PATIENT INFORMATION

Name:
____
First | Middle | Last

Address:
____
Street | City | FL | Zip code

Social Security: ________________________ Gender: □ Male □ Female Marital Status: __________________

Date of Birth: __________________ Age: __________

Home phone: ___________________________________ Can we leave a message for you at home? □ Yes □ No

Work phone: ___________________________________ Can we leave a message for you at work? □ Yes □ No

Cell phone: ___________________________________ Can we send you a text message? □ Yes □ No

Email address: ___________________________________ Can we send email to this address? □ Yes □ No

Preferred method of contact? □ Home □ Work □ Cell □ E-mail

Occupation:
___________________________________Employer:____

Emergency Contact:

Name: ____ Relationship:___________________________________

Home Phone: ____________________________________ Work/Cell Phone:________________________________

Referred by: _________________________________ If website, please specify:______________________________

Preferred Pharmacy: ___________________________ Location & Phone: ________________________________

Primary Care Physician: ___________________________________ Phone: ______________________________

CONSENT TO PHOTOGRAPH

I hereby authorize Dr. Daniel Careaga to use photographs from my medical record in such a manner as deemed appropriate. I understand and agree that photos produced from my medical record may be used for educational and/or marketing purposes as deemed appropriate by Dr. Careaga. I understand and agree that all negatives and prints or any item(s) produced therefore will become the property of Dr. Careaga. Furthermore, I understand and agree that I will receive no compensation from Dr. Careaga, or otherwise, for his use of the above described items and hereby waive all claims against Dr. Careaga which relate in any way to such use. All information contained within this document will be confidential and is for Dr. Careaga's use only.

Release photos to be used in before/after photo album and website □ YES □ NO

PAYMENT POLICY

I understand that I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Daniel Careaga and myself.

Signature: ____ **Date: ______________________**

CANCELLATION & LATE ARRIVALS POLICY

*We have a 24-hour cancellation policy, if you are unable to keep your appointment we ask that you give us a call within the allocated time, if you cancel with less than a 24 hour notice you will be charged a **$50.00 NO-SHOW fee**. We want to respect our patients time and our providers time, by not cancelling with a proper notice we are preventing another patient from scheduling.*

We confirm all appointments 24 /48 hours before your scheduled appointment via call, text and or email, we ask that you return our call to confirm, reschedule, or cancel your scheduled appointment.

Cancellation (not within allocated time), no-show will be charged a non-refundable $50.00 fee

After hour appointments or Saturday's must pre-pay for services

You can reschedule once without penalty. If that appointment is rescheduled again, you will be charged the cancellation fee. The cancellation fee will be charged for every time you reschedule that appointment.

Patients with a history of missed appointments will be asked to pre-pay a reservation fee of $50.00 that can be applied to services but if cancellation policy is not honored will then be a cancelation fee and will not be refundable.

Late appointment arrivals: Please note that Spa, laser and injectable appointments are given a specific time block and if you are late to your appointment it will cut into your procedure time or you may need to be re-scheduled

All cancelation Fees are non-negotiable and non-refundable and must be paid.

Thank you for your cooperation!

_______________________ ____________________________ Date: _________________
Patient Name Signature

NOTICE OF NOT CARRYING MALEPRACTICE INSURANCE

I am aware that my Doctor has decided not to carry Medical Malpractice Insurance. I understand that this is permitted under Florida Law 458.320 subject to certain conditions. I understand that Florida Law imposes penalties against, non-insured physicians who fail to satisfy adverse judgments arising from claims of Medical Malpractice- The doctor agrees to satisfy any adverse judgements up to the minimum amounts pursuant 458.320 This notice is being signed after all explanations that I have requested have been made.

_______________________ ____________________________ Date: _________________
Patient Name Signature

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility.

A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Patient Signature ___________________________ Date ________________________________

List of current Medications and Supplements

Patient Name: ____________________________________ *Date:* __________________________________

Do you have any allergies? Yes __________ *No* __________

If YES, please indicate the name ____

Medication/Supplement Name	Dosage/Milligrams/Units	Frequency

Patient Signature: ____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION To ANOTHER MEDICAL PROVIDER OR MYSELF

Patient's Name: Date of Birth:

Address:

I authorize Dr. Daniel Careaga to release my medical records stored at;

Careaga Plastic Surgery
220 Alhambra Circle 1st floor
Coral Gables, FL 33134
305-960-7511
305-441-2556 FAX

To release healthcare records to your physician please indicate MD information below, if records are for your personal use indicate "self"

Doctors Name: ________________________________

Address:____
____

Telephone: ____________________________________
Fax: ____
Email: ____

Careaga Plastic Surgery offers patients the opportunity to communicate via email. Transmitting patient information via email has several risks that patients should consider before granting consent to use email for these purposes. **Careaga Plastic Surgery** will use reasonable means to protect the security and confidentiality of email information sent and received. However, **Careaga Plastic Surgery** cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with email communication via email and I consent to the condition outlined herein. Any questions I may have had were answered.

Type of information to be released:

___ Ultrasound Reports /Mammogram report/Radiology Reports
___ Medications
___ Lab
___ Office Visits
___ E.K. G
___ History and Physical
___ Medical Clearance
___ Other: ____________________

Patient Signature: ________________________________ Date: ________________________

Print Name: ____ Date: _______________________

E-MAIL CONFIDENTIALITY STATEMENT

IMPORTANT CONFIDENTIALITY NOTICE: This transmission contains confidential information, some or all of which may be protected health information as defined by the Federal Health Insurance Portability & Accountability Act (HIPAA) Privacy and Security Rule under 45 CFR Part 160 and 45 CFR Part 164. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient, or an employee or agent responsible for delivering this **electronic mail transmission** to the intended recipient, you are notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender immediately and destroy all copies of the materials sent.

FAX COVER PAGE CONFIDENTIALITY STATEMENT

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Patient Signature: ____ *Date:* __________________________________