



Emergency Contact Phone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Preferred Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_

Medications:  No Medication

Name of Medication	Dosage	How many times a day

ALLERGIES:  NO ALLERGIES

Penicillin  Sulfa  Tetracycline

Tape  Latex  Iodine

Other: \_\_\_\_\_

Social History:

	FORMER	CURRENT	AMOUNT
<input type="checkbox"/> Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____

[ ] None                      [ ]                      [ ]                      \_\_\_\_\_

**FAMILY HISTORY**

[ ] Unknown family history

Please limit to parents, grandparents and siblings

	<b>FAMILY MEMBER</b>
Coronary Artery Disease	
Hypertension	
Hyperlipidemia	
Stroke	
Diabetes	
Kidney Disease	
Breast Cancer	
Colon Cancer	
Prostate Cancer	
Mental Illnes	
Other	

**PAST MEDICAL HISTORY:**

Y   N

Y   N

Y   N

Angina			Gerd			Skin Cancer		
Atrial Fibrillation			Hepatitis			Stomach Cancer		
Congestive heart failure			Hernia			Uterine Cancer		
Coronary Artery Disease			Irritable Bowel Syndrome			Bipolar Disorder		
Hypertension			Ulcerative Colitis			Anxiety		
High Cholesterol			BPH/Enlarge Prostate					
Mitral Valve Prolapse			Frequent UTI's			Depression		
Past Heart Attack			Incontinence			Demencia		
Palpitations			Kidney Stone			Insomnia		
PVD			Osteoarthritis			Other :		
Stroke			Osteopenia					
Asthma			Rheumatoid Arthritis					
COPD/Emphysema			Osteoporosis					
Chronic Bronchitis			Cataract					
Sleep Apnea			Glaucoma					
Hypothyroidism			Macular Degeneration					
Thyroid Nodule			Chronic Sinusitis					
Diabetes Type I			Breast Cancer					
Diabetes Type II			Colon Cancer					
Colon Polyps			Lung Cancer					
Crohn's Disease			Liver Cancer					

Diverculosis			Prostate Cancer				
Gallstone			Ovarian Cancer				

**Surgical Hystory :**

	Y	N		Y	N
Appendix Removal			Tonsillectomy		
Colon Resection			Sinus Surgery		
Colostomy			Thyroid Removal		
Gallbladder Removal			CABG ( open Heart)		
Gastric Bypass			Valve Repair		
Hernia Repair			Pacemaker		
Hemprroid Removal			Fem-Pop Bypass		
Laparascopy			Skin Cancer Removal		
Cataract Surgery R L			Vein Stripping		
C-Section			Wisdom Teeth		
D & C			Back Surgery		
Hysterectomy			Neck surgery		
Tubal Ligation			Knee Replacement		
Mastectomy R L			Hip Replacement		
Breast Augmentation			Other :		

**Choose if you had any of these procedures :**

Procedure	Date
Colonoscopy	
Endoscopy	
Stest Test	
Pap Smear	
Mammgram	
Bone Density	
Physical Exam	
Flu Vaccine	
Pneumonia Vaccine	
Gardasil Vaccine (HPV)	
Zostavax Vaccine (Shingles)	
<b>WOMEN ONLY</b>	
Age at onset of menstruation:	
Date of last Menstruation :	
Number of bleeding days:	
Heavy periods,irregularity ,spotting, pain, discharge :	
Flow: Light    Medium    Heavy	

**Type of Delivery:**

Year	SEX	VAGINAL	C-SECTION	COMPLICATIONS
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Reason of the Visit: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature

\_\_\_\_\_

Name

\_\_\_\_\_

Date

CASTILLO & TORRES MD PA  
2328 S Congress Ave Suite 1E  
Palm Springs, FL 33406  
PH# 561-324-7224  
Fax# 561-225-1780

CASTILLO & TORRES MD PA  
3046 S Congress Ave  
Palm Springs, FL 33461  
Ph# 561-324-7224  
Fax# 561-225-1780

CASTILLO & TORRES MD PA  
1307 Lyons Rd  
Coconut Creek, FL 33063  
Ph# 954-727-8848  
Fax# 561-225-1780

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#### FINANCIAL POLICY:

The following information is provided to make our financial policies clear and avoid any misunderstandings concerning the payment of professional services.

#### INSURANCE:

Our practice participates in a variety of insurance plans. It is your responsibility to:

- Bring your Insurance Card to every visit
- Be prepared to pay for any co-pays and deductibles that apply
- Payment in full is due at the time of service for any medical care not covered by your insurance

#### SELF PAY PATIENTS:

- Payment for office visits is due at the time of service

#### REFERRALS:

Please allow up to 7 business days from the requested date.

#### LAB FEES:

Please be aware that lab fees for bloodwork and pathology (including PAP smears) are separate from our office charges and may be billed directly to you by the lab company.

Insurance coverage is complicated each policy is different. If you have any questions about your insurance, we are happy to help you. However, details about your coverage must be directed to your Insurance Company's Member Service Department. Their number is usually found on the back of the insurance card.

**PRIVACY:**

These premises are protected by 24-hour audio and video surveillance; by entering you agree to be audio and video recorded.

**ASSIGNMENT OF BENEFITS:**

I authorize payments of medical benefits to CASTILLO & TORRES MDPA practice for services rendered. I understand that I am responsible for all charges not covered by any medical insurance. In addition, I am responsible for any deductible, co-payment, co-insurance amounts.

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SIGNATURE

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DATE

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PRINT NAME

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RELEASE OF INFORMATION

MEDICAL RECORD RELEASE:

I authorize the release of any medical information necessary to process any insurance claim(s). I permit a copy of this authorization to be used in place of the original.

The following person can have access to my medical information:

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

OR

( ) Do not leave me a message or release information to anyone. Speak directly with me before releasing medical information.

By signing this authorization, I understand that medical records released may contain information related to HIV status, sexually transmitted diseases, and other personal information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

CONENT FOR TREATMENT:

I authorize request and consent for the performance of office procedure deemed necessary by the physician and their staff.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If the patient is less than 18 years of age:

\_\_\_\_\_

\_\_\_\_\_

Signature

Date

## Chronic Care Management (CCM) Consent

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_\_\_

What are CCM Services?

Chronic Care Management (CCM) services help manage your health between office visits. The program provides a series of non-face-to-face activities and additional services especially for our CCM patients.

For example:

- You will have a dedicated Care Team that is familiar with your conditions.
- We actively help you manage all your medications.
- We help Coordinate visits with your providers, facilities, labs, radiology, and/or other medical services.
- We provide a personalized and comprehensive care plan management.

Your Care Plan

Your Care Plan includes valuable information that will help you understand your medical conditions. Your Care Plan will help you to be as healthy as possible. Your caregivers and other authorized providers can access your Care Plan 24/7 using our secure medical portal in the event you require care when we are not available.

I consent \_\_\_\_\_ to allow my advanced practitioner and their designees to perform CCM on my behalf. I understand that I can revoke this permission at any time by notifying my PCP. I agree to participate in the Chronic Care

\_\_\_\_\_

PATIENT/PATIENT REPRESENTATIVE SIGNATURE

\_\_\_\_\_

\_\_\_/\_\_\_/\_\_\_\_\_

PATIENT/ PATIENT REPRESENTATIVE PRINTED NAME

DATE

## CASTILLO & TORRES MD PA

### Summary of Privacy Practices

*A copy of the complete "Notice of Privacy Practices" is available upon request or by calling 561.324. 7224*

### **OUR PRIVACY PRACTICES**

While providing healthcare services to you, we may use and disclose your protected health information to carry out treatment, to pursue payment, for health care operations at our facilities and for other purposes that are permitted or required by law. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care service.

*Some of the ways that we may use your information could include the following:*

- Appointment Reminders
- To Discuss Treatment Alternatives
- Health-Related Benefits and Services
- Fundraising Activities
- Hospital Directory
- Individuals Involved in a Patient's Care or Payment for a Patient's Care
- Clinical trials
- As Required By Law
- To Alert a Serious Health or Safety Threat

*In the following special situations, we may also be required to use or disclose your health Information:*

- Organ and Tissue Donation
- Military and Veterans
- Workers' Compensation
- Public Health Risks
- Health Oversight Activities
- Lawsuits and Disputes
- Law Enforcement
- Coroners, Medical Examiners and Funeral Director
- National Security and Intelligence Activities
- Inmates

**Castillo & Torres MD PA** works closely with **CMTD RESEARCH** to provide comprehensive care to our patients. Demographic and medical information may be shared with CTMD Research to make our patients aware of new treatments or services that may Impact their health.

Other uses and disclosures of medical Information not covered by our Notice of Privacy Practices or the laws that apply to us will be made only with a patient's written permission.

### **Patient Rights**

*Patients have the following rights regarding medical Information maintained by Castillo & Torres MD PA*

- **Right of Request Restriction on who has access to Information.**
- **Right to Receive Confidential Communication**
- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to an Accounting of Disclosures**
- **Right to a Paper Copy of the Castillo & Torres MD PA Notice of Privacy Practices**
- **Right to File a Complaint**

Patient will not be penalized for filing a complaint. Castillo & Torres MD PA is committed to protecting an individual's rights under the Health Insurance Portability and Accountability Act (HIPAA) and at no point will require an Individual to waive their right to file a complaint as a condition of the provision of treatment.

**Important Contact Information**

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<http://www.hhs.gov/oc>

By signing this form, I acknowledge that I have been made aware of the Castillo & Torres MD PA "Notice of Practices" and was offered a copy. I understand I am not required to sign this authorization.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NAME