REGISTRATION & CONSENT FORM - please fill out and send to us to below:

H.O.P.E., Helping Our People Everywhere
Phone #: (954) 240-7770
Fax #: (786) 257-5676; E-mail: liz@HOPEpatientconcierge.com

Today's Date / Fecha De Hoy

Primary Care Physician and Specialist(s) Name, Address & Contact Phone #s and E-mail Address(es). ATTACH list of specialists with contact details and date(s) you last saw them. Su Medico Primario y Sus Medicos Especialista(s) Nombre(s), direccion y numero de telefono

Date of Birth (MM/DD/YYYY) / Fecha De Nacimiento

Age / Edad

Gender (M/F)/ Genero

Patient Full Name / Nombre de Paciente

Mr./Mrs./Ms. (write one) / Sr./Sra./Srta.

Contact in Case of Emergency/relationship (name/ph #/e-mail address) / Next of Kin or Patient Caretaker or Representative. Confirm if a Power of Attorney or Guardianship exists - Contacto en caso de emergencia (nombre/# de telefono) / Nombre de su representante y # de telefono

Home Address (details, city, country) / Direccion de Casa (incluir ciudad, pais)

Address in U.S. / Direccion en EEUU: (Street Address, City, State, Zip Code)

If you are staying at a nursing home or hotel, please share details. For Travelers, if you are staying at a private home, name of community. Does it have a gate? if so, gate code # or name of the home owner.

List your medication(s), dose, frequency. When do you take each medication? for ex: in the morning, after breakfast, at bedtime, etc. Please attach a list if space below does not suffice.

E-mail Address / Correo Electronico:

Social Security # (if applicable) / # De Seguro Social

Home Phone # / # De Casa

Mobile Phone #/ # Celular

Phone # when in U.S./# De Telefono Aqui En Los EEUU

Occupation / Ocupacion

Employer / Nombre de Compania de Empleo

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What is your diagnosis / a condition / illness? or if you are looking for a service, please specify what you were told to be in search of this service?
Tiene un diagnostico / condicion / enfermedad? O esta en busquedad de un chequeo? detalles:

Referred by (details please) / Quien lo/a refirio a nosotros (detalles por favor)

For Travelers, when would you like to travel? for ex: as soon as you secure appointments, or in 1 week, 3 days Cuando viaja? por ejemplo: lo antes posible, en cuanto consiga cita(s) o en 1 semana, etc.

Which service or treatment do you need? for ex: Care Management, a diagnostic test, consult with specialist, etc.
Que servicio/tratamiento necesita?por ejemplo: un examen, una consulta con especialista, etc.

For Travelers, do you need assistance with hotel discounts, car rental, transportation for appointments?
Necesita ayuda con hoteles con descuento? Alquiler de carro? o transporte? Alguna preferencia?

Insurance Information: **please attach a copy of your insurance card, front and back.**
Tiene Seguro Medico? Adjunte una copia de su tarjeta, la parte de adelante y atras.

Is patient covered by insurance? Yes/No
El/La paciente tiene cobertura? Si/No

Who is main policy holder? (for ex: Wife, Husband, etc., please confirm relationship, name and employer)
Nombre del dueno/a de la poliza de seguro?

For Travelers, does your insurance cover for overseas healthcare in the U.S.? Have you contacted them to verify and what have they advised?
Su seguro le cubre por servicios/tratamientos aqui en los EEUU? Se ha comunicado con su seguro para confirmar y que les han confirmado?

Insurance Info / Informacion del Seguro (Name on Insurance Company, ID #, Group #, Phone #)

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I provide authorization to the following Requesting Office:
Yo proveo mi autorizaction a la siguiente Oficina:

H.O.P.E., Helping Our People Everywhere
Name: Elizabeth Paucar Harris and Tiffany Santiago, Patient Navigators
Phone #: (954) 240-7770
Address: 2413 Main Street, #146, Miramar, FL 33025

I authorize for them to liaise on my behalf to make appointments, access and the release of any and all of my records regarding treatment to the person(s) listed above.
Yo autorizo todos mis informes medicos relativo a mi tratamiento a la oficina detallada aqui.
Print Name Below and date / Escriba su nombre en prenta:

This request and authorization applies to:
Esta solicitud y autorizacion aplica a lo siguiente:

- ☑ Healthcare Information / Informacion de mi salud/mi caso/mis informes medicos
- ☑ Test results / Resultados de mis examenes, diagnosticos, etc.
- ☑ All Billing Information / Toda informacion con los pagos de servicios/seguro
- ☑ Anything Pertaining to My Medical Care / Todo relacionado con el cuidado medico

Signature and Date / Firma y Fecha