## South Florida Rehab & Training Center
## PATIENT INFORMATION / INFORMACION DEL PACIENTE

_______________________________________ _____/_____/_________ ____________________
Name/Nombre    Date of Birth/Fecha Nacimiento    Social Security Number

______________________________________________________________________________________________
Home Address/Direccion    City/Ciudad    Zip/Codigo Postal

(_____)________________________ (_____)________________________ (_____)________________________
Home Phone No./Telefono de la Casa    Mobile Phone No./Telefono Alternativo    Work Phone No./ Telefono Trabajo

_______________________________________________ __________________________________
Employer/Lugar de Empleo    Occupation/Ocupacion

_______________________________________________ __________________________________
Who may we thank for referring you to us?/Quien lo refirio?    Email Address/Correo Electronico

_______________________________________________ (______)_____________________________
Next of Kin/En caso de Emergencia llamar a?    Phone number/ Telefono

_________________________________ (______)____________________ _________________________________
Insurance Carrier    Insurance Telephone No.    Subscriber No.

Marital Status: Married / Divorced / Widow / Single    Gender: Male / Female

_______________________________________________ (_____)____________________Claim#____________________
If **Worker's Compensation**: Employers Address, Phone Number and Claim Number

Adjusters Name: _______________________________ Phone (_____)_____________________

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**Release of Medical Information**

I hereby authorize any prior or present treating physician, hospital or other health institution, to release all of my medical information, by any means of communication, to South Florida Rehab & Training Center, for the purpose of my physical therapy treatment and/or billing purposes.

**Assignment of Benefits/Consent to Treatment**

I understand and fully agree that I am ultimately responsible for any balance owed to South Florida Rehab & Training Center (Gabriel Carvajal) for any medical services rendered to me. All services must be paid by end of the week that services were rendered. I also understand that any balance not paid after 30 days, will be charged finance charges as allowed per state laws (%Subject to change). Furthermore, I also understand that should my account be transferred to a collections agency or attorney for further collective action, I will also be responsible for the principle amount and any collection fees incurred, if any. I do hereby consent to such treatment by the authorized personnel of South Florida Rehab & Training Center. His consent is intended as a waiver of liability for such treatment except for acts of negligence. If patient is a minor, a parent must sign this form and consent to treatment. Otherwise, services cannot be rendered per State Laws. I have read and understood all of the above and I certify that this information is true and correct t the best of my knowledge. Also, I will notify South Florida Rehab & Training Center if any of the above information changes during the course of my treatment.
I was fully advised of my payment requirements, which is $___________per visit for an hour treatment and agree to accept this responsibility. I understand and accept that there is a late cancellation fee of $25 if I do not notify my therapist within 24 hours.

**(Asignamiento de Beneficios/Consiente la Tratamiento)**

Yo por la preente entiendo y concuerdo completamente que soy responsable por cualquier balance debido a South Florida Rehab & Training Center (Gabriel Carvajal) para cualquier servicio medico rendido a mi. Todos los servicios seran pagados al terminar de cada semana que recibi el servicio. Tambien entiendo que, cualquier tambien que en caso que mi cuenta sea transferida a una agencia de colecciones o abogado para la accion colecta adiciona, yo sere responsable de la cantidad del balance principio y cualquier honorarios de la coleccion, si aplican. Yo por lo presente, consiento al tratamiento por el personal autorizado de South Florida Rehab & Training Center. Este consentimiento se piensa como una renuncia de la obligacion para tal tratamiento menos actos de negligencia.
Si el paciente es minor, un padre debe firmar esta forma y el consentimiento al tratamiento De otro modo, los servicios no se pueden rendir segun las Leyes de Estado. He leido y entendi todo encima y certifico que la informacion es verdadera y correcta al mejor de mi conocimiento. Tambien notificare a South Florida Rehab & Training Center si cualquier de la informacion encima cambia durante mi tratamiento.
Estooy completamente informado(a) de los requisitos de me pago, lo cual es de los requisitos de me pago, porc ada visita lo cual es $___________ y estoy de acuerdo con esta responsabilidad.

_________________________________ _________________________________ _________________________
Patient's Name/Nombre    Signature/Firma    Date/Fecha

_________________________________ _________________________________ _________________________
Parent's Signature/Firma del Padre    Therapist/Terapista    Date/Fecha

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFRMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS VERY IMPORTANT.

**LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on January 1, 2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you in connection with treatment, payment and healthcare operations, for example:

Under no circumstances will protected health information be released (verbally or written) without first obtaining a written "Release of Information Consent" form that is signed by the patient or in the case of a minor, his/her legal guardian. The only exception to the aforementioned would be in life or death situations, or those circumstances mandated by law.

In an effort to assist you in processing, coordination and managing your healthcare operations, (for example: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, etc.) We, upon your request and signed consent, will provide you with a claim form for your submission to your insurance company and will assist you in other related insurance matters. By signing the patient information sheet, you are authorizing us to carry out these functions on your behalf, only upon your request. We do not submit any electronic billing nor do we accept assignment of benefits. Please be aware when a claim form is generated, a diagnosis is given.

Any communication with other healthcare providers, schools or other agencies regarding your healthcare information will only upon your request and a written "Release of Information Consent" form has been signed.

The privacy of your protected health information is very important. We understand that your medical information is personal and we are committed to protecting it!

Patient Information

Name: ______________________________________________________________________________

If minor, Name of parent or legal guardian: ____________________________________________________

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:


**South Florida Rehab & Training Center Inc.**
**(305) 905-4188**
**info@southflcenters.com**


**Right to Revoke**. You will have the right to revoke any release of information consent form that you have signed at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of consent will not affect any action we took in reliance to consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, _________________________________, have had a full opportunity to read and consider the contents of this form and your Notice of Privacy Practices, I understand that by signing this form. I am giving my consent to your use and disclosure of my protected health information in connection with treatment, payment activities and healthcare operations.

**Signature:** _________________________________ **Date:**_______________________________