PATIENT REGISTRATION FORM

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: _____ First Name: _____ MI: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Occupation: _____

Date of Birth: _____ **Sex:** M F **Marital Status:** Married Single Divorced Widowed **Preferred Language:** _____

Race: ☐ American Indian or Alaska native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Unknown/Declined to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined to answer

Home phone: (_____)_____ cell phone: (_____)_____ work phone: (_____)_____

Best daytime number to reach you ☐ home ☐ work ☐ cell Is it ok to leave a message at any of the numbers? ☐ Yes ☐ No

If no, please designate which ones, if any: _____

Primary Care Physician's Name (if applicable): _____ How did you hear about us? _____

Spouse's Name: _____ Date of Birth: _____ Spouse's SS#: _____

RESPONSIBLE PARTY: THIS SECTION REFERS TO THE PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Relationship to Patient ☐ Self (skip to next section) ☐ Parent ☐ Spouse ☐ Other (skip to next section) _____

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Birth date (mm/dd/yyyy): _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home phone: (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

INSURANCE INFORMATION

Primary Insurance Coverage: _____ Copay: $_____

Policy effective date: _____ Deductible: $_____ Met? ☐ Yes ☐ No If no, amount met: $_____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

Secondary Insurance Coverage: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

☐ **Verified Patient Information** Staff Initials: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

DISCLOSURE TO FAMILIES AND LOVED ONES (Emergency Contacts)

I authorize Ladies First OB/GYN, LLC, to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. A photo ID is required for prescription pickup. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Ladies First OB/GYN< LLC to disclose my personal health information to the following people:

Name: _____ Relationship: _____ Phone: (____)_____

Name: _____ Relationship: _____ Phone: (____)_____

Name: _____ Relationship: _____ Phone: (____)_____

CONSENT TO TREATMENT FOR ALL PATIENTS

I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for, and understand that no guarantee or assurance has been made as to the results for which may be obtained. I agree to allow my provider to access all of my medication history including medication prescribed by other providers.

I consent to a medically indicated examination including but not limited to a pelvic exam. _____ Patient initials

PHOTO DOCUMENTATION

I hereby grant authorization for the clerical staff to make a copy of my photo identification to be included in my confidential record as well as take a digital picture for additional protection against the theft of my medical identity. I further grant authorization for the clinical staff to take photo documentation of any injury or procedure that they feel is medically necessary to include in my confidential medical record.

_____ Patient initials

NOTICE OF PRIVACY PRACTICES

I received a copy of the Ladies First OB/GYN, LLC "Notice of Privacy Practices" today and agree with these privacy policies.

_____ Patient initials

INSURANCE ASSIGNMENT AND FINANCIAL RESPONSIBILITY

I hereby authorize the offices of Ladies First OB/GYN, LLC (LFOBGYN), to release any medical information required during the course of examination and treatment to my insurance company, and I permit payment to LFOBGYN from my insurance for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

I understand that I am responsible for all charges incurred regardless of the insurance status. I agree to pay for services incurred after the patient has been charged for the office visit, such as labs, radiology, medical supplies, etc. I agree to pay my bill in full for services rendered by Ladies First OB/GYN, LLC providers.

_____ Patient initials

_____ _____

Date **Signature of Patient or Guardian if patient is Minor**

PATIENT NAME: _____ DATE OF BIRTH: _____

ALLERGIES

Do you have any allergies? YES or NO

If yes, list them;

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

PHARMACY

Name of pharmacy: _____

Address or crossroads: _____ City: _____

MEDICATION LIST

Please list any medications you are taking, including vitamins.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

PAST PREVENTITIVE HISTORY

First day of last period?	
Date of last pap smear?	
Date of last mammogram?	
Date of last colonoscopy?	
Date of last bone density/Dexa scan?	

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT RESPONSIBILITY DISCLOSURE STATEMENT

BUSINESS HOURS

Our business and operating hours are: Monday – Thursday 8:00am-4:45pm & Friday 8:00am-11:45am.
Calls received after the hours noted above, unless it is an emergency, will be handled the next business day.

DEDUCTIBLES AND CO-PAYS

I understand that all charges for services rendered at Ladies First OB/GYN, LLC (LFOBGYN) are due and payable at the time of service, to include unmet deductible amounts, co-pays and co-insurance percentages for in-network or out-of network coverage.

BLOOD HANDELING FEE

I understand that there will be a fee of $20 for GYN patients and $40 for obstetrical (OB) patients, for labs drawn in the office. I have the option of going to the lab contracted with my insurance, to have blood drawn at no additional charge.

MEDICAL INSURANCE

We have contracts with many insurance companies, and we will bill them as a service to you. As a courtesy to our patients, we will verify your insurance benefits. The insurance benefits quoted to you does not guarantee payment from your insurance company, nor does it confirm active coverage at the time the claim is submitted. Payment of claims is subject to all terms, conditions, limitations, and exclusions of the insurance contract that you signed. As the responsible party, you are responsible for the charges if your insurance company declines to pay for any reason, as well as:

- Informing LFOBGYN of the current address and phone number for the patient and the responsible party.
- Presenting all current insurance cards prior to each office visit.
- Verifying at each visit that your patient information is current by speaking to the front receptionist and completing a new demographic form every year.
- Paying any additional amount owed within 30 days of receiving a statement from our office. When LFOBGYN receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you.

AUTHORIZATION / REFERRAL POLICY

I understand that it is also my responsibility to obtain an authorization and/or referral through my primary care physician's office, if required by my insurance company. Failure to do so may result in charges being billed directly to me or my appointment being cancelled and rescheduled once I have obtained the appropriate authorization and/or referral.

RETURN CHECK POLICY

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF) or Account Closed (AC), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $50.00 Service Charge. Once notice is received of the returned check, Ladies First OB/GYN, LLC will send out a letter and/or call to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter or call date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $50.00 Check Service Charge.

_____
Pt Initials

NON-PAYMENT ON ACCOUNT

Accounts that are over 90 days past due may be placed with an outside collection agency for recovery. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the Patient's Responsible Party, understands that Ladies First OB/GYN, LLC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the Patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, collection fees, all court costs and Attorney fees.

_____
Pt Initials

PATIENT NAME: _____ DATE OF BIRTH: _____

PRESCRIPTIONS AND/OR REFILLS

- If you do not have an appointment and are requesting a refill to be called to your pharmacy on allowable medications, please allow 48-72 hours to process your request. On all refills, please call your pharmacy and request your refill and your pharmacy will then notify us with the appropriate information needed to handle your request. We recommend calling a week in advance.
- New prescription requests, if possible, should be discussed during an office visit. Refill requests for 90 day mail in or Navy Hospital will be written and placed at the front desk for pick up, or if requested, mailed to you. Samples are only given out on the day of your appointment. No Exceptions
- Please note that we **DO NOT** refill prescriptions on the weekends or holidays. Weekends begin at 12:00 PM on Fridays and a holiday begins at 4:00 PM on the day prior to a National Holiday.

TEST RESULTS

- Allow 7- 10 business days after Labs and/or Tests were performed for our office to contact you with your results.

APPOINTMENTS

- Bring all medications you are currently taking to each appointment. We recommend you also keep a list of your current medications and a copy of your insurance company's medication formulary to bring to each appointment.
- If you are more than 15 minutes late for your appointment, we may have to reschedule you or ask you to wait for a period of time until the staff can find an opening in the schedule.
- Reminder; this is an OB/GYN office which means we also see and treat pregnant patients. In the event that the
- Physician has to leave the office to deliver a baby during your appointment time, there will be a delay.

PATIENT FORMS COMPLETION

- I acknowledge understanding there may be fees involved if I have a disability, financial, medication or similar forms that need to be completed by Ladies First OB/GYN, LLC office and/or physician. Ladies First OB/GYN, LLC require **14 business days** for processing and/or completion of any form. All form completion fees will be collected prior to form completion.

MEDICAL RECORDS COPY

- In compliance with Florida Statutes 395.3025, Rule 64B8-10.003 of the Florida Administrative Code, the following
- fees will be collected prior to the release of medical records from Ladies First OB/GYN, LLC:
- ***If requesting paper copies of your records:*** There will be a charge of $1.00 per page for the first 25 pages of written
- material and $.25 for each additional page

WIRELESS COMMUNICATION

- By providing a wireless or mobile telephone number, I permit Ladies First OB/GYN, LLC to use that number for contact. Contact includes receiving calls, texts, and messages, including pre-recorded messages and calls from an automatic telephone dialer (auto dialer), from Ladies First OB/GYN, LLC and their authorized agents.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES. REFUSAL TO SIGN THIS STATEMENT RESULTS IN THE CANCELLATION OF APPOINTMENT AND TERMINATION OF FUTURE CARE.

PATIENT/GUARDIAN SIGNATURE	DATE
PRINT PATIENT/GUARDIAN'S NAME FROM ABOVE	GUARDIAN'S RELATIONSHIP TO PATIENT

CONSENT, PERMISSION AND RELEASE
FOR USE OF PHOTO, VIDEO AND/OR AUDIO

I hereby give consent and permission to LADIES FIRST OB/GYN, LLC to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of (print name) _____, age (if minor) _____.

Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by LADIES FIRST OB/GYN, LLC and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing.

I acknowledge that LADIES FIRST OB/GYN, LLC is the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that it has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video and/or audio may be used indefinitely by television, radio, newspapers, magazines, newsletters, brochures, Internet, intranet, or in other media once released.

LADIES FIRST OB/GYN, LLC has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold LADIES FIRST OB/GYN, LLC, its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production.

I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name: _____

Address: _____

Telephone: _____ Email address: _____

Signature: _____ Date: _____

Name of Parent/Legal Custodian (under age 18): _____

Signature of Parent/Legal Custodian (under age 18): _____

Witness Name: _____

Witness Signature: _____ Date: _____

I am revoking this consent. I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold LADIES FIRST OB/GYN, LLC responsible for instances of these violations.

Signature: _____ Date: _____

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

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

( ) a female Gynecological Exam which may include a rectal exam and a pelvic exam

( ) An Ultrasound Exam which may include a probe placed in the vagina.

( ) A rectal exam only

( ) An Ultrasound Exam which may include a probe placed into the rectum.

( ) Other procedures as listed _____

( ) Examination of external genitalia_____

This examination will be performed by any provider from LADIES FIRST OB/GYN, LLC.

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

Name of Patient

_____

Signature of Patient or Patient's Representative if under 18

_____

Date _____

Patient Name: _____

Have you experienced any of the following symptoms within the last two weeks?

Cough	☐ Y ☐ N
Fever or Chills	☐ Y ☐ N
Shortness of breath or difficulty breathing	☐ Y ☐ N
Fatigue	☐ Y ☐ N
Muscle or body ache	☐ Y ☐ N
Headaches	☐ Y ☐ N
New loss of taste or smell	☐ Y ☐ N
Sore throat	☐ Y ☐ N
Congestion	☐ Y ☐ N
Nausea or Vomiting	☐ Y ☐ N
Diarrhea	☐ Y ☐ N
In the last two weeks, did you care for or have close contact with someone diagnosed with COVID-19?	☐ Y ☐ N
In the last two weeks have you worked or volunteered in a healthcare facility?	☐ Y ☐ N
Have you or anyone in your Household been tested for COVID-19? If you answered yes, How many weeks ago and why? _____	☐ Y ☐ N

Have you experienced any other symptoms?

_____

Signature: _____ Date: _____