(Por favor escriba en letra de molde)

Su Nombre como aparece en su tarjeta de seguro médico: Sexo: Masculino Femenino

_____ Fecha de Nacimiento: _____

Domicilio: _____
Calle # de Apartamento Ciudad Estado Código Postal
Raza: _____ Etnicidad: _____ Idioma: _____

Núm. de Seguro Social: __ __ __ - __ __ - __ __ __ __ Estado Civil: Casado/a Soltero/a Viudo/a Divorciado/a

Núm. de teléfono de casa: _____ Núm. de teléfono celular: _____

Correo Electrónico: _____

Médico familiar: _____ Núm. de teléfono: _____
¿Quién lo refirió a nuestra oficina? _____ Núm. de teléfono: _____

Contacto de Emergencia: _____ Núm. de teléfono: _____
Relación al Paciente: _____

Nombre de la parte responsable: _____ Relación al paciente: _____
Domicilio: _____ Núm. de teléfono: _____

Empleador: _____ Núm. de teléfono: _____
Titulo Nombre/ Posición: _____

¿ES EL MOTIVO DE SU VISITA POR UN ACCIDENTE DE TRABAJO?	SI	NO
¿ES EL MOTIVO DE SU VISITA POR UN ACCIDENTE AUTOMOVILÍSTICO?	SI	NO

POR FAVOR LLENE COMPLETAMENTE LA INFORMACIÓN DE SEGURO MÉDICO

SEGURO MÉDICO PRIMARIO: _____ Nombre del dueño de la póliza: _____
Núm. de Identificación: _____ Núm. de Grupo: _____ Relación al paciente: _____
Núm. de Seguro Social del dueño de la póliza: _____

SEGURO MÉDICO SECUNDARIO: _____ Nombre del dueño de la póliza: _____
Núm. de Identificación: _____ Núm. de Grupo: _____ Relación al paciente: _____
Núm. de Seguro Social del dueño de la póliza: _____

MEDICAMENTO ACTUAL:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALERGIAS:

Es usted alérgico a algún medicamento? Si No

SI TIENE REACCIONES ALÉRGICAS a medicamentos, por favor enlístelos junto con su reacción:

Medicamento:	Reacción:
_____	_____
_____	_____
_____	_____

TIENE CONDICIONES MÉDICAS?	HA TENIDO PREVIAS CIRUGIAS?
_____	_____
_____	_____
_____	_____

FARMACIA:

Nombre: _____ Núm. de Teléfono: _____
Dirección o calles principales: _____

HISTORIAL SOCIAL: (Circule uno)

Fuma? Nunca Ex-Fumador Fumador Actual: ____ paquetes / cigarros por día
Consume Alcohol? Nunca Mensual Semanal Diario

Estatura: _____ Peso: _____

Es usted paciente de cuidados paliativos?	Si	No
Es usted alérgico a Látex?	Si	No
Es usted paciente de una clínica para el control de dolor?	Si	No

**Si usted es paciente de una clínica para el control de dolor, por favor provéanos la siguiente información:

Nombre de la clínica: _____
Calles principales: _____
Número de teléfono: _____

_____ _____
Firma del Paciente o Guardian Fecha

Johnny L. Serrano, D.O., F.A.C.O.S.
General Surgery
Board Certified
American Osteopathic Board of Surgery

CONDITIONS FOR TREATMENT

CONSENT TO MEDICAL AND SURGICAL PROCEDURES AND PHOTOGRAPHS

The undersigned (hereinafter "Patient" which shall also include parents or legal guardians if the Patient is a minor or lacks legal capacity and representatives of the Patient), consents to the procedures and services that may be performed by

Dr. Johnny Serrano and Precision Surgery Center, P.C.

(hereinafter referred to as the "Provider"). I consent to the taking of pictures of my medical or surgical condition or treatment, and the use of the pictures and medical history and/or medical records for purposes of my diagnosis or treatment or for education or training programs conducted by the Provider. I understand that I have the right to request the cessation of recording or filming.

PERSONAL BELONGINGS

It is understood and agreed that the Provider shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats and fur garments or other articles of unusual value or of any value.

FINANCIAL AGREEMENT

The Patient agrees, whether he/she signs as agent or as Patient, that in consideration of the services to be rendered to the Patient, he/she hereby individually obligates him/herself to pay the charges of the Provider in accordance with the regular rates and terms of the Provider. If the provider is In-Network with your health plan, you agree to be responsible for any and all copayments, deductibles, co-insurances and non-covered services. If the practice is out-of-network with your Health Plan, you agree to be responsible for FULL Charges after all payments are received by the practice. Late payment of coinsurance, deductibles or patient responsibility shall be subject to interest in the amount of 1% compounded per month (12% annual). A payment shall be deemed late for purposes of interest when it is not received by the 45th day after invoice is sent by Provider or his representative. Should the account be referred to an attorney or collection agency for collection, the Patient agrees to pay actual attorneys' fees and collection expenses plus interest at 10% annum. The Patient, his/her agent or representative, understand that medical bill submission to the Patient's Health Plan is done by the Provider's billing staff or authorized representatives as an accommodation to the Patient; that this does not in any way diminish or eliminate the Patient or his/her agent or representatives obligation to pay their account in full after services are rendered by the Provider. Pre-authorizations of services are any requires referrals are the responsibility of the patient.

CONSENT TO COMMUNICATION BY EMAIL AND TEXT

The Patient and his/her agent or representative hereby voluntarily provide their email address and cell telephone number to the Provider and its authorized representatives, Patriot. The Patient and his/her agent or representative hereby authorize the Provider and its authorized representatives Patriot to send and otherwise communicate with Patient or his/her agent or representative by email and text message with respect to the Patient's Medical Claims. The Patient and his/her agent or representative hereby voluntarily consent to such electronic communication as required by 15 USC 7001 and related state regulations and statutes. The Patient and his/her agent or representative may provide written notice to the Provider or its authorized representative Patriot to receive any communication on paper or non-electronic form. The Patient and his/her agent or representative agree that his/her consent is continuous. However, the Patient and his/her agent or representative may terminate this consent in writing to the Provider or their authorized representative Patriot. There are no hardware or software requirements needed to receive email communication from the Provider or any of their authorized representatives including Patriot other than having an active email account and a cell phone that receives text messages from a vendor that provides such email accounts and texting options. The Provider and its authorized representatives Patriot agree that it will not sell, share, or rent patient email addresses, cell phone numbers or any other personal information collected based upon this consent. My email address is _____ and my cell phone telephone number is _____.

Patient/Guardian Signature

I have read and understand this patient consent agreement and I agree to its terms as a condition of medical treatment. I hereby acknowledge that at the beginning of my Treatment or services rendered by the Provider, I have been furnished with the Provider's Charity Care Policy, Policy for Collection of Patient Deductibles, Coinsurance and Other Patient Balances and this Conditions to Treatment document. I voluntarily sign this acknowledgement that I consent and agree to the Conditions of Treatment for services to be rendered by the Provider.

Agreed to by: _____ / _____

(Patient signature) (Patient Printed Name)

Date: _____

Agreed to by: _____

(Guardian of Patient)

Date: _____

Patient Initial: _____

Johnny L. Serrano, D.O., F.A.C.O.S.
General Surgery
Board Certified
American Osteopathic Board of Surgery

I hereby direct you to forward to Precision Surgery, LLC and their authorized representatives, The Patriot Group and The Force Law Firm, P.C., the following governing plan documents for the purpose of applicability of compliance with Client Protection Affordable Care Act:

1. Summary Plan Description (SPD)
2. 5500 Form (Plan Annual Report)
3. Certified Copy of Certificate for PPACA Grandfathered Plan.

Please forward to the below address immediately:

The Patriot Group
247 West Montauk Highway – 2nd Floor
Lindenhurst, N.Y. 11757

DATED: _____ _____

Patient Name (Please Print)

_____

Patient Signature