Cesar E. Ceballos, MD
7800 SW 87th Ave STE A-110
Miami, FL 33173
P 305-596-2828
F 305-596-6446

Insurance *(Copy of Insurance Cards Required and Photo Identification)*

(Seguro) *(Copia requerida de la tarjeta del seguro y foto de identificaction)*

Insurance Company: _____ **Id#** _____
Phone#_____
(Compania de seguro) *(numero de indentificacion o miembro)* *(telefono)*

Insured Party Name (Policyholder): _____ **Relation:** Self Spouse Parent Other
(Nombre primario en la polica del seguro) *(relacion: usted esposo padre otro)*

Date of Birth: _____ **Sex: Male**___ **Female**____
S.S.#_____
(fecha de nacimiento) *(sexo: masculino - femenino)* *(# de seguro social)*

Please be advised there is a 24 hour cancellation policy- ALL "No Shows" will be charged a $25.00 fee

Insurance Authorization, Assignment and Financial Responsibility:

By signing below, you consent to the use and disclosure of your protected health information by Cesar E. Ceballos, M.D., P.A., its staff and business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for payment purposes including the disclosure of protected health information to insurance carriers concerning my illness and treatment. You may have the right to review our Notice prior to signing this consent.

I hereby assign to Cesar E. Ceballos, M.D., P.A. all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ **Date:** _____
(Firma) *(fecha)*