BALANCE ORTHOPEDICS
JOSE ECHENIQUE, MD.FAAOS
SPORTS & ORTHOPEDIC SURGERY

Patient Register

Please complete the document in its entirety. Please write legibly

Name Initial Last Name

Physical Address

Postal Address

xxx-xx- | |

Social Security: DOB: Month|Day|Year

Residencial Phone: Work Phone: Cell:

Marital Status: Ocupation/Work Place:

Email (**Required**):

Preferred Pharmacy: Name Street & City

¡Contact us!

Telephone:
787-708-6456
787-771-1000

Fax:
787-708-6736
787-771-1001

Website:
balanceortho.com

Emergency Contact

(Only specify one contact)

Name: **Last name:**

Telephone: **Relationship:**

Health Insurance Information

(Completed by patient)

Insurance name: **Contract Num:**

Group Num: **Primary insured:**

Relationship Patient: **DOB Primary Insured:**

Primary Insured work: **Primary Insured phone:**

Please submit with this document:

Insurance card

State ID (current)

Health insurance referral (if applicable).

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Please hand in any imaging related to your injury once you are in the exam room.

(Xray, MRI, CT, Sonogram)

Information related to you appointment or condition

Please complete all the information to better assist you

Injured area: (ex.shoulder, knee)

Right/ Left (Specify):

How did it occur?:

When did it occur ?(estimated time):

Where did it occur?

Date of incident (If it was an accident):

About you

The following information is necessary to complete your medical record.

Allergies(**Required**):

Medications(**Required**):

Height (**Required**): Weight(**Required**):

Other health conditions:

By signing this document, I certify that the information provided is accurate and reliable.

Patient signature or representative Date

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At **Balance Orthopedics** our goal is to be able to provide the best individual treatment for each patient. Accordingly, we have implemented a Medical Appointment Cancellation Policy that best allows us to schedule appointments for all patients.

Appointment Cancellation: To be respectful of the needs of other patients, please call us immediately if you are unable to keep your appointment. This will be reassigned to a patient who also needs treatment. If it is necessary to cancel your scheduled appointment, we ask that you call at least 24 hours in advance.

Missed appointment: Failure to show up for your appointment will be marked on your medical record as "no show" (absent). We reserve the right to charge a fee of thirty dollars ($ 30.00) for not showing up for your appointment.

Patient signature or representative | Date

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Authorization and Consent for Medical Treatment

I _____, or for lack of consent, through _____ (legal representative), I give my consent to receive general medical services related to the practice of orthopedics, which may include routine diagnostic procedures and medical treatment. that the doctor, his assistants or the persons he designates consider necessary in his sole discretion. I also acknowledge that no guarantee has been given to me regarding the results of the treatment. All treatment will be carried out according to the best medical judgment.

Notice of Privacy Practices

Your protected health information (PHI) will be used by Balance Orthopedics and disclosed by Dr. Jose Echenique, and any person designated by him, to other entities for treatment purposes, to obtain reimbursements and to facilitate continuity of treatment with others providers. The exchange of your protected information will include means of mail, fax, telephone, text messages, email and any other means according to the policy of the practice.

Signature

I have had the opportunity to review this consent and have received a copy of the Notice of Privacy Practices. I give Dr. Jose Echenique and any person designated by him permission to use and disclose my protected health information in accordance with such practices.

* I authorize my health insurance to make all payments for the services provided on my behalf by Dr. José Echenique and I understand that I am responsible for these charges and / or services, which are not covered by my medical plan.

Patient signature or representative | Date