Sylvia K. Velarde, M.D.

TopLine MD Alliance

Welcome to Sylvia Velarde. M.D. LLC. For those of you who have been to our practice before. We appreciate your support and confidence you have in our practice. For those of you who are a new patient to our office, we will strive to meet your expectations.

Please be advised that we only deliver and work out of **Memorial Hospital West**. If you seek care at any other hospital other than **Memorial Hospital West**, we will be unable to care for you while you are in the hospital.

Please note that it is possible that our patients may be seen by my colleagues in Obstetrics/Gynecology that offer coverage in unforeseen emergencies, vacations, and seminars, etc.

Once again, we welcome you to our practice. Please feel free to let us know if you have any questions or concerns.

Español

Bienvenidos a Sylvia Velarde, M.D, LLC. Para aquellos pacientes que han estado en nuestra practica anteriormente, apreciamos su apoyo y cofinancia. Para aquellos de ustedes que son pacientes nuevos, nos esforzamos por satisfacer sus expectativas.

Tenga en cuenta que solo trabajamos con el hospital **Memorial Hospital West**, si busca atención en cualquier otro hospital que no sea **Memorial Hospital West**, no podremos ofrecerle atención medica mientras este en el hospital.

Por favor tenga en cuenta que es posible que nuestros pacientes sean vistos por mis colegas obstétrico/ginecólogos que me ofrecen cubertura en caso de emergencia imprevista, vacaciones, o semanarios, etc.

Una vez más, le damos la bienvenida a la práctica. Por favor no dude en hacer cualquier pregunta o expresar cualesquiera inquietudes.

_____ _____

Patient's Name (Please Print) Patient's Signature

_____ _____

Witness Date

Sylvia K. Velarde, M.D.
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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

Sylvia Velarde, MD, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have receive or have been given the opportunity to receive a copy of your Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Español

Entiendo que conforme a la Ley de responsabilidad y portabilidad del seguro de salud (HIPAA). Tengo ciertos derechos de privacidad con respecto a mi información medica protegida. Reconozco que he recibido o se me ha brindado la oportunidad de recibir una copia de su Aviso de practicas de privacidad. También entiendo que esta practica tiene el derecho de cambiar su Aviso de Practicas de Privacidad y que puedo comunicarme con la practica en cualquier momento para obtener una copia actual de la Notificación de Privacidad.

_____ _____

Patient Name or Legal Guardian (Print) Date

_____

Signature

Sylvia K. Velarde, M.D.

TopLine MD Alliance

NO-SHOW AND LATE CANCELLATION POLICY

When we make your appointment, we are reserving an appointment for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible to give your reserved room to another patient.

It is our office Policy to charge you a **$30.00 dollars** fee for not showing up, rescheduling or cancelling your appointment on the same day.

If you have any question, please call our office at 954-251-3186.

Español

POLITICA DE CANCELACION Y TARDE

Cuando hacemos su cita, estamos reservando una habitación para sus necesidades particulares.

Le pedimos que, si tiene que cambiar una cita, por favor dénosla con al menos 24 horas de anticipación. Esta cortesía hace posible dar su habitación reservada a otra paciente.

Es nuestra política de oficina cobrarle una **tarifa de $30.00 dólares** por no presentarse. Reprogramar o cancelar el mismo día de su cita.

Si tiene alguna pregunta, llame a nuestra oficina al 954-251-3186.

_____ _____

Patient Signature Date

Sylvia K. Velarde, M.D.

TopLine MD Alliance

Dear Valued Patient,

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.

This is permitted under Florida law subject to certain conditions. Florida law-imposed penalties against non-insured physicians who fail to satisfy adverse judgment arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Florida Statue § 458.320(5)(g)(1)

_____ _____

Patient Signature **Date**

Sylvia K. Velarde, M.D.

TopLine MD Alliance

LAB TEST AGREEMENT

This Agreement pertains to all patients of Dr. Sylvia Velarde M.D, LLC.

For those who cannot afford the time and hassle of waiting at a lab draw station (where appointments are not given), as a convenience, we will offer this service at our office.

Due to many insurance companies now contracting directly with the laboratory, we are being put in the position of having to provide you a prescription for any labs deemed necessary and expect you to have them drawn in the time frame stipulated.

Patient who desires **Sylvia Velarde M.D, LLC** to draw blood, understand that they will be charged a twenty-dollar ($20.00) convenience fee. It is understood that this convenience fee is not for the drawing and handling of your blood and that it is not “Covered Service” by your insurance company. Therefore, this fee is not reimbursable by your insurance company.

If you are in agreement with this policy and would like to have your labs drawn at our office, please indicate your acceptance of this policy by signing below.

I have read, understand and agree to the office policies stated above.

_____ _____

Patient Signature Date

Sylvia K. Velarde, M.D.
TopLine MD Alliance

PATIENT FINANCIAL RESPONSIBILITY FORM

Patient Name: _____ D.O.B_____

Thank you for choosing Dr. Sylvia Velarde M.D, LLC as your health provider. We are honored by your choice and are committed to providing you with the highest quality health care. We ask that you read and sign this from to acknowledge your understanding of our patient financial policies.

- The patient (or patient's guardian, if minor) is ultimately responsible for the payment for the treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedure or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, and most major credit cards at our office.
- Patients may incur, and are responsible for the payment of additional charges at the discretion of Dr. Sylvia Velarde M.D LLC. These charges may include (but are not limited to):
    - Any costs associated with turning unpaid accounts over to our collection agency

I have read the policy regarding my financial responsibility to the practice, for providing medical service to me or the above names patient. I certify that the information is to the best of my knowledge, true and accurate. I authorized my insurer to pay any benefits or if applicable any amount due alter payment has been made by my insurance carrier.

Signature of Patient or Guardian Date

Sylvia K. Velarde, M.D.

TopLine MD Alliance

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

I _____, understand that as part of my health care, this facility originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basic for planning my care and treatment,
- A mean of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A tool for routine healthcare operations such as assessing quality and reviewing the compresence of healthcare professionals.

I understand and have been provided with a Notice of information practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges.

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purpose,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that this facility is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, expect to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the code of Federal Regulations. I further understand that this facility reserves the right to change their notice and practice prior to implementation, in accordance with Section 164.520 of the code of federal regulations. Should this facility change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:_____
_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to other entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

☐ **I fully understand and accept** **or** ☐ **decline the terms of this consent.**

_____ _____

Patient's Signature Date

_____ _____

Witness Date