Innovative Cancer Institute
5995 SW 71 St. | Miami, Florida 33143 | T.305-669-6833 | F.305-666-4030

TASACION DE DOLOR, DEPRESION Y CAIDA

DOLOR (si usted tiene dolor, complete preguntas 1-3)

1. ¿Cuándo comenzó su dolor? (hoy, ayer, hace un mes) ☐ NO HAY DOLOR (sigue a la próxima sección)
2. ¿Dónde es el dolor?
3. En la escala del 1 al 10 ¿Que tan grave es su dolor?

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

DEPRESION

1. ¿Se siente usted triste, deprimido o sin esperanza? ☐ Si ☐ No
2. ¿Ha pensado usted en hacerse daño? ☐ Si ☐ No
3. ¿Se siente usted mal consigo mismo o siente que ha fracasado o que ha decepcionado a su familia o a usted mismo? ☐ Si ☐ No
4. ¿Se siente cansado o con poca energía? ☐ Si ☐ No

CAIDA

1. ¿Usted se ha caído en el último año? ☐ Si ☐ No
2. ¿Usted requiere asistencia para caminar (silla de ruedas, bastón, o caminador)? ☐ Si ☐ No
3. ¿Usted tiene temor de caerse o se siente inestable al pararse o caminar? ☐ Si ☐ No
4. ¿Se siente mareado cuando se pasa de estar acostado a sentado o de pie? ☐ Si ☐ No

INNOVATIVE CANCER INSTITUTE
DR. BEATRIZ AMENDOLA, MD, FACR, FASTRO
5995 Southwest 71st Street
South Miami, FL 33143
Phone number: 305-669-6833
Fax: 305-666-4030

PATIENT'S NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

The above named patient has been referred to us for radiation therapy. We would appreciate your sending us the medical records indicating below:

☐ Operative Records

☐ Clinical Summary

☐ Pathology Reports

☐ Radiation Therapy Records

☐ Mammogram/Ultrasound

☐ X-Rays, CT's, MRI, PET/CT, US's and Bone Scan.

Please forward these as soon as possible directly to the Radiation Oncologist at the address listed above.

RELEASE OF MEDICAL RECORDS

I hereby authorize the release of my medical records as requested above.

_____ Witness

_____ Patient's Signature

_____ Date

_____ Date

DRA. BEATRIZ AMENDOLA, MD, FACR, FASTRO

Hoja De Información Del Paciente

Apellido: _____ Nombre: _____ 2do. Nombre: _____

Dirección: _____ Ciudad: _____ Estado: _____ Código Postal: _____

Fecha de Nacimiento: _____País Natal: _____ Género: _____

Raza: _____ Grupo Étnico: _____ Ciudadanía: _____

Número de Teléfono (celular): _____ Compañía de celular: _____

Número de Teléfono (casa): _____ Dirección de correo electrónico: _____

Idioma Principal: _____ Nombre de la Farmacia: _____ Número de Teléfono (farmacia):_____

Número de Seguro Social: _____Estado Civil: divorciado(a)/Soltero(a)/Casado(a)/Viudo(a) (Por favor circule)

Empleo: _____ Número de Teléfono: _____

Si jubilado(a), anterior empleador y/o industria _____

Contacto De Emergencia: _____ Relación: _____ Número de Teléfono: _____

Dirección: _____ Ciudad: _____ Estado: _____ Código Postal: _____

Motivo de Consulta:_____

Alergias: _____

Lista de medicaciones y dosis: _____

_____

Lista de todas las operaciones, hospitalizaciones y enfermedades previas: Fechas:

_____ _____

LISTA DE SUS DOCTORES: _____ _____

Lista de exámenes diagnósticos: _____

Referido por: _____

¿Cómo se enteró de nuestro centro? _____

¿Ha visitado a nuestra página de internet? _____

_____ _____

Fecha Firma de Paciente

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am hereby entitled, including Medicare, private insurance, and any other health plan to Beatriz E. Amendola, MD FACR.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. Returned checks and balance older than 30 days may be subject to additional collection, attorney, court costs and interest charges of 1.5% per month. I certify that I have read and understand fully the providers billing policy and agree to make payment in full and/or satisfactory arrangements when asked to do so as specified above.

***** ALL COPAYMENTS / DEDUCTIBLES DUE AT TIME SERVICE RENDERED *****

Aviso- Sobre el Parqueo

Innovative Cancer Institute provée parqueo gratis -bajo techo- a nuestros pacientes.

Por favor, sírvase estacionar en el garaje designado llamando al 305-669-6833 al llegar y se le abrirá la puerta del garaje.

Si estaciona en otro lugar, no nos hacemos responsables de multas ni de gastos de grúas.

Al firmar aquí debajo, usted acepta la política de estacionamiento de Innovative Cancer Institute

Nota: La entrada al parqueo se encuentra en la avenida 61 del SW

Gracias.

_____ _____

Nombre Firma

INNOVATIVE CANCER INSTITUTE
DR. BEATRIZ AMENDOLA, MD, FACR, FASTRO

FINANCIAL POLICY

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Innovative Cancer Institute firmly believes that a good doctor/patient relationship is based upon understanding and open communication.

This practice will file all insurance claims to your primary and secondary carriers. Our practice will require you to assign all insurance company payments directly to our office to avoid any misunderstanding regarding payment for professional services. Your insurance coverage is a contract between you and your insurance carrier; however, we will assist you to maximize your insurance benefits. If you request your insurance company to pay your directly, we will require full payment when services are rendered.

By law, your insurance carrier must remit payment or deny your insurance claim within 30 days of initial notice of claim. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier, as we feel it if necessary to work together to resolve any insurance problem.

Payment is expected at time of service. Please be prepared to pay the unpaid insurance percentage, your co-insurance, or any outstanding deductible when services are rendered.

All past due balances are subject to outside collection agency placement. Innovative Cancer Institute reserves the right to obtain any information needed from credit reporting agencies to ascertain a patient's current financial/credit status. This practice follows CMS and CCI guidelines for billing. Using these guidelines, Innovative Cancer Institute considers bundled incidental to any services or supplies that are deemed not medical necessary/ medical necessity, will be considered non-covered services and will be the patient's responsibility for these non-covered services. You will be will be responsible to pay the rate we are contracted with you insurance provider.

Our staff is ready and willing to make every effort to assist you with your questions. PLEASE do not hesitate to ask us. We are here to help you.
(305)-669-6833

INSURANCE INFORMATION

1. PRIMARY INSURANCE CO:_____
   MAILING ADDRESS:_____ PHONE # :(____)_____
   CITY:_____ STATE:_____ ZIP:_____
   POLICY #:_____ GROUP #:_____
   INSURED PERSON'S NAME:_____ INSURED PERSON'S SOC. SEC. #:_____
2. SECONDARY INSURANCE CO:_____
   MAILING ADDRESS:_____ PHONE # :(____)_____
   CITY:_____ STATE:_____ ZIP:_____
   POLICY #:_____ GROUP #:_____
   INSURED PERSON'S NAME:_____ INSURED PERSON'S SOC. SEC. #:_____

LIFETIME AUTHORIZATION
MEDICARE AND/OR OTHER INSURANCE – CERTIFICATION FOR PAYMENT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or Carriers any information needed for this or related **Medicare** and or **Other Insurance** claim. I request that the payment of authorized benefits for **Medicare** or **Other Insurance** Companies be made to Innovative Cancer Institute on my behalf.

FOR **MEDICAID PATIENTS:** I certify that I am a recipient of the Medicaid program, Title XIX, and request that payment of authorized benefits be made on my behalf. I authorize Innovative Cancer Institute to make available to the Florida Department of Children and Family Services any request information concerning medical insurance and financial records related to my treatment. I hereby certify all health insurance shall be assigned to Innovative Cancer Institute

I request that this authorization also apply to all **Other Insurance**.

I understand the above policy and agree that, after any contractual arrangements between Innovative Cancer Institute and the insurance carrier are satisfied, I am ultimately responsible for the balance on this account.

Signature:_____ _____
Signature of Parent or Legal Guardian
If patient is a Minor

Printed Name:_____

Date:_____

INNOVATIVE CANCER INSTITUTE
DR. BEATRIZ AMENDOLA, MD, FACR, FASTRO, FACRO

NOTICE OF PRIVACY PRACTICES

Effective date: January 1, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. YOUR RIGHTS WITH RESPECT TO YOUR CONFIDENTIAL INFORMATION

- **a. To inspect, copy (including a paper copy) and receive information**
- **b. To request the right to amend your information (although we are not required to do so)**
- **c. To receive an accounting of non-routine or non-authorized disclosures of your information for 6 years**
- **d. To request a restriction on certain uses and disclosures of your information (although we are not required to do so)**
- **e. To file a complaint if your believe your rights have been violated***

2. THE FOLLOWING ARE VARIOUS USES AND DISCLOSURES OF YOUR CONFIDENTIAL PATIENT INFORMATION THAT MAY BE USED BY YOUR PHYSICIAN (No specific medical consent is required)

- **a. For your medical treatment**
  - **i. For example, your health care team may share your medical information including their observations, in order to determine how you are responding to treatment**
  - **ii. For example, we may use your health care information to contact you regarding an appointment**
- **b. To bill for your medical services**
  - **i. For example, a bill may be sent to your insurance company which contains your diagnosis, procedure performed or supplies used.**
- **c. For our operational purposes**
  - **i. For example, your information may be used in connection with quality improvement activities in order to improve the quality and effectiveness of the services we provide.**
  - **ii. For example, our business associates may need access to your confidential information so they can perform the job we asked them to do. Business associates include accreditation agencies, state hospital associations, our attorneys and accountants.**

3. USES AND DISCLOSURES OF YOUR CONFIDENTIAL INFORMATION WE MAY MAKE UNLESS YOU OBJECT

- **a. To family and friends involved in your care**
- **b. With respect to treatment alternatives or other health related benefits which may be of interest to you**

4. **USES AND DISCLOSURES OF YOUR CONFIDENTIAL INFORMATION WE MUST MAKE (Without your consent).**

   a. **When required by state or federal law**
   b. **To state and federal public health authorities for disease prevention**
   c. **To protective service agencies authorized to receive reports of abuse, neglect and domestic violence**
   d. **To governmental oversight agencies**
   e. **When required pursuant to a court order**
   f. **For law enforcement purposes**
   g. **To a coroner, medical examiner or funeral director for the purpose of carrying out their duties**
   h. **To organ procurement organizations**
   i. **Pursuant to established research protocols (IRB or Privacy Board approval)**
   j. **When required to avert a serious threat to health or safety**
   k. **In connection with workers compensation programs**

Any other uses other than what is described above is prohibited unless specific authorization is given by you. You have the right to revoke such authorization at any time in writing, except to the extent we have already relied on it.

5. **OUR DUTIES**

   a. **We are required to maintain the confidentiality of your medical information and to provide you with notice of our legal duties and privacy practices**
   b. **We are required to abide by the terms of this Notice**
   c. **We reserve the right to change the terms of this Notice and will post the new Notice when it becomes effective**

6. ***RIGHT TO COMPLAIN**

   a. **You may complain to the office manager or privacy officer if you believe your rights identified in this Notice have been violated. Contact our office for the form for filing a complaint.**
   b. **If you are unhappy with how your complaint was handled, you may contact the Secretary of Health and Human Services.**
   c. **The law prohibits any retaliation for filing a complaint**

7. **FOR FURTHER INFORMATION**

   You may contact Michelle Milan, Office Manager at 305 669 6833 for any further information with respect to this policy.

_____ _____

Patient Signature (or legal representative) **Date**