

# Patient Registration Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*Nombre* LAST FIRST MI *Fecha*

Address: \_\_\_\_\_  
*Dirrección* STREET APT. # CITY STATE ZIP CODE

Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
*Teléfono de casa* *Teléfono de trabajo* *Celular*

Social Security No. \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Email address: \_\_\_\_\_  
*Número de seguro social* *Fecha de nacimiento*

Sex:  Female  Male Marital Status:  Single  Married  Divorced  Widowed  
*Femenino* *Masculino* *Estado civil* *Soltero* *Casado* *Divorciado* *Viudo*

Ethnicity:  Caucasian  African American  Hispanic  Asian  Native American  Other \_\_\_\_\_  
*Etnicidad*

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
*Empleo* *Cargo*

Employer's Address: \_\_\_\_\_  
*Dirrección* STREET CITY STATE ZIP CODE

Primary Care Physician: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_  
*Doctor primario* *Número de teléfono*

Preferred Pharmacy Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_  
*Nombre de farmacia* *Número de teléfono*

Emergency Contact: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_  
*En caso de emergencia:* *Número de teléfono*

Relation: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
*Relacion* *Idioma principal*

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_  
*Seguro Primario* *Poliza*

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_  
*Seguro Secundario* *Poliza*

ADVANCED DIRECTIVES: A document called a *Living Will* advises your family and physicians of your desires should you become incapacitated and unable to make decisions regarding your healthcare. Have you prepared a living will?  Yes  No  
If **yes**, with whom: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

## Lifetime Medical Authorization and Guarantee of Payment

I authorize **Miami International Cardiology Consultants, Inc.** to submit a claim to my insurance carrier for services rendered to me. I also request that benefits payable for these services be assigned to Miami International Cardiology Consultants, Inc. and be paid directly to Miami International Cardiology Consultants, Inc.

I authorize and holder of medical information of other information about me to be released to my insurance carrier of its intermediaries, and information needed for this claim, or any future claims for services rendered by Miami International Cardiology Consultants, Inc.

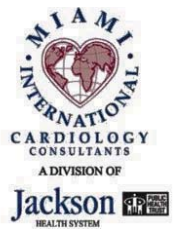
In consideration of Miami International Cardiology Consultants, Inc. providing services to me, I agree that I will not cancel, revoke or limit this authorization for any reason, as long as my insurance company, my attorney, or I, if any, owe any money to Miami International Cardiology Consultants, Inc. for the medical services provided to me or on my behalf.

I authorize my insurance carrier to release information regarding my claim to Miami International Cardiology Consultants, Inc.

I agree to be responsible for payment of any denied claims and for any unpaid balance of any claim for services rendered to me or on my behalf by Miami International Cardiology Consultants, Inc.

\_\_\_\_\_  
Patient Signature Date

# General Consent for Treatment



1. I, the undersigned patient or \_\_\_\_\_ (name of authorized representative acting in behalf of patient) consent to examination, care and treatment from the physicians and other healthcare professionals of Miami International Cardiology Consultants (MICC), a division of Jackson Health System, including but not limited to necessary tests, treatments and other procedures.
2. I understand that MICC is operated by the Public Health Trust of Miami-Dade County, Florida, an agency and instrumentality of the government of Miami-Dade County, and is part of the Jackson Health System. I further understand that the MICC doctors in delivering medical care to me are agents of the Public Health Trust and therefore, as agents of a government entity, are provided with sovereign immunity protection from malpractice liability. This means the only remedy for and injury or damage suffered as a result of any act or omission by an MICC doctor acting within the scope of his/her or duties with the Public Health Trust is an action against the Public Health Trust under §768.28, Florida Statutes.
3. I have been told the name of the physician who has primary responsibility for my care, as well as the names, professional status and professional relationships of the other individuals who will be involved in my care.
4. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me by a MICC doctor as to the results of diagnosis, examinations or treatments in a MICC facility, or in a hospital, or other tertiary facility.
5. I hereby grant to members of the Public Healthy Trust medical staff and other medical researchers access to my medical records for the purposes of bona fide medical research. I further authorize them to use my medical records and results for bona fide medical research. However, my records may no be identified as pertaining to me specifically, without my express written permission.
6. I hereby understand that my medical records will be assessed by senior management of the Public Health Trust for the specific purpose of evaluating the ongoing quality and efficiency of career rendered at MICC and by its staff. I further understand the senior management may use portions of my medical records as necessary for educational and disciplinary purposes, provided that the records will not be identified as pertaining to me specifically without my express written consent.
7. I understand that medical information and records may be released to other institutions, agencies, healthcare organizations of healthcare providers, who accept me for medical or institutional care. I further understand that my medical information may be released to my insurer(s), managed care organization(s), governmental entities responsible for paying for my care, and/or pharmaceutical manufacturers, and their respective agents, for purposes including, but not limited to, payment, Utilization Review and Quality Assurance Review, and to support applications for patient assistance programs.
8. I hereby authorize payment directly to MICC and such other entities as may be authorized by the Public Health Trust of any benefits due to me in any pending claim and/or any health insurance coverage otherwise payable to me, provided that such direct payments do not exceed the amount then due and owing.
9. I hereby agree that a photostatic, digital or faxed copy or transmission of this authorization is as valid as the original.

Signature of patient	Date	Time
Authorized representative, sign and print	Indicate relationship to patient	
Witness, sign and print, include title	Interpreter's signature	
	Witness of Interpreter, sign and print	

**MINOR'S CONSENT:** Patients who are unemancipated minors (patients who are under the age of eighteen, who have never been married) must have parent's or guardian's signature.


Parent signature	Interpreter's signature
Guardian, or authorized representative, sign and print	Witness of interpreter, sign and print
Indicate relationship to patient	
Witness, sign and print, include title	Date
	Time

**MIAMI INTERNATIONAL CARDIOLOGY CONSULTANTS**  
 a division of Jackson Health System  
 Miami, FL 33136-1094

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**GENERAL CONSENT FOR TREATMENT**

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## HIPPA Consent Form

I give consent to Miami International Cardiology Consultants, a division of Jackson Health System, to discuss my health information with the following friends/family members:

Date: \_\_\_\_\_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

May we leave a voice message on a telephone answering machine with our name and telephone number?

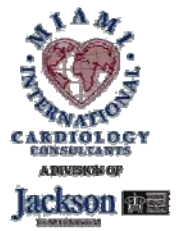
Yes     No

\_\_\_\_\_  
Signature of patient/guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date



# Records Release Form

## Doctor:

- |                                   |                                     |                                  |                                   |
|-----------------------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Bazzi    | <input type="checkbox"/> Concepcion | <input type="checkbox"/> Hurwit  | <input type="checkbox"/> Ross     |
| <input type="checkbox"/> Bratschi | <input type="checkbox"/> Correa     | <input type="checkbox"/> Jaraki  | <input type="checkbox"/> Speziani |
| <input type="checkbox"/> Bryan    | <input type="checkbox"/> Coy        | <input type="checkbox"/> Lister  | <input type="checkbox"/> Tzur     |
| <input type="checkbox"/> Cerami   | <input type="checkbox"/> Elias      | <input type="checkbox"/> Rechani |                                   |

To: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize the release of all my medical records or copies such as labs, EKGs, HIV, CXRs, test results including echocardiograms, reports, exams, procedures, etc. and request that they be transferred to:

- |   |   |
|---|---|
| <input type="checkbox"/> <b>AVENTURA OFFICE - MICC</b><br>21097 NE 27th COURT, SUITE 100<br>AVENTURA, FL 33180<br>O. (305) 792-0012 F. (305) 792-0030           | <input type="checkbox"/> <b>JACKSON NORTH OFFICE - MICC</b><br>100 NW 170 STREET, SUITE 401<br>NORTH MIAMI BEACH, FL 33161<br>O. (305) 655-1877 F. (305) 249-0790           |
| <input type="checkbox"/> <b>BISCAYNE OFFICE - MICC</b><br>3801 BISCAYNE BOULEVARD, SUITE 300<br>MIAMI, FLORIDA 33137<br>O. (305) 571-0620 F. (305) 576-8099     | <input type="checkbox"/> <b>PEMBROKE PINES OFFICE NORTH - MICC</b><br>601 NORTH FLAMINGO ROAD, SUITE 407<br>PEMBROKE PINES, FL 33028<br>O. (954) 433-5666 F. (954) 433-5592 |
| <input type="checkbox"/> <b>HIALEAH OFFICE SUITE 401 - MICC</b><br>7150 WEST 20th AVENUE, SUITE 401<br>HIALEAH, FL 33016<br>O. (305) 571-0671 (305) 362-9823    | <input type="checkbox"/> <b>PEMBROKE PINES OFFICE SOUTH - MICC</b><br>252 SOUTH FLAMINGO ROAD<br>REMBROKE PINES, FL 33027<br>O. (954) 437-8888 F. (954) 437-6256            |
| <input type="checkbox"/> <b>HIALEAH OFFICE SUITE 314 - MICC</b><br>7150 WEST 20th AVENUE, SUITE 314<br>HIALEAH, FL 33016<br>O. (305) 654-7887 F. (305) 654-1350 |   |

\_\_\_\_\_  
Patient name (print)

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Patient date of birth

\_\_\_\_\_  
Social Security number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

Do not write below this line. Office use only.

Requested by: \_\_\_\_\_ Date: \_\_\_\_\_ Received by: \_\_\_\_\_

Sent on: \_\_\_\_\_ By: \_\_\_\_\_ Via: \_\_\_\_\_

