

Pestana & Pestana, MD., PA

3100 Coral Hills Dr. Suite 201

Coral Springs, FL 33065

PH: (954) 755-8844 FAX: (954) 755-0272

Authorization for Release of Information

I hereby authorize the release of records for:

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Relationship to Patient: _____

I understand that these records are privileged and confidential and cannot be released to those or myself designated by me or my legal guardian without this consent.

Unless otherwise specified below, I authorize the release of **ALL** medical records to the office of Pestana & Pestana, M.D., P.A.

If there are *exceptions* of records you wish to **withhold** from being released, please list them:

I understand that if I have listed any records above, they will not be released.

I understand and agree that I am financially responsible for the fees associated with my request; copying charges, including the cost of the supplies, labor, and postage related to the production of my information deemed by the physician whose records are being requested.

I understand this information includes copies of all progress notes for well visits, acute sick visits, immunization records, consult notes, and if applicable information about HIV or AIDS. Information about substance abuse treatment and information pertaining to mental health services will also be provided. Unless I have indicated above that I wish to have such records withheld and not released.

I understand that I have the right to withdraw the authorization at any time except to the extent that action has already been taken pursuant to the authorization. I must do so in writing and present the written revocation to this office. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws.

UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM DATE OF SIGNATURE.

Signature: _____ Date: _____

Pestana & Pestana, M.D.

IVO D. PESTANA, MD., P.A.
ELSA S. PESTANA, M.D., P.A.
TATIANA PESTANA, M.D.,P.A
3100 CORAL HILLS DRIVE, SUITE 201
CORAL SPRINGS, FL 33065
FAX 954-755-0272

PERMISSION TO SEND MEDICAL DOCUMENTS

I AUTHORIZE PESTANA AND PESTANA, MD TO SEND ANY PATHOLOGY REPORT, OPERATIVE REPORT, OFFICE NOTE OR ANY OTHER MEDICAL DOCUMENT REQUESTED BY MY INSURANCE COMPANY FOR THE SOLE PURPOSE OF A REIMBURSEMENT OF PAYMENT FOR A MEDICAL CLAIM.

NAME OF PATIENT

PATIENT/GUARDIAN

DATE

WITNESS

DATE

Pestana & Pestana, M.D.

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TO OUR VALUED PEDIATRIC AND MEDICINE PATIENTS

We would like to notify you that as of June 1st, 2005, we will be changing our appointment cancellation policy.

We would like to remind you that appointments are made so that the doctors can dedicate that time especially to you and your health concerns. When appointments are cancelled without appropriate notice, this time is denied to others who might have benefited from it.

Our office requires a 24-hour time period for office visit cancellations. We reserve the right to charge a nominal fee of \$50.00 for cancellations made after that time, as well as for un-kept appointments. Keep in mind that this fee is NOT covered by insurance and will be billed to you.

Thank you for you understanding.

I, _____, have read and understand the above office policy.

Signature

Date

Pestana & Pestana, MD., PA.

PLEASE CHECK ONE:
3100

CORAL HILLS DRIVE SUITE 201
CORAL SPRINGS, FL 33065

___ ELSA PESTANA, MD
___ TATIANA PESTANA, MD

PED

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Name _____ Age _____
SSN _____ DOB _____ Sex M / F
Home Phone _____ Wk Ph _____ Cell Ph _____
Address _____ City _____ State _____ Zip _____
Name & Phone # of Emergency contact _____

INSURANCE INFORMATION

SUBSCRIBER RELATIONSHIP _____

INSURANCE _____ ID # _____ GRP # _____

INSURANCE PHONE: _____ CLAIM ADDRESS _____

(This information is required and must be filled in)

*SUBSCRIBERS NAME _____ SSN _____ DOB _____

GUARANTOR INFORMATION (If different from above) _____

(name, address, SSN and phone #) _____

PARENT/GUARDIAN NAME: _____

Allergies to medication: _____ Current Medications: _____

Referred By: _____

FORM OF PAYMENT CASH CHECK CREDIT CARD

I understand that I am financially responsible for all charges incurred in this office regardless of insurance or litigation coverage. I understand that assignment of benefits is not accepted as payment in full in those cases in which this practice does not participate in my insurance program. In the event that my bill is not already paid in full, I assign payment of these benefits I am entitled under the revisions of my insurance coverage to Pestana and Pestana, M.D., P.A. Please, we would appreciate that you let us know if you belong to any of the health insurance programs in which we participate as this may affect your financial responsibility. If payment is not made to this office, patient is responsible for 35% additional collection and 25% attorney's expenses incurred for collection. If more that one billing is necessary to collect payment (after insurance payment, if applicable a \$10.00 billing fee will be added to all subsequent billing statements. Please be aware that plastic surgery costs applied to a credit card are not entitled to a refund unless authorized by the physician. If you have any questions, please do not hesitate to ask us, we will be more than glad to assist you.

I HAVE RECEIVED AND READ THE "NOTICE OF PRIVACY PRACTICES", OF THE PESTANA AND PESTANA, M.D. P.A. OFFICE.

NAME _____ DATE _____

WITNESS _____ DATE _____

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ATTENTION PATIENTS

If you have been prescribed bloodwork or radiological studies, and you *do not* hear from Dr. Pestana with your results, it is because **Dr. Pestana has not received them.**

If you do not hear from Dr. Pestana with your results within several days after your studies, **IT IS YOUR RESPONSIBILITY** to call the office with information about *where and when* you had your studies done, so that we may retrieve them. **Assume we have not received the results until Dr. Pestana calls you.**

Thank you,

Drs. Tatiana & Elsa Pestana

I have read, understood the above notification, and agree that I am responsible for notifying the office of when and where my studies were done. I understand that if I do not hear from the physician, I should assume she has not received the results, and any abnormal results have not been reviewed.

PRINT NAME

DATE

SIGNATURE (Patient, Parent or Legal Guardian)

WITNESS

Pestana & Pestana, MD., PA

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Office Use Only:

MR# _____

Name: _____ DOB: _____
FIRST LAST MM / DD / YEAR

Please list any Doctor that you wish to request medical records from.
(Include your previous Primary Care Physician & any Specialist you currently see.)

- | | | Specialty: |
|----------------------------|--|----------------------|
| 1) _____
Name of Doctor | PHONE: (____) _____
FAX: (____) _____ | <input type="text"/> |
| 2) _____ | PHONE: (____) _____
FAX: (____) _____ | <input type="text"/> |
| 3) _____ | PHONE: (____) _____
FAX: (____) _____ | <input type="text"/> |
| 4) _____ | PHONE: (____) _____
FAX: (____) _____ | <input type="text"/> |
| 5) _____ | PHONE: (____) _____
FAX: (____) _____ | <input type="text"/> |
| 6) _____ | PHONE: (____) _____
FAX: (____) _____ | <input type="text"/> |