PETER MARTINEZ NODA D.O.
General Family Medicine
Antiaging & Wellness Center

2019 - Patient Information & Permanent Lifetime Signature

Name: _____ SS#:_____

Address:_____ City:_____

State: _____ Zip:_____ Primary Language_____

Email Address: (private) _____

Home Phone _____ Cell Phone: _____

Leave msg on recorder Y_____ N _____ Leave msg with other person? Y_____ N _____

Birthday: _____ Age:_____ Marital Status _____

Place of Birth: _____ Ethnicity: Caucasian ____ African American____

Race: _____ White _____ Black _____ Hispanic _____ Indian American _____ Other_____

Employer: _____ Ocuppation:_____ Emergency

Contact:_____ Phone: _____ Relationship to patient:

_____ May we share medical information with
this person? _____ Y _____ N Whom may we thank for referring you _____

Do you have a Living Will _____ Y _____ N

Insurance Information

Primary Insurance _____ ID#_____

Primary Insured: _____ DOB: _____ Relationship:_____

Insurance through employer: _____ Y _____ N Employer: _____

If the policy is an HMO, is it Medicaid? _____

Secondary Insurance: _____ ID#:_____

Insured Name: _____ DOB:_____ Relation:_____

Assignment & Release

I hereby authorize payment directly to Dr. Peter A. Martlnez-Noda for any and all major medical benefits payable to me under the terms of my Insurance. 1 promise to pay Dr. Peter Martlnez-Noda all balances due on my account and further agree that an Interest charge of 12% annum (1% per month) shall be added to any and all outstanding balance remaining unpaid after Insurance payment or denial. I further agree to pay all costs of collection of any such balance, Including reasonable attorney fees. I hereby authorize Dr. Peter A. Martinez-Nods to release any Information acquired In the course of my examination or treatment to physicians and/or Insurance company.

Signature: _____ Date_____

PLEASE ATTACH YOUR INSURANCE CARD AND A PICTURE ID FOR THE FILE

PETER MARTINEZ NODA D.O.
General Family Medicine
Antiaging & Wellness Center

PAST MEDICAL HISTORY:

DIABETES	_____ Y _____ N
KIDNEY DISEASE	_____ Y _____ N
THYROID DISEASE	_____ Y _____ N
STROKE	_____ Y _____ N
HIGH BLOOD .PRESSURE	_____ Y _____ N
HEART DISEASE	_____ Y _____ N
ARTHRITIS	_____ Y _____ N
CANCER	_____ Y _____ N
STROKE	_____ Y _____ N

Chief Complaint:_____

AIlergies: _____

List current medications and dosages: _____

_____

List all Operations, hospitalizations, or serious illness: _____

_____

_____

List any Diagnostic test: _____

Do you Smoke: _____Non _____Previous _____Current Are you pregnant _____ Y _____ N

Referred By: _____

Patient Signature _____ Date_____

Assignment of Benefits

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 Peter Martinez-Noda, P:A. -All 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 of 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 1 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 / DEDUCTABLES ARE DUE AT TIME OF VISIT **********

PETER MARTINEZ NODA D.O.
General Family Medicine
Antiaging & Wellness Center

FINANCIAL POLICY

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

Peter A. Martinez-Noda, D.O., P.A. 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 you 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 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 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.

Ali past due balances ore subject to outside collection agency placement. Peter A. Martinez-Noda, D.O., P.A. 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, Peter A. Martinez-Noda, D.O., P.A. 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 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) 273-4454

1. PRIMARY INSURANCE: _____
   MAILING ADDRESS: _____ PHONE #: _____
   CITY: _____ STATE: _____ ZIP: _____
   POLICY #: _____ GROUP #: _____
   INSURED PERSON'S NAME: _____
   INSURED PERSON'S SS #: _____
2. SECONDARY INSURANCE CO: _____
   MAILING ADDRESS: _____ PHONE #: _____
   CITY: _____ STATE: _____ ZIP: _____
   POLICY #: _____ GROUP #: _____
   INSURED PERSON'S NAME: _____
   INSURED PERSON'S SS #: _____

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 Peter A. Martinez- Noda, D.O, P.A

I Request That This Authorization Also Apply To All Other Insurance. Date:_____

I understand the above policy and agree that, after any contractual arrangements between carrier are satisfied. I am ultimately responsible for the balance on this account. Peter A. Martinez-Noda, D.O., P.A. and the insurance

Signature: _____ _____

Signature of Parent or Legal Guardian
If Patient is a Minor

Printed Name: _____

PETER MARTINEZ NODA D.O.
General Family Medicine
Antiaging & Wellness Center

PHARMACY INFORMATION

Name _____ Phone Number_____

_____ (patient initials) Pharmacy Consent. I give the Jackson Medical Group authorization to obtain my prescription records from participating pharmacies.

PRESCRIPTION ORDER PICK-UP

There may be times when you need a friend or family member to pick-up a prescription order from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to be present, bring a valid picture identification and sign for the prescription;

_____ (patient Initials) I wish to designate the following member/friend to pick up an order on my behalf.

Designee Name _____

_____ (patient Initials) I do not want to designate anyone to pick up my prescription order.

Patient Signature_____ Date_____

PETER MARTINEZ NODA D.O.
General Family Medicine
Antiaging & Wellness Center

NO SHOW POLICY

Dear Patient:

We understand that there are legitimate reasons for having to cancel an appointment. We ask you to show consideration by calling well in advance if you are unable to keep an appointment so we have the option of offering that appointment to another patient who needs to see the doctor. Please let this letter serve to notify you that if you fail to give us a 24 hour notice of cancellation, there will be a $25.00 cancellation fee billed to your account that cannot be filed to your insurance company.

Thank you,

Estimado Paciente:

Nosotros comprendemos que hay razones legitimas para cancelar una cita. Le rogamos consideracion solicitando con antelacion Ia cancelacion de su cita y de esta forma poder brindarle Ia posibilidad a otro paciente necesitado de ser visto por el doctor. Sirva esto como una notificacion que si usted no cancela con 24 horas de anticipacion, tendra un recargo de $25.00 y no sera cubierto por su seguro,

Gracias,

Dr. Martinez-Noda

Patient's Signature: _____ Date: _____

Patient Name:_____ Date of Birth:_____

HIPAA Notice of Privacy Practices
Peter A. Martinez-Noda, DO, PA
7000 S.W. 97th Avenue, Suite 101
Miami, Florida 33173

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry your treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

Uses and disclosure of Protected Health Information.

Your medical information may be used and disclosed by us, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of our practice and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of our health care with a third party. For example, we would disclose your medical information necessary, to a home health agency that provides care to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your information will be used as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your medical information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. We may use a sign-in sheet at the registration desk or we may call you by name in the waiting room when your physician is ready to see you. We may also contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by Law. **Public Health issues.** Communicable Diseases.

Health Oversight. Abuse or Neglect, Drug Administration requirements. **Legal Proceedings, Law Enforcement, Coroners, Funeral Director, Organ Donation,** Research Criminal Activities, **Military Activity and National Security, Workers' Compensation, Inmates;** Required Uses and Disclosures. Under the law, we must make disclosures to you and When required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. **You may revoke this authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information. **You have the right to inspect and copy your protected health information.** Under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. **To inspect and copy your medical information you must submit your request in writing to our office.** If you request a copy of your medical records, we may charge a fee for the cost of the

supplies and mailing charges associated with your request. You have the right to request a restriction of your protected health information. **This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of our protected health information not be disclosed to family members** or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your medical information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an **Alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you agreed to accept this notice alternatively, i.e. electronically. **You may have the right to have your Physician amend your protected health insurance.**

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of our protected health information. **We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.**

Complaints

You may complain to us or to the Secretary of Health and Human Services. If you believe we have violated your privacy rights. You may file a complaint with us by notifying our privacy officer of your complaint. We will not retaliate against you for filing a complaint.

This notice becomes effective April 14, 2003

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance officer in person or by phone at our Main Phone Number (305)448-4431.

Signature below is only acknowledgement that you have received and read this Notice of our Privacy Practices.

PATIENT NAME	PATIENT OR GUARDIAN'S SIGNATURE	Date

PETER MARTINEZ NODA D.O.
General Family Medicine
Antiaging & Wellness Center

Join us for exclusive giveaways, the best deals, new products and more!

How did you hear about us?

Referred _____ Facebook___ Yelp___ Instagram___ Twitter ___ Linkedin ___ ZocDoc___

Flyer ___ Radio ___Google Maps___Website ___ Magazine ___ Newspaper___ Medical Insurance ___ Other_____

Name: _____ D.O.B: _____

Address: _____

Cell Phone: _____ Email: _____

Please let us know how we can better serve you by informing us of Antiaging services you are interested in:

____ Weight Loss Programs

____ Bioidentical Hormone Replacement Therapy

____ Botox

____ Fillers

____Facials

____ Chemical Peels

____Microdermabrasion

____Radiofrequency

____Cavitation

____Body Waxing

____ Others

PETER MARTINEZ NODA D.O.
General Family Medicine
Antiaging & Wellness Center

2019 - Patient Information & Permanent Lifetime Signature

Patient Name_____ Home Phone_____

DOB_____ Sex_____ Primary Language_____

Social Security No._____ Email_____

Home Address_____

City_____ State_____ Zip Code_____

Referred By_____ Responsible Financial Party_____

Race:
- White
- Black

Ethnicity:
- Caucasian
- African American
- Hispanic
- Indian American
- Other

FATHER'S INFORMATION

Name_____

Social Security No._____

Driver's License No._____

Employer's Name_____

Work Phone_____

Martial Status_____

Date of Birth_____

Cellular Phone_____

MOTHER'S INFORMATION

Name_____

Social Security No._____

Driver's License No._____

Employer's Name:_____

Work's Phone_____

Marital Status_____

Date of Birth_____

Cellular Phone_____

EMERGENCY CONTACT INFORMATION

Nearest Local Relative_____ Phone_____

Is emergency treatment authorized?_____ By Whom?_____

INSURANCE INFORMATION

Primary Medical Insurance Company_____

Policy Holder's Name_____

Policy Holder's Social Security No._____ DOB_____

Policy No._____ Group No._____

If the policy is an HMO, is it Medicaid?_____

Secondary Medical Insurance Company_____

Policy No._____ Group No._____

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Signature_____ Date_____

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By law, your insurance carrier must remit payment or deny your Insurance claim within 30 days of initial 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 any insurance problem.

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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) 273-4454

1. PRIMARY INSURANCE: _____
   MAILING ADDRESS: _____ PHONE #: _____
   CITY: _____ STATE: _____ ZIP: _____
   POLICY #: _____ GROUP #: _____
   INSURED PERSON'S NAME: _____
   INSURED PERSON'S SS #: _____
2. SECONDARY INSURANCE CO: _____
   MAILING ADDRESS: _____ PHONE #: _____
   CITY: _____ STATE: _____ ZIP: _____
   POLICY #: _____ GROUP #: _____
   INSURED PERSON'S NAME: _____
   INSURED PERSON'S SS #: _____

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

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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 Peter A. Martinez- Noda, D.O, P.A

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Signature: _____ _____

Signature of Parent or Legal Guardian
If Patient is a Minor

Printed Name: _____

PETER MARTINEZ NODA D.O.
General Family Medicine
Antiaging & Wellness Center

PHARMACY INFORMATION

Name _____ Phone Number_____

_____ (patient initials) Pharmacy Consent. I give the Jackson Medical Group authorization to obtain my prescription records from participating pharmacies.

PRESCRIPTION ORDER PICK-UP

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_____ (patient Initials) I wish to designate the following member/friend to pick up an order on my behalf.

Designee Name _____

_____ (patient Initials) I do not want to designate anyone to pick up my prescription order.

Patient Signature_____ Date_____

PETER MARTINEZ NODA D.O.
General Family Medicine
Antiaging & Wellness Center

NO SHOW POLICY

Dear Patient:

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Thank you,

Estimado Paciente:

Nosotros comprendemos que hay razones legitimas para cancelar una cita. Le rogamos consideracion solicitando con antelacion Ia cancelacion de su cita y de esta forma poder brindarle Ia posibilidad a otro paciente necesitado de ser visto por el doctor. Sirva esto como una notificacion que si usted no cancela con 24 horas de anticipacion, tendra un recargo de $25.00 y no sera cubierto por su seguro,

Gracias,

Dr. Martinez-Noda

Patient's Signature: _____ Date: _____

Patient Name:_____ Date of Birth:_____

Legal Guardian Name:_____

Legal Guardian Signature:_____

HIPAA Notice of Privacy Practices
Peter A. Martinez-Noda, DO, PA
7000 S.W. 97th Avenue, Suite 101
Miami, Florida 33173

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Uses and disclosure of Protected Health Information.

Your medical information may be used and disclosed by us, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of our practice and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of our health care with a third party. For example, we would disclose your medical information necessary, to a home health agency that provides care to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your information will be used as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your medical information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. We may use a sign-in sheet at the registration desk or we may call you by name in the waiting room when your physician is ready to see you. We may also contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by Law. **Public Health issues.** Communicable Diseases.

Health Oversight. Abuse or Neglect, Drug Administration requirements. **Legal Proceedings, Law Enforcement, Coroners, Funeral Director, Organ Donation,** Research Criminal Activities, **Military Activity and National Security, Workers' Compensation, Inmates;** Required Uses and Disclosures. Under the law, we must make disclosures to you and When required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. **You may revoke this authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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supplies and mailing charges associated with your request. You have the right to request a restriction of your protected health information. **This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of our protected health information not be disclosed to family members** or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your medical information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an **Alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you agreed to accept this notice alternatively, i.e. electronically. **You may have the right to have your Physician amend your protected health insurance.**

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of our protected health information. **We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.**

Complaints

You may complain to us or to the Secretary of Health and Human Services. If you believe we have violated your privacy rights. You may file a complaint with us by notifying our privacy officer of your complaint. We will not retaliate against you for filing a complaint.

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Signature below is only acknowledgement that you have received and read this Notice of our Privacy Practices.

PATIENT NAME	PATIENT OR GUARDIAN'S SIGNATURE	Date

PETER MARTINEZ NODA D.O.
General Family Medicine
Antiaging & Wellness Center

Join us for exclusive giveaways, the best deals, new products and more!

How did you hear about us?

Referred _____ Facebook___ Yelp___ Instagram___ Twitter ___ Linkedin ___ ZocDoc___

Flyer ___ Radio ___Google Maps___Website ___ Magazine ___ Newspaper___ Medical Insurance ___ Other_____

Name: _____ D.O.B: _____

Address: _____

Cell Phone: _____ Email: _____

Please let us know how we can better serve you by informing us of Antiaging services you are interested in:

____ Weight Loss Programs

____ Bioidentical Hormone Replacement Therapy

____ Botox

____ Fillers

____Facials

____ Chemical Peels

____Microdermabrasion

____Radiofrequency

____Cavitation

____Body Waxing

____ Others