIDENTIAL"

4) I UNDERSTAND THAT UNLESS OTHERWISE SPECIFIED, THIS OFFICE WILL CALL ALL PHONE NUMBERS IN MY RECORDS (INCLUDING HOME, WORK AND CELL) TO CONFIRM APPOINTMENTS, DISCUSS LAB AND XRAY RESULTS AND OTHER HEALTHCARE INFORMATION. **I AM AWARE THAT PHONES MAY NOT BE SECURE OR PRIVATE LINES.**

5) I UNDERSTAND THAT UNLESS OTHER WISE SPECIFIED, THIS OFFICE MAY LEAVE CONFIDENTIAL MESSAGES INCLUDING APPOINTMENT REMINDERS ON TELEPHONE, ANSWERING MACHINE, VOICEMAIL OR CELL PHONE VOICE MAIL.

PATIENT NAME______________________ PATIENT/GUARDIAN SIGNATURE ______________

- YOU MAY GIVE US SPECIAL INSTRUCTIONS ON ANY PART OR ALL OF THIS AUTHORIZATION
- WE CANNOT CONDITION OUR PROVISION OF SERVICES OR TREATMENTTO YOU ON THE RECEIPT OF THIS SIGNED AUTHORIZATION.
- WE MUST PROVIDE YOU WITH A COPY OF SIGNED AUTHORIZATION IF YOU REQUEST IT
- YOU HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANYTIME, PROVIDED THAT YOU DO SO IN WRITING AND EXCEPT TO THE EXTENT THAT WE HAVE ALREADY USED OR DISCLOSED THE INFORMATION. IT IS YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES ON EXISTING AUTHORIZATION.
- YOU MAY INSPECT A COPY OF THE PROTECTED HEALTH INFORMATION TO BE DISCLOSED BY SUBMITTING A WRITTEN REQUEST AND PAYMENT FOR COPIES ($1 PER PAGE/REQUEST CAN TAKE UP TO 30 DAYS).

PF-2000 ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES. I HAVE READ, RECEIVED OR BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR THE DIEZ CENTER FOR WOMEN;S CARE, LLC

PATIENT NAME ______________________ **DATE** ______________

PATIENT/GUARDIAN SIGNATURE ______________________

Mauro E. Diez, M.D., F.A.C.O.G.
Diplomate, American college of Obstetric & Gynecology
GYNECOLOGY, Infertility & Laparoscopic Surgery

DATE:________________________

Insurance Information
Informacion de Seguro

PATIENT'S INSURANCE COMPANY____
(SEGURO DE EL PACIENTE)
POLICY/GROUP NUMBER__________________PERSON INSURED_______________
SOCIAL SECURITY OF PERSON INSURED____________________________________
INSURANCE TELEPHONE NUMBER____

PATIENT'S SECONDARY INSURANCE CO. (IF ANY)
(SEGURO SECUNDARIO)
NAME OF SECONDARY COMPANY____
POLICY/GROUP NUMBER_________________INS. TELEPHONE_________________

Payment is due at the time that services are rendered to you by the doctor or staff. For all insurance plans which we participate in. you will be responsible for any co-payment and/or deductible applicable in accordance with out verification of your plan benefits. With all other insurance plans (which we are not providers for or participate in). payment is due in full when services are rendered.

******DUE TO THE SMALL SIZE OF OUR STAFF, ALL COPAYS ARE COLLECTED AT THE RECEPTION WINDOW IN ADVANCE. ******

Tenga en cuenta que será responsable de un cargo de $50 a su cuenta por cancelaciones en el mismo día y no presentarse a las citas cuando no se haya proporcionado un aviso de 24 horas.

Please be advised you will be responsible for a $50.00 charge to your account for same day cancellations and no show appointments where a 24 hour notice has not been provided.

A $35.00 service charge will be applied to your account for any returned checks. There will be a 1.5% service charge per month on any remaining balance. Should this account be placed out for collections you will be responsible for all reasonable collection and/or attorney's fee.

Patient Name: ______________________________________

Patient Signature: ____________________________________ **Date:** ________________

THE DIEZ CENTER FOR WOMEN'S CARE, LLC
MAURO E. DIEZ, M.D.,F.A.C.O.G.
DIPLOMATE, AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY

E-PRESCRIBING/MEDICATION HISTORY DOWNLOAD CONSENT FORM

E-PRESCRIBING IS DEFINED AS A PHYSICIAN'S ABILITY TO ELECTRONICALLY SEND AN ACCURATE, ERROR FREE AND UNDERSTANDABLE PRESCRIPTION DIRECTION TO A PHARMACY FROM THE POINT OF CARE. CONGRESS HAS DETERMINED THAT THE ABILTIY TO ELECTRONICALLY SEND PRESCRIPTIONS IS AN IMPORTANT ELEMENT IN IMPROVING THE QUALITY OF PATIENT CARE. E-PRESCRIBING GREATLY REDUCES MEDICATION ERRORS AND ENHANCES PATIENT SAFETY. THE MEDICARE MODERNIZATION ACT (MMA) OF 2003 LISTED STANDARDS THAT HAVE TO BE INCLUDED IN AND E-PRESCRIBE PROGRAMS. THIS INCLUDES:

- FORMULARY AND BENEFITS TRANSACTIONS- GIVES THE PRESCRIBER INFORMATION ABOUT WHICH DRUGS ARE COVERED BY THE DRUG BENEFIT PLAN.
- MEDICATION HISTORY TRANSACTION- PROVIDES THE PHYSICIAN WITH INFORMATION ABOUT MEDICATIONS THE PATIENTS ALREADY TAKING TO MINIMIZE THE NUMBER OF ADVERSE DRUG EVENTS.
- FILL STATUS NOTIFICATION- ALLOWS THE PRESCRIBER TO RECEIVE AN ELECTRONIC NOTICE FROM THE PHARMACY TELLING THEN IF THE PATIENT'S PRESCRIPTIONS HAS BEEN PICKED -UP OR PARTIALLY FILLED.

BY SIGNING THIS CONSENT FORM YOU ARE AGREEING TO THAT THE DIEZ CENTER FOR WOMEN'S CARE CAN REQUEST AND USE YOUR PRESCRIPTION MEDICATION HISTORY FORM OTHER HEALTHCARE PROVIDERS AND/OR THIRD PARTY PHARMACY BENEFITS PAYOR FOR TREATMENT PURPOSE.

UNDERSTANDING ALL OF THE ABOVE, I HEREBY PROVIDE INFORMED CONSENT TO THE DIEZ CENTER FOR WOMEN'S CARE TO ENROLL ME IN THE E-PRESCRIBE PROGRAM. I HAVE HAD THE CHANCE TO ASK QUESTIONS AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

PRINT PATIENT'S NAME   D.O.B.

SIGNATURE PATIENT'S OR GUARDIAN'S   DATE

RELATIONSHIP TO PATIENT

THE DIEZ CENTRE FOR WOMEN'S WELLNESS

MAURO E. DIEZ, M.D., F.A.C.O.G.
Diplomat, American College of Obstetrics & Gynecology
GYNECOLOGY, INFERTILITY & LAPAROSCOPIC SURGERY

ASSIGNMENT OF BENEFITS AUTHORIZATION AND RELEASE OF MEDICAL RECORDS:

I hereby authorize Mauro E. Diez, M.D./ The Diez Centre for Women's Wellness to furnish copies of my medical records to my insurance company upon written request as of today and until this authorization is canceled by me. I hereby assign to Mauro E. Diez, M.D./The Diez Centre for Women's Wellness payments directly from my insurance company, now and in the future, for service rendered by him to myself and/or dependents. I further agree that should the amount paid by my insurance company be insufficient to cover my total medical or surgical bill, or if my insurance company should file bankruptcy, I shall be responsible for the remaining balance. I agree that a copy of this signature is as valid as the original.

I understand that in accordance with federal law my medical records **will only be released** (by this office) after written instruction bearing my **signature** is received (even when Dr. Diez is referring you to another specialist).

IN AN EFFORT TO BETTER SERVE OUR PATIENTS, WE ARE REQUIRING A 24 HOUR ADVANCE NOTICE IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT.

I understand the importance of keeping my scheduled appointment and agree to notify the office at least 24 hours in advance if I am unable to keep it. **I also understand that there is an $50.00 fee for same day cancellations/or no shows where 24 hour notice is not given.**

I understand that it may take up to **48 hours** for any routine prescription refills to be called in to my pharmacy by the doctor.

I understand that it may take Dr. Diez up to **48 hours** to return my call for all non-emergency problems, lab result or routine questions.

Patient's Signature_______________________________ Date____________

Legal Guardian_________________________________ Date____________

THE DIEZ CENTER FOR WOMEN'S
MAURO E. DIEZ, M.D., F.A.C.O.G.
Diplomate, American College of Obstetrics & Gynecology
GYNECOLOGY, INFERTILITY & LAPAROSCOPIC SURGERY

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I,______________________________ hereby authorize ________________________ to
Patient's name Physician's name
release Medical, Psychiatric, Drug, and or Alcohol abuse or HIV Testing, ARC or Aids information to:

MAURO E. DIEZ, M.D., F.A.C.O.G./ D/B/A THE DIEZ CENTER FOR WOMEN'S CARE, LLC- 2712 SOUTH FERN CREEK AVE, Orlando, Fl 32806, FAX#: 407-423-2535, phone: 407-422-0037.

for the purpose of _____ Continuing Gyn Care,______ Second Opinion. I understand that specific reports disclosed shall include _______ Pap Smear Results, _____Mammogram Results, ________ Dexa Scan, ________ Operative Reports, ________ Pathology Results, ________ Labs, X rays & Blood Work, ________ All Office Notes available on the above patient.

Alcohol and Drug Abuse information, if present has been disclosed from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part II) prohibits making any further disclosure of it without written consent by the undersigned, or as otherwise permitted by such regulation. HIV testing, ARC and or Aids related diagnosis is further prohibited from further disclosure by State Regulation without the specific written consent from the patient.

Date of Authorization

____

Patient's Full Signature

____

Date of Birth

____

Parent or Legal Guardian

____

Social Security Number

____

Witness

____

Mailed or Faxed to:________________________
Date Requested:___________________________