BEACON HALLANDALE OBGYN

Dr. Lev Kandinov

800 S.E. 4th Ave Suite 502 Hallandale, Fl 33009

Tel: 305-931-8844 Fax: 305-935-4113

Patient Registration Form

Today's date: _____ PCP info: _____

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Age: _____ SS:_____ Marital Status: S / M / D / Sep / W

Street Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email Address (please print): _____

Pharmacy Name and Phone number: _____

ALL FEES PAYABLE AT THE TIME SERVICES ARE RENDERED

Primary Insurance Name: _____ Subscriber's Name:_____

Member ID #: _____ Group #: _____

2nd Insurance Name: _____ Member ID #: _____

Patient relation for an account: Self ___ Spouse ___ Child ___ Other ___

Employer: _____ Occupation:_____ Work Phone: _____

IN CASE OF EMERGENCY

Contact Name: _____ Relation to Patient:_____ Phone: _____

Patient Signature: _____ Date: _____

What is your main reason for coming to the doctor today? _____

_____

Menstrual History:

Age at which periods started: ____ Number of days separating the beginning of each cycle: ___

Number of days period lasts: _____

Date of last PAP Smear: ____/____/____

Date of last period start: ____/____/____

If menopausal, age at which periods ended: ____ Have you ever taken hormones? Yes___ No__

What are you using for Birth Control? _____

History of STD's (Gonorrhea, Chlamydia, HPV, HIV, Trichomonas, Herpes, Syphilis)?

_____

_____

Pregnancy History:

# of pregnancies: _____ # of therapeutic abortions: _____

# of miscarriages: _____ # of children born alive: _____ # of stillbirths: _____

Have you ever had any blood transfusions? Yes___ No___

Have you ever taken a fertility drug of any kind? _____ Which? _____

Have any of your children had birth defects of any kind? _____

_____

Summary of Previous Pregnancies:

Date	Weeks	Birth Weight	Sex	Delivery Type	Anesthesia	Complications	Location (city/state)

Date of last Mammogram: _____

Bone Density: _____

Have you ever had any of the following operations/procedures? Please check any that apply:

_____ Laparoscopy _____ D & C _____ Surgery of Endometriosis

_____Appendectomy _____Tubal Pregnancy _____ C-Section_____ Tubal Ligation _____

_____Gallbladder removed (open or laparoscopy)

_____Mastectomy (please specify which breast): _____

_____Lumpectomy (please specify which breast): _____

_____Bladder Repair _____LEEP or cervical conization

_____Ovaries Removed: _____Left _____Right _____Both

_____Hysterectomy type: ___ Vaginal ___ Abdominal ___Laparoscopic ___DaVinci (robotic)

Reason for Hysterectomy: _____

Please list any surgeries not listed above: _____

Have you ever had any of the following? Please check all that apply:

_____Abnormal PAP Smear

_____Stroke (CVA) _____High Blood Pressure _____ Frequent Headaches/Migraines

_____Kidney Infection(s) _____Bladder Infection(s)

_____Diabetes Type I ____2____

_____Loss of urine when coughing or sneezing _____Urinary urgency with loss of urine

_____Depression _____Anxiety

_____DVT (blood clot in leg) _____PE (blood clot in lung)

_____Any heart related problems? Please specify: _____

_____Cancer? What type: _____

Which of the following habits do you practice?

___Smoking ___ Packs per day ___Drugs (Which)_____

___Alcohol ___ Drinks Per Day ___ Drinks Per Week

Please list any medications you taking regularly:

Medication Name	Doses	Reason

Please list Medications you are Allergic to: **Reaction from taking this medication:**

FAMILY HISTORY

	Mother	Father	Sister	Brother	Maternal GM	Maternal GF	Paternal GM	Paternal GF	Aunt	Uncle
High Blood Pressure										
Diabetes										
Breast Cancer										
Colon Cancer										
Ovarian Cancer										
Uterine Cancer										
Other Cancer type										
Thyroid Disease										
Kidney Disease										
Heart Disease										
Anemia										
Birth Defects										

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CONSENT FOR PELVIS AND/OR RECTUM EXAMINATION

GENERAL CONSENT FOR COMPREHENSIVE EXAM INVOLVING PELVIS AND/OR RECTUM

I understand the planned procedure and I consent to a medically indicated physical exam which may include, but may not be limited to the following:

(X) a female gynecological exam which may include a rectal and pelvis exam

(X) an ultrasound exam which may include a probe placed in the vagina

(X) exam of external genitalia

The consent will remain active until I withdraw my consent in writing.

Patient Name: _____

By signing this consent, _____ I authorize

(Patient Signature)

Date: _____

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List of Special Services Fees

-Blood Draw Convenience Fee $25

-Copies of Medical Records $1 per page

-FMLA forms $25

(All patient forms/Medical Records/Letters will be completed within 5-7 business days)

-Returned Checks/Credit Card chargeback Fee $25

-Collection Fees

(40% of the amount turned over to the collection agency: the fee charged by the collection agency)

Print Patient/Guardian Name: _____

Signature Patient/Guardian: _____ Date: _____

** These Fees are subject to change without notice**

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KNOW YOUR INSURANCE POLICY

Dear Patient,

We ask that you please read and sign this form as it concerns you, the patient

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes. It is not always possible.

Therefore, we urge you, the patient, to please check with your insurance company regarding your coverage. You can access this important information on your policy web portal which is provided by the insurance company free of charge.

It is your responsibility to know your individual coverage and its limitations. Failure to obtain this information prior to your visit or procedure could result in you being responsible for all costs incurred. Please remember that your insurance policy is a contract between you and your insurance company.

To assist you in finding what coverage you have please feel free to ask for assistance. Some insurance companies require referrals from your primary care physician (PCP) Some insurance plans state you cannot go **out-of-network.** Changes are being implemented within insurance companies constantly. It is for your benefit that you **know your insurance policy**. Utilize the insurance company's website as your primary resource.

Please advise us of any changes in your billing address, if you have changed your medical insurance carrier or of any changes in your deductible policy. We will make every attempt to verify your benefits but it is imperative that you know them as well.

We thank you for your help

Beacon Hallandale OBGYN

Print name: _____ Date: _____

Signature: _____

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CANCELATION/ NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to a seemingly" FULL "appointment book.

If an appointment is not cancelled at least 24 hours in advance, you will be charged fifty dollars ($50) fee that is not covered by your insurance.

SCHEDULED APPOINTMENS

We understand that delays can happen, however we must try to keep the other patients and doctors on time. If you are aware, you will be running late, please contact our office prior to the appointment to let us know. If a patient is **30 minutes late** past their scheduled time without a call most likely we will have to reschedule the appointment.

_____	_____	_____
Print Patient Name	Signature patient/guardian	Date

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Beacon Hallandale OBGYN, will securely maintain your credit card information to be used for payment of your co-pays, deductibles and co-insurance responsibilities. Payments will be processed after your claim has been successfully processed by your insurance.

CREDIT CARD AUTHORIZATION

I authorize and agree to pay the amount charged to my credit card per the card issuer agreement (Merchant Agreement if credit voucher). I also authorize Beacon Hallandale OBGYN to charge my card on file the balance that is owed after insurance and/or point-of-service (patient) payment for a specific date of service have been applied to my account. This authorization will expire when the associated credit card expires, or when, in writing, I cancel this authorization.

Patient Name (please print): _____

Authorized Signature: _____ Date: _____

Name of the card holder if not the patient: _____

Email address: _____

By signing the above, you give Beacon Hallandale OBGYN permission to pay your portion of claims which are deemed your responsibility, with the credit card information you have provided to us. Should you dispute any charges with your credit card vendor, **there will be a $25 chargeback fee** added to your account.

Internal use only: Recurring ID: _____ Masked ID: (last4) _____ Type of Card: _____ Initials: _____

Please check which card type you will be using:

1.American Express ___ 2.Visa___ 3.Mastercard ___ 4. Discover___

Name as it appears on your credit card:_____

Credit Card Number: _____

Expiration Date: _____ (AmEx only 15 number)

Card holders Billing address (street info only):_____ ZipCode:_____

Your credit card information will be destroyed once your card is established

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ACKNOWLEDGEMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Beacon Hallandale OBGYN Notice of Privacy Practices effective 01/01/2010

Name (please print): _____

Signature: _____ Date: _____

I am a parent or legal guardian of _____ (patient name) I have received a copy of Beacon Hallandale OBGYN Notice of Privacy Practices effective 01/01/2010

Name (please print): _____

Relation to patient: ____ Parent ____ Legal Guardian

Signature: _____ Date: _____

If the Acknowledgement was NOT signed by the patient or legal guardian:

Notice of Privacy Practices effective 01/01/2010 given to individual on: _____(date)

__ In Person __ Mailing __Email __ Other _____

Reason individual or parent/legal guardian did not sign this form:

__ Declined

__ Did not respond after more than one attempt

__ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to and outcome as applicable the efforts that were made to obtain the signature. More than one attempt must be made

__ In person conversation _____

__ Telephone contact _____

__ Mailing _____

__ Email _____

Staff Name (please print) _____ Title _____

Signature _____ Date _____

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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

This notice took effect on 01/01/2010 and remains in effect until further notice

1.OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1.Keep your medical information private

2.Give you this notice describing our legal duties privacy practices and your rights regarding your medical information

3.Following the terms of the current notice

We have the Right to:

1.Change our privacy practices and the terms of this notice at any time provided that the changes are permitted by law

2.Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep including information previously created or received before the changes

Notice of Change to Privacy Practices:

Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may share medical information about you to your other healthcare providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

WORKERS COMPENSATION: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

HEALTH OVERSIGHT ACTIVITIES: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including adults, civil, administrative or criminal investigations or proceeding inspections, licensure or disciplinary action or other authorized activities.

LAW ENFORCEMENT: Under certain circumstances we may disclose information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

APPOINTMENT REMINDERS: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

ALTERNATIVE AND ADDITIONAL MEDICAL SERVICES: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you and to describe or recommend treatment alternatives.

4.YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1.Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $1 per page.

2.Receive a list of all the times we or our business shared your medical information for purposes other than treatment, payment and health care operations and other specified exceptions.

3.Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency)

4.Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.

5.Request that we change certain parts of your medical information. We may deny your request if we did not create the information, you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation.

6.If you have received this notice electronically and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

TopLine MD Alliance

Cambiar a *Español*

Welcome to TopLine MD Alliance

With this patient portal, you can communicate with providers affiliated with TopLine MD Alliance and access your health records through a convenient and secure environment. If you are experiencing an emergency, please call 911.

healow

Access your health records through the healow mobile app

DOWNLOAD THE FREE HEALOW APP

Download on the App Store

Get it on Google play

JiABCD

Find us using our

LOGIN TO YOUR ACCOUNT

We will send verification code to confirm access to this number. Standard text messaging rates apply.

Using Mobile Phone

OR

Enter the details below