2531 N Dixie Hwy – Lake Worth Fl 33460
Ph.561-582-0330 Fax 561-582-0339

Español	English
Apellido:	**Last Name:**
Nombre:	**First Name:**
Direcciòn:	**Address:**
Ciudad:	**City:**
Zip Code:	**Zip Code:**
Fecha de Nacimiento: / /	**Date of Birth: / /**
Correo electronico:	**E-mail address:**
Telèfono: ( ) -	**Phone # ( ) -**
Sexo: Masulino / Femenio	**Sex: Male / Female**
Seguro Social #: - -	**S.S.# : - -**
Estado Marital:	**Marital Status:**
Numero de Medicare:	**Medicare ID:**
Numero de Medicaid:	**Medicaid ID:**
Compania donde trabaja:	**Employer:**
Telefono del trabajo: ( )	**Work phone: ( )**
Contacto de emergencia: ( )	**Emergency contact:**
Nombre:	**Name:**
Relacion:	**Relationship:**
I give permision to commuinicate my Private Healthcare Information to/ Doy permiso para compartir mi Informacion Medica Privada a:	
Name/Nombre:	**Relationship/Relacion:**
Name/Nombre:	**Relationship/Relacion:**
Name/Nombre:	**Relationship/Relacion:**
Idioma primario:	**Primary language:**

I hereby acknowledge that I have read, understand and agree with the information provided as being true and correct. I also authorize the release of any medical information necessary to process claims arising out my health care. _____ (initials)

Por la presente reconozco que he leído, entiendo y estoy de acuerdo con la información proporcionada como verdadera y correcta. También autorizo la divulgación de cualquier información médica necesaria para procesar reclamaciones que surjan de mi atención médica. _____ (iniciales)

X_____ Date:_____/_____/_____

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REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____
Physician's Institution's name (Print)

Address: _____

City: _____State: _____ Zip Code_____

Fax: _____ Phone: _____
I hereby request that my medical records be released

To: Johnson Medical Services_____
Physician's Institution's name (Print)

Address: 2531 N Dixie Hwy _____

City: Lake Worth_____ State: Florida_ Zip Code: 33460_____

Fax: (561) 582-0339_____ Phone: (561) 582-0330_____

Date: _____/_____/_____

Patient's Name (Print): _____

Date of Birth: _____/_____/_____Social Security: _____

Patient's Signature: _____

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ATTENTION TO ALL PATIENTS

UNDER FLORIDA LAW, PHYSICIANS ARE GENERALLY REQUIRED TO CARRY MEDICAL MALPRACTICE INSURANCE OR OTHERWISE DEMOSTRATE FINANCIAL RESPONSIBILITY TO COVER POTENCIAL CLAIMS FOR MEDICAL MALPRACTICE.

YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE; THIS IS PERMITED UNDER FLORIDA LAW SUBJETED TO CERTAIN CONDITIONS. FLORIDA LAW IMPOSES PENALTIES AGAINST NONINSURED PHYSICIANS WHO FAIL TO SASTIFY ADVERSE JUDGEMENTS ARISING FROM CLAIMS OF MEDICAL MALPRACTICE.

THIS NOTICE IS PERSUANT TO FLORIDA LAW. I HAVE READ THIS STATEMENT AND FULLY UNDERSTAND IT.

PATIENT SIGNATURE: _____

ATENCION PACIENTES

BAJO LAS LEYES DE LA FLORIDA, SE REQUIERE QUE GENERALMENTE LOS MEDICOS TENGAN SEGURO DE MALAPRACTICA MEDICA, O SI NO MUESTRAN FINANCIERA PARA CUBRIR POSIBLES RECLAMACIONES POR MALPRACTICA MEDICA.

SI SU MEDICO HA DECIDIDO NO TENER SEGURO DE MALAPRACTICA MEDICA, ESTO SE PERMITE POR LAS LEYES DE LA FLORIDA SUJETO A CIERTAS CONDICIONES.

LAS LEYES DE LA FLORIDA IMPONEN MULTAS A LOS MEDICOS NO ASEGURADOS QUE NO SATISFAGA JUICIOS ADVERSOS DERIVADOS DE RECLAMACIONES DE MALAPRACTICA MEDICA ESTE AVISO HA SIDO PROVISTO SIGUIENDO LAS LEYES DE LA FLORIDA SU DOCTOR.
YO HE LEIDO Y HE ENTENDIDO PERFECTAMENTE ESTE AVISO.

FIRMA DEL PACIENTE: _____

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CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALHTCARE OPERATIONS.

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatments and any plans for future care or treatment.

I understand that this information serves as:
- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

No restrictions

I understand that I have the right:
- To object to the use of my health for directory purpose.
- To request restrictions as to how my health information may be used or disclosure to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to t he restrictions requested.
- To revoke this consent in writing except to the extend that the organization has already taken actions in reliance there on.

SIGNATURE _____ DATE ____/____/____

CONSENTIMIENTO PARA EL USO Y DIVULGACIÓN DE INFORMACIÓN MÉDICA PARA OPERACIONES DE TRATAMIENTO, PAGO O ATENCIÓN MÉDICA.

Para el Paciente – Por favor lea cuidadosamente las siguientes declaraciones.

Proposito del cosentimiento, al firmar este formulario, usted estará consintiendo a nuestro uso y acceso de su Informacion protegida de salud, a realizar tratamiento, actividades de pagos y operaciones del cuidado de la salud.

Aviso de las practicas de confidencialidad. Usted tiene el derecho de leer nuestro aviso de las practicas de Confidencialidad antes de decidir si quiere firmar este consentimiento. Nuestro aviso proporciona una descripción de nuestro tratamiento, actividades de pagos y operaciones del cuidado de la salud, de las aplicaciones y de los accesos. Podemos hacer de su informacion protegida de salud y de otras materias importantes sobre su informacion protegida de salud. Una copia de nuestro aviso acompaña este consentimiento. Le animamos a que lea cuidadosamente y completamente ese documento antes de firmar este consentimiento.

Reservamos el derecho de cambiar nuestras practicas de confidencialidad según descrito en nuestro aviso de las Practicas de confidencialidad. Si cambiaramos nuestras practicas de confidencialidad, publicaríamos un revisado aviso de las practicas de confidencialidad, que contendrán los cambios. Esos cambios pueden ser aplicados a cualquiera de nuestra información protegida que mantengamos.

FIRMAR_____ FECHA ___/____/____

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This Form is not to released as part of the patient's medical record under Any circumstances unless specifically authorized by the patient below

HIV TESTING

Name of Patient_____

Human immune-virus (HIV) is the cause of acquired immune deficiency syndrome (AIDS). Blood tests for HIV is available, however they are not 100% accurate and sometimes these blood test produce false positive and false negatives test results. The presence of HIV antibodies means that a person probably has been infected with the AIDS virus, does not necessarily mean that a person will develop AIDS. Women who are generally considered to be at a higher risk the development of HIV infection are those that engage in sexual activity with bisexual men, have multiple sex partners, use drugs intravenously, receive multiple blood transfusion, or those who received blood transfusion prior 1985, the absence of any of these risk factors does not eliminate the possibility of having acquired an HIV infection, Pregnant women who are HIV positive are at very high risk for transmitting the virus that causes AIDS to their unborn child during pregnancy, there are, however, treatments that can in many instances prevent transmissions of HIV virus to the fetus.

Considering the above information I choose not to have my blood drawn for HIV testing.

Date_____ _____

Signature of patient

CONSENT FOR HIV TESTING

I hereby authorize Johnson Medical Services, Inc. and or such associates as may be selected by them test my blood for the presence of HIV antibodies.
The procedure(s) necessary to perform the blood test have been explained to me. The reason these test are advisable have been explained to me as well as an alternatives. I Have been informed regarding the measures for the preventing of, exposure to, and transmission of HIV.
I understand that my physician is required by law to inform me of the results of the test in person and agree to return this purpose.

* A. I authorized my doctor's office to furnish my insurance companies and other third party payers with any and all information it has or may hereafter have, either written ororal, pertaining to or in any manner connected with the tests authorized herein, I authorize the release of information by the doctor's office along with other medical information at any time they receive request, authorized by me, to release my medical record, I further agree that no person, firm, o corporation shall be held liable in any manner for furnishing or having furnished such information.
* B. I do not consent to the release of the nature of the test(s) to my insurance companies or any person. I understand that this will mean that I must pay the bill for the test myself, at the time the service is rendered and should not submit the bill to my insurance company for reimbursement.

Subject to the foregoing, Johnson Medical Services, to the best of its ability, will not disclose the results of these tests to others except to the extend required by law or to the extent such disclosure is required to safeguard the well being it's employees or the other person at risk beginning January 1, 1997, state law requires that positive tests for HIV be reported to the county health department.
On this basis, I authorize my physician or his/her designee to perform the above test.
Date_____ _____

Signature of patient

Pre-test counseling performed by Dr._____on_____
HIV results_____
Post-test counseling performed by Dr._____on_____

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LIVING WILL

Declaration made this _____ day of _____, 2____, I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____(initial) I have a terminal condition,

or _____(initial) I have an end-stage condition,

or _____(initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. I do ___, I do not ___ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name _____

Street Address _____

City _____ State _____ Phone _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

AdditionalInstructions(optional):_____

_____

_____

_____

_____

(Signed) _____

Witness _____ Witness _____

Street Address _____ Street Address _____

City _____ State _____ City _____ State _____

Phone _____ Phone _____

At least one witness must not be a husband or wife or a blood relative of the principal.

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DESIGNATION OF HEALTH CARE SURROGATE

Name: _____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name _____

Street Address _____

City _____ State _____ Phone _____

Phone: _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name _____

Street Address _____

City _____ State _____ Phone _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional instructions (optional):

_____

_____

_____

_____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name _____

Name _____

Signed _____

Date _____

Witnesses 1. _____

2. _____