

**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 Physician and Specialist(s) Name, Address & Contact Phone #s and E-mail Address(es)  
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 - Contacto en caso de emergencia (nombre/# de telefono) / Nombre de su representante y # de telefono

Address at Home (details, city, country) / Direccion de Casa (incluirl ciudad, pais)      Address in U.S. / Direccion en EEUU: (Street Address, City, State, Zip Code)

If you are staying at a hotel, please advise the name the reservation is under:

If you are staying at a private home, please advise the name of community. Does it have a gate? if so, gate code # or if it has a security guard, please advise the name of the home owner.

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 busqueda de un chequeo? detalles:

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

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: an MRI, a consult with specialist, etc.

Que servicio/tratamiento necesita?por ejemplo: un examen, una consulta con especialista, etc.

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?

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 autorizacion a la siguiente Oficina:

H.O.P.E., Helping Our People Everywhere

Name: Elizabeth Paucar Harris

Phone #: (954) 240-7770

Address: 2413 Main Street, #146, Miramar, FL 33025

**I authorize the release of any and all of my records regarding treatment to the person(s) listed above. Print Name Below and date:**

Yo autorizo todos mis informes medicos relativo a mi tratamiento a la oficina detallada aqui.

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