NEXT LEVEL
OBGYN

1951 SW 172nd Ave ▪ Suite 416 ▪ Miramar, FL 33029
Phone 954-332-9972 ▪ Fax 954-213-6969

PATIENT INFORMATION			
Patient Number	Gender:	Date of Birth:	
Last Name:		Age:	Marital Status:
First Name: Initial:			
Address:		Home Phone:	
City, State, Zip:		Work Phone:	
Email Address:		Cell Phone:	
Employer:			
RESPONSIBLE PARTY			
Last Name:		Gender:	
First Name:		Date of Birth:	
Address:		Home Phone:	
City, State, Zip:		Work Phone:	
Employer:		Patient Relationship to Guarantor:	
INSURANCE INFORMATION			
Primary Insurance:		Policy/Subscriber:	
Date of Birth:		Insured Policy ID:	
Plan Phone:		Group Number:	
Secondary Insurance:		Patient Relationship to Subscriber:	
Date of Birth:		Policy/Subscriber:	
Group Number:		Insured Policy ID:	
EMERGENCY CONTACT INFORMATION			
Emergency Contact:		Patient relationship to Emergency Contact:	
Contact Home Phone:		Contact Work Phone:	

Patient Name: **Date of Birth:**

What is your Pharmacy: **Pharmacy has not changed** **Patient's (or Guarantor's) Initials _____**	**New Pharmacy information** **Name: _____** **Phone: ( ) _____-_____** **Location: _____**

OFFICE AND FINANCIAL POLICY

Thank you for choosing Next Level OBGYN, LLC as your healthcare provider. We are committed to building a successful physician - patient relationship. The following is a statement of our Financial Policy. Our office will be happy to answer any questions or concerns you may have.

In accordance with Florida law, we hereby notify that we have elected not to carry medical malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgements up to the minimum amounts pursuant to Statute 458.320 (5) (g). Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is pursuant to Florida law.

BY SIGNING BELOW, YOU CONFIRM THAT YOU HAVE READ THIS POLICY AND AGREE TO THE TERMS OUTLINED.

INSURANCE AUTHORIZATION & RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize Next Level OBGYN, LLC to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. This release may be used to process my insurance claim, and I allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I hereby assign all medical and surgical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment directly to Next Level OBGYN, LLC for medical services rendered to myself and/or my dependents, regardless of my insurance benefits, if any. **I understand that not all my services are covered benefits and I am responsible for any amount not paid, regardless of insurance policy.**

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We are in network with most major insurance carriers. However, it is the patient's responsibility to verify that we are a participating provider of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

HMO/REFERRALS: It is the patient's responsibility to obtain a referral form from your primary care physician if your insurance carrier requires it for your visits. If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.

FINANCIAL POLICY: I have requested the medical services of Next Level OBGYN, LLC on behalf of myself and/or dependents, and I understand by making this request, I become fully responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered, and agree to pay all such charges, in full, immediately upon presentation of the appropriate statement. As part of the contract with your insurance company, all co-payments, co-insurances and deductibles must be paid at time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud

COLLECTION POLICY:

Should your account become past due, the patient/debtor assumes all costs of collection, including but not limited to, collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

MEDICAL RECORDS POLICY:

If you wish to release your records to yourself, another physician, or another third party, **you must sign a release of records.** We will process the request within ten (10) business days. Fees for medical records may apply.

ADMINISTRATIVE POLICIES: It is your responsibility to inform our office of any address or telephone number changes. Your account is to be kept current. **All self-pay or insurance co-payments, co-insurance and deductibles will be collected at the time of services. Payments to be made by cash, check, Visa, MasterCard, Discover, American Express, Apple Pay or Google Pay.**

- A returned check will result in a $25 service charge. All future payments will be required to be made in the form of **CASH** or **CREDIT CARD.**

MESSAGING SERVICES: By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events and to leave a detailed message on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

PROTECTED HEALTH INFORMATION

I acknowledge that the Notice of Privacy Practices is available. (If you would like a copy of the Privacy Practices, please request one at the front desk)

We cannot discuss your protected health information with anyone other than yourself, unless you authorize us to do so.

You ARE NOT required to list any names if you do not choose. By listing names, you authorize Next Level OBGYN, LLC to release or discuss information related to your health condition (including information related to your treatment plan, medication information, and/or billing information). Your protected health information will be disclosed to the individual(s) listed below until you notify us otherwise in writing. This authorization will remain in effect for one year.

1._____ Relationship _____

2. _____ Relationship _____

Please be advised that any person not referred to on this list will not be given any information related to your care, including billing information. You may change, restrict, or expand this list at any time.

Please provide your preferred contact number where you would like us to contact you for test results, appointment reminders, or changes to scheduled appointments. _____

May we send you a detailed text message? Yes _____ No _____

I have read and understand the above Office and Financial Policy and agree to meet all financial obligations.

Patient Signature: _____ **Date:** _____

Patient Full Name:_____

CONSENT, TO RELEASE PHOTOS GIVEN AS A GIFT
TO
Next Level OBGYN, LLC

I,_____, age (if minor _____) hereby give Next Level OBGYN, LLC permission to display photography and testimonial ***given as a gift of my newborn child*** **to** Next Level OBGYN, LLC on their social media sites, Facebook, YouTube, Twitter and clinic and clinic website.

I hereby release and discharge Next Level OBGYN, LLC from any and all claims arising out of use of the photos.

I also understand that this file may have been copied without permission, and I agree not to hold Next Level OBGYN, LLC responsible for instances of these violations.

Signature: _____ **Date:**_____

Patient Full Name: _____

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS

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 vaginal exam and a pelvic exam
  Patient's (or Guarantor's) Initials _____

- An Ultrasound Exam which may include a probe placed in the vagina.
  Patient's (or Guarantor's) Initials _____

- Examination of external genitalia
  Patient's (or Guarantor's) Initials _____

I further understand Next Level OBGYN, LLC will send your specimen to the laboratory. The laboratory will submit to your insurance a claim for all services. I will be responsible for all copayments, coinsurances, deductible and non-covered services indicated by my insurance plan.
Initials _____

This examination will be performed by any provider and ultrasound technician Next Level OBGYN, LLC.

_____
Patient or Guarantor Printed Name

_____
Patient or Guarantor Signature

_____
Date:

_____
Witness Signature

MISSED APPOINTMENT

If you are unable to keep your appointment, kindly notify us 24 hours in advance so that we may offer that time to another patient.

"No show" or late cancellations may result in an assessment of cancellation/no show fee of $50 for each incident.

We ask that you arrive on time to your appointment in order to reduce patient wait times. If you arrive 20 minutes or more past your scheduled appointment, the office reserves the right to reschedule your appointment.

Credit Holder Name: _____

Credit Card Type: _____

Credit Card #: _____

Exp #: _____ **CVV #:** _____ **Billing Zip Code:** _____

I further understand, by signing this form, I authorize Next Level OBGYN, LLC to charge my credit card for no show fee.
Patient's (or Guarantor's) Initials _____

_____
Patient or Guarantor Printed Name

_____
Patient or Guarantor Signature

_____
Date:

_____
Witness Signature