

R I C A R D O E S T A P E , M D , L L C
R I C A R D O E S T A P E , M . D .
N I C H O L A S L A M B R O U , M . D .

PATIENT INFORMATION

Patient Name: _____
Nombre del Paciente
Home Address: _____
Direccion del Hogar
City: _____ State: _____ Zip Code: _____
Ciudad Estado Codigo Postal
Occupation: _____
Ocupacion
Employer: _____
Empleo
Emergency Contact: _____
Contacto de Emergencia
Referred By: _____
Referido Por
Allergies/Alergias _____
****IF YOUR VISIT IS FOR A WELL WOMAN EXAM, CHECK HERE: _____**

Home Phone: _____
Telefono del Hogar
Work Phone: _____
Telefono del Trabajo
Date of Birth: _____
Fecha de Nacimiento
Social Security #: _____
Numero de Seguro Social
Marital Status: _____
Estado Civil
Phone Number: _____
Telefono
Driver's License #: _____
Numero de Licencia de conducir
E-mail address: _____

Si su visita es para un examen annual, marque aqui _____

INSURANCE INFORMATION

Name of Primary Insurance: _____
Nombre del Seguro
Address: _____
Direccion
Group Number: _____
Numero de Grupo
Name of Subscriber: _____
Nombre del Asegurado
Subscriber's Employer: _____
Empleo del Asegurado
Name of Secondary Insurance: _____
Nombre del Seguro Secundario
Address: _____
Direccion
Group Number: _____
Numero de Grupo
Name of Subscriber: _____
Nombre del Asegurado
Subscriber's Employer: _____
Empleo del Asegurado

Phone Number: _____
Telefono
Policy or I.D. Number: _____
Numero de Poliza
Date of Birth: _____ Relation to Patient: _____
Fecha de Nacimiento Relacion al Paciente

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept Visa, Master Card, American Express and Discover Card. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of your policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos Visa, Master Card, American Express y Discover. Su seguro medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsable de los gastos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum Amounts pursuant to S.458.320 (5)(g).Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida Law.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to Ricardo Estape,MD, LLC Inc. of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by Ricardo Estape,MD, LLC. I understand that I am financially responsible to Ricardo Estape, LLC for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a Ricardo Estape,MD, LLC, todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico.

PATIENT'S/GUARANTOR'S SIGNATURE: _____

DATE: _____