Dr. Brunilda Ducellari

PLEASE PRINT PATIENT INFORMATION

Name ____ Date of Birth ______________ Sex: F / M
Address ____ City ___________________
State _____ Zip __________ Phone # _____________________ Mobile # ________________________

Please Check: Single Married Divorced Widowed Dependent
If married, spouse's name: ____

EMERGENCY CONTACT
Name: _________________________ Relationship: _________________ Phone# __________________
I authorize the following for medical information, lab results, and other documents:

PATIENT_____ EMERGENCY CONTACT _____ OTHER: ___________________________
I authorize messages on my answering machine about: Medical results yes no Medication information yes no
For Prescriptions: Name of Pharmacy ____
Phone # ___________________ Address ____

LIST OF ALLERGIES ____
Current Medications: ____
____

It is our goal to provide continuity of quality care for our patients. For this, we need your cooperation. When you need a medication prescription, call your pharmacy 24 hours in advance. Your pharmacy will call us with your request and provide the necessary information. This will allow time for your doctor to review your request and your records and authorize your prescription.
With the volume of patients and prescription requests we have, a 24-hour notification is mandatory. We cannot honor last-minute requests. If you have not been seen in a period of three months, your doctor may request that you make an appointment for a new evaluation before a medication can be refilled. We apologize for any inconvenience, but it is necessary for the proper dispensing of medications.

HIPPA NOTICE OF PRIVACY PRACTICES *CONTACT PERSON*-- Administrator of Miami Feet
I understand that if I have questions or complaints regarding my privacy rights, I will contact the person mentioned above. I also acknowledge that I have been presented with a copy of BRUNILDA DUCELLARI, DPM notice of privacy practices. My signature indicates that I have read and accept all the conditions and information on this page.

Signature: ____ Date:____________________
Dr. Brunilda Ducellari

MIAMI FEET

Dr. Brunilda Ducellari

INSURANCE AND PATIENT RESPONSIBILITY

Patient Name: ____
Date of Birth: ________________________________
Primary Insurance: ____
Secondary Insurance: ____

Health Insurance Information

I certify that the information I have provided is true, correct, and up to date. I have given all information regarding my existing insurances and coverage.

Patient or Responsible Party: _______________________________________
Relation to Patient: __________________________________
Signature: _______________________________________ Date: __________________________

Patient Responsibility

I acknowledge that I am responsible for all charges for the services provided to the mentioned patient. This includes any co-payments, charges not covered by my health insurance, or charges for which I am responsible under my health insurance plan. In the event that I have no coverage or it has expired at the time of the visit, I acknowledge that I am responsible for all charges for the services rendered.

Patient or Responsible Party: _______________________________________
Relation to Patient: __________________________________
Signature: _______________________________________ Date: __________________________

Dr. Brunilda Ducellari

Phone: (305) 480-2045 - Email: drducellari@miamifeet.com - Address: 1401 SW 107th Ave, Suite 301E Miami, Florida 33174

Dr. Brunilda Ducellari

NOTICE OF PRIVACY PRACTICES

This notice describes how your personal and medical information may be used and disclosed and how you can access this information. Please review it carefully.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and shared by us. It also tells you how you can access this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosures of your information.
6. The right to a copy of this notice.

We want to assure you that your personal and medical information is secure with us. This notice contains information on how we will ensure that your information remains private.

If you have any questions about this notice, the name and number of our contact person is listed below:

Effective Date of This Notice: 5/31/2024 - Contact Person: Administration - Phone Number: (305) 480-2045

Consent to the Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices of Brunilda Ducellari, DPM I understand that if I have questions or complaints regarding my privacy rights, I can contact the person listed above. I understand that the practice will offer me updates to this notice if it is modified.

Date: ___________________________________
Patient or Responsible Party: ____
Signature: ____
Patient refused to sign: ____
Patient unable to sign: ____

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APPOINTMENT CANCELLATION OR NO-SHOW POLICY

At Miami Feet, we understand that sometimes you need to cancel or reschedule your appointment and that emergencies arise. If you are unable to attend your appointment, please call us at least 24 hours in advance. You can cancel your appointment by calling us at (305) 480-2045 during our business hours.

To ensure that each patient is given the appropriate amount of time for their visit and to provide the highest quality care, it is very important that each scheduled patient attends their visit on time. As a courtesy, you will be called to remind you of your appointment one business day before your scheduled appointment. If we are unable to speak with you directly, a voicemail message will be left if possible. However, it is the patient's responsibility to confirm their appointment and arrive on time for the appointment.

Please Review the Following Policy

- If you do not show up for your appointment and do not call to cancel, a $25 fee will be charged to your account.
- Cancel your appointment at least 24 hours in advance.
- If you cancel with less than 24 hours' notice, this will be considered a no-show or late cancellation and a $25 fee will be charged to your account.

I have read and understand the Appointment Cancellation No-Show Policy of Miami Feet and understand my responsibility to plan my appointments accordingly. It is my responsibility to notify the Miami Feet office appropriately if I have difficulty keeping my scheduled appointments.

____ ______________________

Patient Name Date of Birth Date

____ ______________________

Patient or Parent/Guardian Signature Relationship to Patient

____ ______________________

Employee or Witness Signature Date

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