CENTRAL FLORIDA PRIMARY CARE

Pedro L. Ortega, MD, Internal Medicine
Yolanda Molinaris, MD Iveth Mastrapa, ARNP

Date: _____

Dear New Patient:

On behalf of Dr. Pedro Ortega, we would like to welcome you to our practice. We would like to take the time to thank you for choosing us to provide all of your Internal Medicine needs. For your convenience, our offices hours are **Monday-Thursday 8:00am-5:00pm and Friday 8:00am-3:00pm.**

If you experience a medical problem after hours, please call us first at **(407) 478-0028.** We are on call 24/7. Non-Life-threatening emergent telephone access is handled immediately.

As part of the preventative health care that we practice, all new members are given a physical examination. After this initial visit, we will be seeing you on a regular basis, the frequency of which you will be seen will depend on your individual needs.

Included with this letter are our office policies regarding hospitalizations, referrals, authorizations, prescription refills, etc. Please familiarize yourself with these policies and bring a signed copy with you at your first visit or we will have a copy for you to sign at that time.

We look forward to providing you with quality medical services in the most courteous and efficient manner possible.

If you have any questions, please do not hesitate to call us.

Sincerely,

Central Florida Primary Care

CENTRAL FLORIDA PRIMARY CARE

Pedro L. Ortega, MD, Internal Medicine
Yolanda Molinaris, MD Iveth Mastrapa, ARNP

Office Policies/Procedures

EMERGENCIES/HOSPITALIZATIONS: Our Answering Service is available **BEFORE** and **AFTER** office hours. Do not wait for your symptoms to get to the point that you have to go to the emergency room.

Please call this office BEFORE going to the hospital, even after hours, or on the weekend. We must try to prevent unnecessary emergency room visits. If it's a life-threatening emergency, call 911.

In the event that you do go to the hospital, please let them know that you are a patient of Dr. Ortega.

REFERRALS/AUTHORIZATIONS: **Per the Health Plan, all referrals and authorizations MUST come from this office.** This provides Dr. Ortega the opportunity to identify your issues/concerns and to determine and proper treatment plan. It also allows us to provide your Health Plan with the required documents and office notes if there is a need for a referral/authorization or pre-certification. Dr. Ortega has developed a professional relationship with many specialists and will recommend which one you should see. You need to make an appointment with us after you see the specialist for follow up care. Once we receive the recommendations from the specialist, Dr. Ortega will determine if your specific condition is stable and he will decide if you need further testing or follow up referrals. Your prescriptions and follow up testing will be ordered by the office. Lab services are required to go to lab authorized by your health plan and we will recommend which free standing radiology center to use. Authorizations and Pre-Certifications require review from the Health Plan and may be denied by the Health Plan. We will require 5 business days for any routine referrals and at least 5-7 business days for authorizations or pre-certifications.

PRESCRIPTION REFILLS: Generic medications will be used whenever available. **Please give our office a 72-hour notice** for all prescription refills to be called in. Refills will **NOT** be given if you have not been seen recently in the office or after hours and weekends.

***CANCELLATION AND TARDINESS*:** Please let us know at your earliest convenience if you cannot make your appointment. This will assist in accommodating other patients. Failure to comply with this policy could result in **a $45.00 missed office visit charge.** You **MUST** cancel 24 hours in advance either in person or over the phone. Cancellations made through voicemail or the answering service will not be accepted as notice. If you anticipate being more than 15 minutes late for your appointment, please call our office to see if your appointment needs to be rescheduled.

By signing below, you are indicating that you have read and agree to the above policies.

Patient Name (Please Print): _____

Signature of Patient or Legal Guardian: _____ **Date:** _____

CENTRAL FLORIDA PRIMARY CARE

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REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name:	Middle:	First Name:

Marital Status: (Circle One) Single Married Divorced Widowed Separated	Preferred Language:	Email Address:	Date of Birth:	Age:	Sex: (Circle One) Male Female

Address:

Social Security Number:	Home Phone Number:	Cell Phone Number:
Preferred Pharmacy Name:	Pharmacy Phone Number:	Pharmacy Location:

Race: (Circle One)
American Indian/ Alaska Native Asian Black/African American
Native Hawaiian/Pacific Islander Hispanic White/Caucasian
Decline Other _____

Ethnicity: (Circle One)
Hispanic/Latino
Non-Hispanic/Latino
Decline

RESPONSIBLE PARTY / INSURANCE INFORMATION

Name of Primary Insurance:

Patient's Last Name:	Middle:	First:	Address: (If Different):
Date of Birth:	Relation:	Social Security Number:	Occupation:
Home Phone Number:	Cell Phone Number:	Work Phone Number:	Other:

Subscriber Last Name:	Subscriber First Name:	Date of Birth:	Group Number:	Policy Number:	Relation:

Name of Secondary Insurance (If applicable):

Subscriber's Last Name:	Subscriber's First Name:	Group Number:	Policy Number:

IN CASE OF EMERGENCY

Emergency Contact's Full Name:	Relationship to patient:	Address:	Best Contact Phone Number:

The above information is true to the best of my knowledge. I understand that I am responsible for all charges incurred for services rendered and that payment is due at the time of service unless other arrangements are made in advance. I understand that I am responsible for any services that are not covered by my insurance carrier. I authorize Central Florida Primary Care and staff to release to my insurance carrier and its agent(s) any information concerning health care services and treatment. I authorize my insurance company or any other responsible party to make payment directly to Central Florida Primary Care for any services rendered.

All self-pay and non-participating insurance patients must pay in full prior to medical services being rendered. We are unable to file a claim with non-participating insurance companies.

I understand that I will receive regular monthly statements of my account reflecting a balance due and that **FINAL PAYMENT OF MY ACCOUNT REMAINS MY SOLE RESPONSIBILITY** regardless of or lack of payment by my insurance carrier.

This authorization and assignment is to be a continuing one, remaining in force until revoked in writing by the undersigned.

I hereby consent & authorize Central Florida Primary Care, its healthcare providers, technical, nursing, and/or other healthcare personnel, as may be necessary to diagnose and render care to the above named patient as deemed necessary.

_____ _____

Signature of Patient or Legal Guardian Date

Revised: 01/30/2023

CENTRAL FLORIDA PRIMARY CARE

Pedro L. Ortega, MD, Internal Medicine
Yolanda Molinaris, MD Iveth Mastrapa, ARNP

NOTICE OF PRIVACY PRACTICES

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.

OUR LEGAL DUTY - We are obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. This notice takes effect as of April 21, 2015 and will be in effect until we replace it. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us at Central Florida Primary Care, 3727 N. Goldenrod Rd., Suite 106 Winter Park, FL 32792, Phone: (407) 478-0028 Fax: (321) 203-4720.

USES AND DISCLOSURES OF MEDICAL INFORMATION - We use and disclose medical information about you for treatment, payment, and health care operations. This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMOs and PPOs, managed care organizations, IPAs, CMS, or other governmental or third-party payers, or any organizations contracting with any of the above entities to perform such functions. Copies of your medical information may be delivered to any other physician who is directly or indirectly responsible for your medical care or the payment thereof.

We may use or disclose your medical information to notify a family member or another person responsible for your care based on our professional judgment and the circumstances. We may use your medical information to contact you to provide appointment reminders, and to attempt to call you to notify you that lab test results are available. We may use your name and your location in our facilities directories.

We may use or disclose your medical information for purposes involving public health and safety issues and activities, death, certain requests from your employer, governmental personnel and programs, organ donation, judicial and administrative proceedings, law enforcement, abuse, neglect or domestic violence issues and workers' compensation issues.

INDIVIUAL RIGHTS - This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time. You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You may have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. We will charge a cost-based fee for copying of records and for postage.

QUESTIONS AND COMPLAINTS - You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

X _____

Signature of Patient or Legal Guardian Date

CENTRAL FLORIDA PRIMARY CARE

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Yolanda Molinaris, MD Iveth Mastrapa, ARNP

CONSENT TO USE OR DISCLOSE HEALTHCARE INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information ("PHI") about you. You have the right to review our Notice before signing this form. Your signature below acknowledges that you have received a copy of our Notice of Privacy Practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting one of our offices. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health operations as described in our Notice. These disclosures may be by phone, mail, fax or electronic transmission. **Unless you indicate otherwise in writing, if you allow a third party other than one of the practice's physicians or staff to be in the exam room while one of our physicians or staff is examining you or discussing your care, treatment or medical condition with you, by signing this Consent Form you are consenting to the disclosure of your PHI to that third party.** You have the right to revoke this consent, in writing except where we have already made disclosures in reliance on your prior consent. If you refuse to sign this consent or revoke this consent, Central Florida Primary Care may refuse treatment or provide further treatment as of the time of the revocation, except to the extent that treatment is required by law.

I am consenting to the disclosure of my protected health information ("PHI") to the following individuals:

Name:	**Relation:**
Name:	**Relation:**
Name:	**Relation:**
Name:	**Relation:**
Name:	**Relation:**

I have read and understand the information in this acknowledgement. I am the patient or I am authorized to act on behalf of the patient to sign this document. By signing below, I will acknowledge and agree to the above conditions.

X

Signature of Patient or Legal Guardian Date

CENTRAL FLORIDA PRIMARY CARE

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Yolanda Molinaris, MD
Iveth Mastrapa, ARNP

PERSONAL MEDICAL HISTORY

Patient Name: _____ DOB: _____

Please check off if you have had any problems in the past or a presently experiencing any of the following:

	Past	Current		Past	Current		Past	Current
Allergic Rhinitis	o	o	Depression	o	o	Lymphoma	o	o
Abdominal Discomfort	o	o	Diabetes Type 1	o	o	Macular Degeneration	o	o
Abnormal Bleeding	o	o	Diabetes Type 2	o	o	Migraines	o	o
Alzheimer	o	o	Diarrhea	o	o	Myocardial Infarction	o	o
Anesthesia Issues	o	o	Difficulty Urinating	o	o	Nausea/Vomiting	o	o
Anemia	o	o	Eczema	o	o	Osteoporosis	o	o
Abnormal Vaginal Discharge	o	o	Epilepsy (Seizures)	o	o	Overactive Bladder	o	o
Angina	o	o	Fibroids	o	o	Painful Intercourse	o	o
Aortic Stenosis	o	o	Frequent Urination	o	o	Painful Periods	o	o
Anxiety	o	o	Fibromyalgia	o	o	Palpitations	o	o
Aneurysm	o	o	Erectile Dysfunction	o	o	Pancreatis	o	o
Arterial Thrombosis	o	o	Gall Bladder Disease	o	o	Rectal Bleeding	o	o
Arthristis (Rheuma)	o	o	Gallstones	o	o	Rheumatic Fever	o	o
Arthritis (Osteo)	o	o	Gastritis	o	o	Shortness of Breath	o	o
Back Pain	o	o	Gout	o	o	Stent (Heart)	o	o
Atrial Fibrilation	o	o	Glaucoma	o	o	Stent (Leg)	o	o
Asthma	o	o	GERD	o	o	Strong urges to Urinate	o	o
B12 Deficiency	o	o	Headache	o	o	Swollen Ankles	o	o
Blood Disorders	o	o	Heart Attack	o	o	Tuberculosis	o	o
Blood in Stool	o	o	Hematuria (Blood in Urine)	o	o	Unexplained Weight Gain	o	o
Bronchitis	o	o	Hemmorhoids	o	o	Unexplained Weight Loss	o	o
Cancer (Melaoma)	o	o	Heart Disease	o	o	Venereal Diseases	o	o
Cancer (Colon)	o	o	(Circle One) Hepatitis A B C	o	o	o Other		
Cancer (Lung)	o	o	High Blood Pressure	o	o		Past	Current
Cancer (Breast)	o	o	High Cholesterol	o	o		o	o
Cancer (Ovarian)	o	o	Hypothyroidism	o	o		o	o
Cataract	o	o	Incomplete Emptying	o	o		o	o
Changes in Bowel Habits	o	o	Indegestion	o	o		o	o
Cancer (Prostate)	o	o	Infertility	o	o		o	o
Chest Pain or Chest Tightness	o	o	Involuntary/Unintended Urine Loss	o	o		o	o
Cancer (Skin)	o	o	Irritable Bowel Syndrome	o	o		o	o
Chronic Kidney Disease	o	o	Kidney Disease	o	o		o	o
Cogestive Heart Failure (CHF)	o	o	Kidney Stones	o	o			
Colon Polyp	o	o	Lightheadedness	o	o			
Constipation	o	o	Lower Back Problems	o	o			
Coronary Artery Disease	o	o	Lupus	o	o			

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PERSONAL MEDICAL HISTORY (CONTINUED)

Patient Name: _____ DOB: _____

Allergies to Medications, X-Ray Dyes or Other Substances: ○ No ○ Yes

(Please Specify)

_____

_____

Surgeries: (Please list and provide dates for each surgery)

Year	Reason

Hospitalizations: (Please list and provide dates for each hospitalization)

Year	Reason

Immunization History: (Which have you had?)

Pneumovax Immunization	○ No	○ Yes	Date:
Influenza (Flu) Immunization	○ No	○ Yes	Date:
Shingles Immunization	○ No	○ Yes	Date:

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PERSONAL MEDICAL HISTORY (CONTINUED)

Patient Name: _____ DOB: _____

Current Medications: (Prescription, Over the Counter, Vitamins, Herbs, etc...)

Medication	Dosage	Medication	Dosage

Exams: (Please provide the last time you had any of these exams done)

Colonoscopy	Date:
Mammogram	Date:
Eye Exam	Date:
Pap Exam	Date:

Family History: (Has any member of your family including Parents, Grandparents, and Siblings ever had any of the following illness)

Illness	Which Family Member	Age when diagnosed
Cancer (Describe Type)		
High Blood Pressure		
Heart Disease		
Diabetes		
Stroke		
Mental Disease		
Drug or Alcohol Addiction		
Glaucoma		
Bleeding Disease		
Other: _____		

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AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____ SSN: _____-_____-_____

I, _____ hereby authorize Central Florida Primary Care to:

□ Release records to: □ Obtain records from:

Name of Facility/Doctor: _____

Address: _____

City: _____ State: ____ Zip: _____ Phone: _____ Fax: _____

For the purpose of:

□ Continuity of treatment □ Personal records □ Transfer in/out □ Other: _____

Items to be released or obtained: (Please mark all that apply)

□ Complete Records □ Diagnostic test results □ Lab results
□ Pathology/Cytology results □ Radiology reports □ Consult/Progress notes
□ ER/Hospital notes □ Clinical/Discharge reports □ Office notes
□ Other (specify): _____

I understand that this content is revocable upon written notice to the facility, except to the extent that actions by the facility have been taken in reliance on this authorization, and that this consent shall remain in force for a period of 365 days from the date it was signed, in order to affect the purpose for which it is given.

Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR, Part II) prohibit making further disclosure of any protected health information without the specific written consent of the undersigned or as otherwise permitted by such regulations

I hereby authorize Central Florida Primary Care to: obtain/release the information specified above to the organization or individual named on this request. I understand that such may include information regarding the following conditions: Drug Abuse or Alcoholism, HIV/AIDS and Sexually Transmitted Disease Testing, Sickle Cell Anemia, and/or Psychiatric, Psychological or Psychotherapeutic notes.

X_____ _____

Signature of Patient or Legal Guardian Date

Please send requested records to:

3727 North Goldenrod Road, Suite 106, Winter Park, FL 32792 Phone: (407) 478-0028 Fax: (321) 203-4720
6150 MetroWest Boulevard, Suite 205, Orlando, FL 32835 Phone: (407) 781-0088 Fax: (407) 781-0087
12554 South John Young Parkway, Suite 105, Orlando, FL 32837 Phone: (407) 559-3800 Fax: (407) 559-3801

Revised: 01/30/2023

CENTRAL FLORIDA PRIMARY CARE

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MEDICAL SERVICES FINANCIAL AGREEMENT

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients.

Insurance

If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card. We are required by law to obtain your signature for permission to release information to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements.

We will gladly submit claims for your covered medical services to your insurance company. However, we expect payment of all services within 60-90 days. ***It may be necessary for you to pay your account in full if your insurance company fails to pay for services within 90 days.*** It is your responsibility to understand your coverage and benefits, including pre-certifications, referrals and authorization requirements, and to be sure all insurance information is current. Should you fail to provide this information, you will be financially responsible. If you give the wrong insurance information and a referral is required, you will be responsible for the charges. We will, however, assist you to ensure that all plan requirements are met.

_____ **please initial**

Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy the we extend to patients, all charges are your responsibility from the date the services are rendered.

_____ **please initial**

Payment for services

Payment for services, including insurance copayment, coinsurance and deductibles or self-pay balance amount, is due at the time services are rendered unless payment arrangements have been approved in advance by the Office Manager. Our failure to collect these amounts may be a violation of our contract with your insurance company. In Addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to your employer and/or insurance company representative.

_____ **please initial**

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party Name of Patient/Responsible Party (please print)

Date: _____ Relationship to Patient: _____

CENTRAL FLORIDA PRIMARY CARE

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NOTIFICATION OF ADVANCE DIRECTIVES

(In compliance with the Patient Self-Determination Act)

An Advance Directive is a written statement about how you want medical decisions made should you not be able to make them yourself.

***** ALL PATIENTS ARE STRONGLY ENCOURAGED TO HAVE AN ADVANCE DIRECTIVE *****

At this time, I have prepared a:

Living Will	o No o Yes
Advance Directive	o No o Yes
Durable Power of Attorney	o No o Yes
Designation of Healthcare Surrogate	o No o Yes

I understand that the information I have provided may be changed at any time, and I must provide another copy after any changes have been made.

I understand that it is my responsibility to provide my physician with a copy of my Advance Directives.

I have provided my physician at Central Florida Primary Care a copy of my:

Living Will	o No o Yes
Advance Directive	o No o Yes
Durable Power of Attorney	o No o Yes
Designation of Healthcare Surrogate	o No o Yes

X _____

Signature of Patient or Legal Guardian Date

X _____

Printed Name of Patient or Legal Guardian Date

CENTRAL FLORIDA PRIMARY CARE

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FINANCIAL POLICY

INSURANCE: We accept most insurances, Commercial, Medicare, and Medicare Advantage assignments. We are not contracted with worker compensation carriers. Please call your insurance company to assure if your office visit will be covered. *Patients are responsible for co-pays, co-insurance, and/or deductibles at time of visit.*

LAB SERVICES: We do have the ability to collect blood work in our in-house lab ***for a convenience fee of $25*** *for patients with insurance and a TBD price for self-pay patients*. We also send our patients out to the laboratories that their insurance companies are contracted with. Insurance companies change their contracts with laboratories all the time, so each patient needs to know which laboratories their insurance allows them to go to. This will help us send them to the correct laboratory. We work very diligently to make sure you are sent to the correct lab. If for any reason a lab bill is denied for payment, it is not the doctor's or the practice's responsibility to pay this bill. All lab bills are the patient's responsibility. If you choose to go to another lab, which is not paid by your insurance you will be responsible for the balance.

PATIENT'S RESPONSIBILITY: *Our policy states that as a courtesy to our patient, we submit their claims to their insurance companies as a way of helping them ensure the payments are sent for the services that we rendered.* We are not responsible for claims that are not filed in a timely matter for reasons such as (wrong insurance information was given; wrong ID numbers or claims that are sent to the wrong insurance address). Ultimately, it is the patient's responsibility for payment of services that are rendered. *The patient is responsible to pay the balances left from deductibles, co-insurance or any balance due to a change in co-pay amounts within 30 days after the insurance pays your claim.*

PAYMENTS: ***ANY***, *and* ***ALL*** co-payments, which are determined by the patient's insurance companies, ***are required to be paid at the time services are rendered***. If the patient is a self-pay patient, we require payment in full for all services. At times exceptions are made in order, to assist a patient due to financial hardship. We are dedicated to help patients obtain the healthcare they need.

FORMS OF PAYMENT: We accept cash or credit (Visa, MasterCard, Discover or American Express). ***ALL balances of $40 or less must be paid in CASH***, *We do not accept Credit Cards Payments below $40.00, There will be a $10 additional fee, to pay those balances with Credit Cards or Debit Cards, without exceptions.*

FORMS TO BE FILLED: If a patient needs a form to be filled out, such as an FMLA form, a ***fee of $35 and up*** will be charged according to the document. Forms will not be filled out immediately, they **can take up to 3-5 business days** for the providers' ample time to review the patient's record and fill them out accordingly. Our staff will call the patient when the form is ready to be picked up or faxed and to collect payment.

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FINANCIAL POLICY (page 2)

NO SHOW POLICY: Patients' sign this agreement at the time a patient becomes part of the practice, so they understand how important it is for us to help all patients obtain an appointment. ***There is a $45 no show fee that will be assessed to the patient's account automatically if the patient does not show up or call.***

COLLECTION PROCESS: We work diligently to resolve all claims with the patient's insurance companies. We send patient statements/bill every month to each patient with a balance. This is done each month along with a collection letter attached to the second and third request. At the end of 60 days, we call each patient to remind them that a balance for services rendered has not been paid as of today and it is past due. We try to obtain payment for these accounts. If payment is not received in the allotted time, we then transfer this patient's account to our in-house collections and the account is placed in a frozen status. When all efforts have been exhausted, we then dismiss the patient from the practice after giving them one last chance to pay their balance. Although we will be able to provide emergency services to you on a cash only basis for the next 30 days, you must arrange to have medical services elsewhere. A 35% handling fee will be added to all patient balances when they are transferred to an outside collection agency and will become the patient's responsibility to pay. At which time the patient will be dismissed from our practice.

REFUND POLICY: All refunds to the insurance companies and patients are done at the end of each month if there are no pending claims. ***We do no refund any payments made by a self-pay patient that is in the process of obtaining insurance.*** The patient has the options to reschedule their appointment and wait for their insurance to be active.

Signature of Patient or Legal Guardian:	**Date:**
Signature of Witness:	**Date:**

CENTRAL FLORIDA PRIMARY CARE

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Yolanda Molinaris, MD Iveth Mastrapa, ARNP

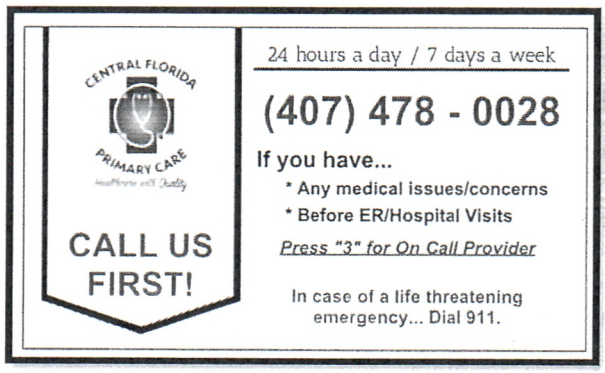
Acknowledgment of Receipt

(Acuse de Recibo)

Patient Name: _____ DOB: _____

My signature confirms receipt of the information detailed below from CFPC:

Con mi firma confirmo que recibí de CFPC la información que se detalla abajo:



Patient's sign: _____ *Date:* _____

CFPC Staff sign: _____ *Date:* _____