DAVID LUBETKIN, M.D., F.A.C.O.G
COURTNEY MCMILLIAN, CNM,MSN,ARNP
POLINA GOLDENBEG, CNM,MSN,ARNP

PATIENT INFORMATION SHEET

First, Middle, and Last Name
_____

Address _____
City _____

State _____ Zip Code _____

Home Phone ( ) _____
Cell Phone ( ) _____
Work Phone ( ) _____

Social Security # _____
DOB _____

Preferred # Circle one: Home Cell Work

Primary Language Spoken _____ Race _____
Ethnicity _____

Pharmacy Name_____
Location_____

Pharmacy Phone
#_____

Referred
By_____

Email
Address_____
Do you give permission to discuss your results via email? Circle One: YES or NO
Leave a message on your voicemail? Circle One: YES or NO
Leave a message at your place of employment to return our call? Circle One: YES or NO

Discuss your medical condition? Circle One: YES or NO

If yes, whom?
Name:_____
Relationship: _____

Name: _____
Relationship:_____

I certify that the above information is correct and further authorize any holder of medical information to be released to any insurance carrier for any claim. I request payment of authorized benefits for physician services to the physician furnishing the service or authorize such a physician to submit a claim for me. I also agree that should this account be referred to any agency or attorney for collection that I will be responsible for all collection fees, attorney fees and court costs. I am also aware that payment is expected when services are rendered unless other arrangements have been made in advance.

Signature_____
Date_____

David I. Lubetkin, MD LLC
Annual Examination Questionnaire

Kindly fill out the enclosed personal medical history. The responses to the questions that follow will become part of your permanent office record and will remain strictly confidential. The purpose of gathering this information is to maximize the efficiency of your visit today.

Name:_____Age:_____D.O.B._____

Social Security Number:_____ Marital Status:_____

What is the purpose of today's visit?

_____

_____

_____

_____

General Medical Information

Do you currently have or have had any of the following medical problems (check all that apply):

_____Asthma
_____Diabetes
_____Thyroid Condition
_____Sinusitis
_____Hay Fever/Allergies
_____Migraines
_____Seizures/Epilepsy
_____High Blood Pressure
_____Stroke
____Mitral Valve Prolapse
____Cardiac Arrhythmias
____Heart Attack
____Pneumonia
____Crohn's Disease
____Ulcerative Colitis
____Kidney Stones
____Hysterectomy
____Fibroid Uterus
_____Ovarian Cysts
_____Arthritis
_____Cancer
_____Hepatitis
_____Breast Masses
_____Fibrocystic Breast Conditions
_____Liver Disease
_____History of Blood Clots

Please List Any Medical Problem Not Listed Above :

_____

_____

Have You Smoked in the Past NO YES If yes, number of packs per day_____ for how many years? _____

Do you Smoke Now? NO YES If yes, number of packs per day_____ for how many years? _____

Do you Drink Alcohol? NO YES If yes, How many drinks per day?_____

Review of Systems

Please Circle any of the following that pertain to you:

General:	Weight Loss	Weight Gain	fever	Fatigue
Ear Nose Throat	Sinusitis	ringing in ears	headaches	
Cardiovascular	chest pain	swelling	palpitations	Shortness of breath with exercise
Respiratory:	Coughing	Wheezing	Coughing up Blood	Shortness of breath
Gastrointestinal:	Diarrhea	Constipation	Bloody stools	abdominal pain
Genitourinary:	Blood in urine	Pain with urination	urgency	loss of urine
	Frequency of urination	Incontinence	Pain with intercourse	Change in Menstrual period
Breast:	Breast pain	Nipple discharge	Breast lump	
Neurological:	fainting	seizures	numbness	trouble walking
Psychological:	depression	anxiety		
Endocrinology:	Diabetes	Fatigue	Thyroid problems	
Hematology:	Easy Bruising	Unexpected bleeding	Swollen lymph nodes	
Menopausal symptoms:	hot flashes	Night sweats	Insomnia	

Please list all medications, prescriptions, and over the counter medications you currently take

_____

_____

_____

Allergies to Medications: _____

SURGICAL HISTORY - Please list **ANY** surgeries you have had and dates of surgery

_____

_____

_____

_____

GYNECOLOGIC/MENSTRUAL HISTORY

Last menstrual Period_____

At what age did you first begin to menstruate?_____

How long does your period last?_____

How many days between menstrual cycles? _____

Are your Periods: REGULAR or IRREGULAR Amount: LIGHT MODERATE HEAVY Pain: YES NO

Date of Last GYN exam _____

Date of Last Pap Smear _____

Have you ever had an abnormal pap smear? _____ If yes, please give details _____

_____

Have you ever had a bone density exam? _____ If yes, when and what were the results_____

Are you sexually active?_____ What is your current form of birth control? _____

Have you ever been exposed to Gonorrhea, Chlamydia, Syphillis, Herpes or Genital warts (HPV)? _____

Last mammogram? _____ Results? _____

If menopausal, are you on hormone replacement therapy? _____ If Yes, what type? _____

If no, were you ever on hormone replacement therapy? _____

Do you have any Gynecologic Problems that the doctor needs to know about? _____

_____

OBSTETRICAL HISTORY

Have You Ever Been Pregnant? _____

If yes, how many: Full Term Births_____ Miscarriages?_____ Terminations?_____ Ectopics?_____

Month	Year	Full Term?	Type of Delivery	Sex	Weight	Complications?

FAMILY HISTORY

Mother: Alive or Deceased Any significant Medical Problems? _____

Father: Alive or Deceased Any significant Medical Problems?_____

Siblings: Alive or Deceased Any significant Medical Problems? _____

Any other significant family medical problems? _____

PRINT NAME_____ **SIGNATURE** _____ **DATE** _____

David I. Lubetkin, MD FACOG

Courtney McMillian, CNM, ARNP

Polina Goldenberg,CNM, ARNP

Bladder Health Questionnaire

Name _____

1. Over the past month, have you **leaked** urine (even a few drops) or wet yourself when you: Cough, Sneeze, Laugh, Walk quickly, or change position?

Not at All	1-2 Times per month	1 time a week	3-4 times a week	5-6 days a week	Every day	Your score
0	1	2	3	4	5	

2. Over the past month, have you experienced a sudden strong **urge** to urinate causing you to rush to the bathroom?

Not at All	1-2 Times per month	1 time a week	3-4 times a week	5-6 days a week	Every day	Your score
0	1	2	3	4	5	

3. How many times do you wake at night to urinate? _____

4. Would you be interested in learning more about a treatment for leaking **WITHOUT** medicine or surgery? _____ YES _____ NO

Notice of Privacy Practices

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. To file a complaint with our office. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying "Acknowledgement" form.

David Lubetkin, MD, FACOG

Courtney McMillian, CNM, MSN, ARNP

Polina Goldenberg, CNM, MSN, ARNP

Notice of Privacy Acknowledgement

I understand that under Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. 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 this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Private Practices.

_____ _____

Patient Name or Legal Guardian (Print) Date

_____

Signature

David Lubetkin M.D.
Courtney McMillian, CNM
Polina Goldenberg, CNM

Diplomats, American Board of Obstetrics and Gynecology

Important Notice

January 1, 2003

Dear Patient

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

DR. LUBETKIN MEETS THESE REQUIREMENTS AND HAS DECIDED TO BECOME SELF-INSURED AND NOT CARRY COMMERCIAL MEDICAL MALPRACTICE INSURANCE.

This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law Title XXXII Chapter 458.320."

The undersigned patient., spouse and/or legal guardian or parents acknowledges that she or he has received a copy, read and understands this Medical Malpractice Insurance notice. Furthermore, the undersigned acknowledges this notice was not signed under duress and that all of the patient's questions relating heretofore have been answered to the patient's satisfaction.

___/____/____ _____ _____

Date | Patient's signature | Patient's spouse, legal guardian or Parent

David I. Lubetkin M.D., F.A.C.O.G.
Courtney McMillian, CNM, MSN, ARNP
Polina Goldenberg, CNM, MSN, ARNP
Obstetrics. Gynecology. Infertility

OFFICE FINANCIAL POLICY

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

1. We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be responsible for payments of:
a. The annual deductibles
b. Copayments
c. Charges for noncovered services

If you have Medicare as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.

2. If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill your primary and secondary insurance plan for contracted plans. You will be responsible for payment of:

a. The annual deductibles
b. Copayments
c. Charges for noncovered services

In the event that you, as the patient, or we, as the physicians, are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

3. For non-Medicare patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following:

a. We will file both your primary and secondary insurance. If we do not receive payment from your primary carrier within 60 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.

b. If we receive payment from the primary, we will file a claim with your secondary. If we do not receive payment from your secondary carrier within 60 days of filing, you will be billed for the remaining amount. Payment is due 10 days after receipt of the statement.

c. If you only have primary insurance (e.g., no secondary/supplemental coverage), any coinsurance or deductible amounts not paid by your insurance company will be billed to you. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. The entire balance remaining after your primary carrier has paid will be billed to you and is due and payable 10 days after receipt of the statement.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_____

Patient Signature & Date