



Ivonne Maria Reynolds, DO, LLC

OBSTETRICS AND GYNECOLOGY



Welcome to our practice!

We want to take this opportunity to thank you for choosing Dr. Ivonne Reynolds and Dr. Jessica White-Videa for your OB/GYN care needs. Just a bit about our office. We answer our phones on Monday and Wednesday 8:30am to 12:30 and 2:00pm to 5:30pm, on Tuesday and Thursday from 8:30am to 12:30 and 2:00pm 4:00 pm and on Friday from 8:30am until 1pm. For any calls outside of office hours, including holidays and weekends, our answering service will contact our on-call provider to address urgent matters. Medication refills, laboratory and imaging results, forms and letters can only be addressed during office hours. We have privileges to treat our patients at Northwest Medical Center and Coral Springs Medical Center.

We do have a NO CHILDREN POLICY. Children under the age of 12 are not permitted in the office. If you need to bring your child, they must be accompanied by another adult to watch them in the waiting room only. If your child is under the age of 2, they must remain in a stroller or carrier at all times. If you do bring your child and do not follow the office policy, you will be asked to reschedule your appointment.

Please take the time to complete these forms prior to your visit and bring them with you to your first appointment. If you have not given your insurance information in detail when making your appointment, please call the appointment desk prior to your visit so we may verify your benefits before you arrive; this will decrease your wait time to see your chosen provider. After your visit, you may receive a survey about your experience in our office, we appreciate and value your input.

Thank you in advance for the completion of the attached forms. We look forward to meeting you and providing you with the quality care you deserve.

Once again, welcome to our practice,

Ivonne Reynolds, DO, FACOOG

Jessica White-Videa, DO, FACOG



Ivonne Reynolds, DO, FACOOG – Jessica White-Videa, DO, FACOG

Name _____ Today's Date _____
Last First Middle Initial

Date of Birth _____ Age _____ Social Security # _____

Mailing Address _____
Street City State Zip

Cell Phone _____ Home Phone _____

Employer _____ Employer Phone _____

Primary Care Physician _____ Physician Phone _____

Marital Status Single Married Divorced Widowed

Referred by: Physician Family/Friend
 Insurance Google Search Social Media

Primary Insurance

Ins. Co Name _____ Phone _____

Address _____
Street City State Zip

I.D. No _____ Group No _____

ARE YOU A DEPENDENT ON THIS PLAN? YES - If yes, WHO is the PRIMARY INSURED? NO

PRIMARY POLICY HOLDER /SUBSCRIBER _____ Relationship to Patient _____

Policy Holder Date of Birth _____ Check here If the subscriber has the same billing address as you

Address _____

Secondary Insurance Not applicable

Ins. Co Name _____ Phone _____

Address _____
Street City State Zip

I.D. No _____ Group No _____

ARE YOU A DEPENDENT ON THIS PLAN? YES - If yes, WHO is the PRIMARY INSURED? NO

PRIMARY POLICY HOLDER /SUBSCRIBER _____ Relationship to Patient _____

Policy Holder Date of Birth _____ Check here If the subscriber has the same billing address as you

Address _____

To web enable/telemedicine capabilities please provide a legible email:

Email address: _____

PHARMACY INFORMATION

CVS TARGET WALGREENS WALMART PUBLIX OTHER

Phone Number _____

Cross Streets/Address _____

In Case of Emergency

Who Should We Contact? _____ Relationship _____

Phone _____ Work _____ Cell Phone _____

Fees and Insurance Information Dr. Ivonne M. Reynolds, DO, LLC will assist its patients in making every effort to collect payments from the patient's or guarantor's insurance company through courtesy filing of insurance claims and other required documentation. Since most carriers have time limits for filing correct information, it is imperative that we receive complete and correct insurance information. Though assistance will be provided, it is the patient's responsibility to make sure his/her insurance carrier pays his/her claim. Patients, or their guarantors, are responsible for payment in full of financial obligations whether or not their insurer makes a payment. All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment of all charges is the patient's responsibility and should it be necessary for this account to be turned over to either a collection agency for collection, I understand that I will be liable for any charges incurred, including collection agency's fee, attorney's fee and or court costs. In accordance with Florida law, we have elected not to carry medical malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to S.458.320 (5) (g). Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgment arising from claims of medical malpractice; this notice is pursuant to Florida law. **Physicians Release and Assignment:** I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier/HMO/TPP for services rendered by the physician. I understand that I am financially responsible to the physician for any and all co-insurance, deductibles, copays and/or non-covered service charges that the carrier declines to pay. I hereby authorize the release of my medical records to my insurance provider as deemed necessary for payment of insurance benefits.

Signature _____ Date _____

How would you like to be contacted by us?

Patient's rights of disclosures

In general, the HIPAA privacy rule gives the individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communications of health information be made by alternative means.

I, _____, wish to be contacted in the following manner:

HOME

Ok to leave a detailed message

Leave message with callback number only

CELL PHONE Ok to leave a detailed message

Leave message with callback number only

WORK

OK to leave detailed message

Leave message with callback number only

Written communication

OK to mail to home

OK to fax to home _____ Fax number

OK to fax to work _____ fax number

List all persons in your household who, in your absence, may make requests on your behalf, and with whom we may speak regarding your medical information. NAME Relationship

Patient Signature: _____ Date: _____



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OBSTETRICS AND GYNECOLOGY



FINANCIAL POLICY

Thank you for choosing our practice. We want to ensure every experience you have with us is a positive one. We have developed a set of guidelines regarding financial responsibility. If you have any questions, please speak with the billing coordinator.

You must present your insurance card prior to or at the time of your visit. If we do not receive your insurance card before you see the doctor, that visit becomes a fee-for-service, and payment is expected.

Co-pay, Deductible and Co-insurance. A copay is a set dollar amount you owe for each office visit. Some insurance plans are subject to a deductible and coinsurance. Our office staff will attempt to contact you, prior to your visit, to advise of your responsibility. You will be expected to make payment when services are rendered.

Estimation of Services. Whenever possible, our office staff verifies your benefits with the insurance company and will provide you with the approximate cost of the service. Please remember we can only assure you of the cost of the procedure on the day when the doctor has determined the actual procedure/code being used. The estimate of our charges will not include any outside lab or pathology service.

Lab/Pathology Fees. If any laboratory testing is collected (blood work, cultures, biopsy, pap smear, etc.) in our office to confirm a diagnosis or to determine a course of treatment, the laboratory will perform the actual testing of the sample. **THIS MEANS YOU WILL RECEIVE A SEPARATE BILL FROM THE LAB/PATHOLOGIST.**

Forms of Payment. For your convenience, we accept cash, check, MC, Visa, Discover and American Express. ***If a credit/debit card is used a 3.9% fee is added to the cost by the credit card merchant.***

Collection Efforts. We will make every effort to work with you to make payment arrangement should your bill become outstanding. If all efforts do not bring about a resolution of the account after 90 days, the account balance will be turned over to an outside collection agency – First Federal Credit Control – 1800-486-5500.

PRINT NAME

SIGNATURE

DATE

Notice of Privacy Practices

Ivonne M. Reynolds, DO, LLC

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.

HOW WE MAY USE AND DISCLOSE HEALTH

INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:

We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:

We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:

We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services.

We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care.

When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for electronic copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying
"Acknowledgement" form

Peggy Narcisi
2964 N. State Road 7, Suite 310
Margate, FL 33063
Office: (954) 917-4997
Fax: (954) 917-5404



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Notice of Privacy Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that the practice of Ivonne Reynolds, DO, LLC has the right to change its Notice of Privacy practices and that I may contact the practice at anytime to obtain and current copy of the NPP.

PATIENT LEGAL NAME (PRINT)

SIGNATURE

DATE

OFFICE USE:

WE HAVE MADE THE FOLLOWING ATTEMPT TO OBTAIN THE PATIENT'S SIGNATURE ACKNOWLEDGING RECEIPT OR NOTICE OF PRIVACY PRACTICES.

ATTEMPT BY

DATE

FMLA/DISABILITY Form Notification

I acknowledge that there is a \$25.00 fee for any disability, FMLA or any other paperwork that needs to be completed by the physician. As a patient, I am required to provide the paperwork from my employer (and/or disability company) and complete the patient portion(s). This fee is not paid by the insurance company, nor is it included in the visit. Please allow 3-5 business days for your paperwork to be completed.

PATIENT LEGAL NAME (PRINT)

SIGNATURE

DATE



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CONSENT FOR MEDICAL EVALUATION

Written consent of the patient or the patient’s legal representative or guardian is required prior to a medical examination. Part of your evaluation may include but is not limited to a breast examination as well as a pelvic examination including rectal examination.

A pelvic examination is defined by and includes an examination of the vulva, vagina, cervix, uterus, fallopian tubes, ovaries, uterus, rectum, or external genitalia, or pelvic organs using a combination of modalities, which may include, but not be limited to, the healthcare provider’s gloved hand or instrumentation.

I understand and consent to a **“MEDICALLY INDICATED GYN EXAMINATION INCLUDING BUT NOT LIMITED TO A PELVIC EXAMINATION AND/OR RECTAL EXAMINATION”**. This may be performed by the doctor, physician assistant, and/or medical resident.

Patient Name: _____ Date _____

Patient Signature: _____

Signature of Legal Representative or Guardian: _____
(If patient under the age of 18)

Witness Signature: _____



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Welcome to our patient portal!!!

We are honored that you have chosen us as your healthcare provider. Today we have exciting news regarding your health management!

As we continue in our efforts to provide our patients with the highest quality of care, we are constantly looking for methods of working together with you to ensure that you are not only aware of, but also involved in the management and improvement of your health.

We are proud to inform you that our practice now offers the opportunity to use the power of the web to track the most important aspects of your healthcare through our office. The Patient Portal enables our patients to communicate with our doctors, nurses, and staff members easily, safely, and securely *via* the Internet.

Participating patients are given secure User IDs and passwords, enabling them to access the Portal to view their personal and private documents, including lab and diagnostic test results, educational information, billing statements, and other health information.

Through the Patient Portal, you are able to:

- ask questions of doctors, nurses, and staff members
- request prescription refills and referrals
- request appointments
- view your personal health record

... all from the comfort of your home, whenever it is convenient for you!

By using the Patient Portal, you no longer have to call the office, leave a message, and wait for a response to get the results of your lab work; those results will be available to you through the Portal. You can also send a message to the office through the Portal and expect a prompt reply.

The enclosed brochure provides additional information.

Begin today to take an active role in managing your healthcare!

Yours truly,

Ivonne Reynolds, DO FACOOG
Jessica White-Videa, DO, FACOG



Ivonne Maria Reynolds, DO, LLC

OBSTETRICS AND GYNECOLOGY



WEB PORTAL ACCESS

The following pertains to access to and use of online communications:

- Online communications do not decrease or diminish any other ways in which you can communicate with your provider. It is an additional option and not a replacement.
- The practice may stop providing online communication or change the services provided online at any time without prior notification to you.

I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communications between me and my physician's office. I consent to the conditions outlined and I agree to keep my password confidential and notify the office if my email address changes at any time.

I am over the age of 18 and have sole responsibility for my medical care

No **(We do not offer the patient portal to minors or those patients which do not make their own medical decisions and this time. We apologize for any inconvenience)**

PRINT PATIENT NAME: _____

DATE OF BIRTH: _____

EMAIL ADDRESS FOR PORTAL USE _____

please print legibly

I choose not to participate in Patient Portal at this time because

I do not have an email address

I do not wish to share my email address

English is not my preferred language

Other