Date _____
Fecha

Patient Registration
Registración del Paciente

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

Patient Information - *Información del Paciente*

Social Security # _____
Numero de Seguro Social

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*

Last Name _____
Apellido

Sex _____ Date of Birth ____/____/____
Sexo *Fecha de Nacimiento*

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Estado Civil *Casada* *Soltera* *Divorciada* *Viuda*

(Check One) ☐ Employed ☐ Retired ☐ Full-Time Student
Marque Uno *Empleada* *Retirada* *Estudiante Tiempo Completo*

☐ Other _____
Otro

Employer _____
Empleador

Home Address _____
Direccion del Hogar

_____

City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*

Email Address _____

Home Phone (_____) _____
Telefono del Hogar

Work Phone (_____) _____
Telefono del Trabajo

Cell Phone (_____) _____
Telefono Cellular

Referring Physician _____
Referida Por el Dr:

How did you hear of us? _____
Como usted supo de nosotros?

Insurance Information - *Información del Seguro*

Please provide your insurance card to the receptionist - *Por favor entregue su tarjeta de seguro a la recepcionista*

Pharmacy Number or Location:

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

Farmacia Telefono o Direccion:

Insurance company _____
Compañia de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado *Relación*

Policy # _____ Group # _____ Phone (_____) _____
Numero de Poliza *Numero de Grupo* *Telefono*

Secondary Insurance Information - *Información del Seguro Secundario*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

Insurance company _____
Compañia de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado *Relación*

Policy # _____ Group # _____ Phone (_____) _____
Numero de Poliza *Numero de Grupo* *Telefono*

Emergency Contact - *En Emergencias, contactar a:*

Social Security # _____
Numero de Seguro Social

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*

Last Name _____
Apellido

Sex _____
Sexo

Home Phone (_____) _____
Telefono del Hogar

Work Phone (_____) _____
Telefono del Trabajo

Spouse / Guarantor / Responsible Party - *Esposo / Persona Responsable*

Social Security # _____
Numero de Seguro Social

Relationship _____
Relación

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*

Last Name _____
Apellido

Address _____
Direccion

City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*

Sex _____ Date of Birth ____/____/____
Sex *Fecha de Nacimiento*

DAYTIME PHONE (_____) _____
Teléfono durante el dia

EMPLOYER _____
Empleo

ADDRESS _____
Direccion

CITY _____ STATE _____ ZIP _____
Ciudad *Estado* *Codigo Postal*

Signature Required Please See Reverse Side
Firma Requerida Por Favor mire al Dorso

Beatrice Hecker MD LLC

8955 SW 87th CT Suite 115
Miami, Florida 33176

Financial Responsibility Agreement

The undersigned agrees whether he/she signs as parent, spouse, guarantor, guardian, or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, I authorize attorney to obtain my credit report; and the undersigned shall pay reasonable attorney's fees and collection expenses.

Print Patient's Name

Date: _____ _____

Date: _____ **Patient's Signature**

_____

Convenio De Responsibilidad Financial

El suscrito/ a conviene que al firmar como padre, esposo/a, fiador, guardian o paciente, assume la responsibilidad y obligacion por cualquier balance pendiente que derive a causa de tratamiento medico a dicho paciente. En caso de que la cuenta fuse referida a un abogado, yo autorizo al abogado que obtenga mi reporte de credito; y el suscrito/a pagara dichas cuentas legales y asumira costos de coleccion.

Print Patient's Name

Date: _____ ✘ _____

Date: _____ **Patient's Signature**

✘ _____

Beatrice Hecker MD LLC

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Miami, Florida 33176

Patient Attestation Request

Message to all patients:

Due to the ongoing global threat and imminent risks of the coronavirus, we have to take specific measures and follow health friendly recommendations.

We ask that you read below, initial and sign in agreement, to ensure that ou may be seen on this day. Thank You.

- ✘ _____ I have not traveled outside of the country or to any CORONAVIRUS contaminated location in the past 20 days.
- ✘ _____ I have not experienced any flu-like symptoms, cough, sore throat, fever, in the past 20 days.

✘ _____
Patient Name

✘ _____
Patient Signature

_____
Date

Beatrice Hecker MD LLC

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Miami, Florida 33176

Pelvic Examination Consent Form

A pelvic examination has been ordered by your physician. There are many reasons why this examination has been ordered. A pelvic examination is the physical examination of the external and internal female pelvic organs. It is frequently used in gynecology for the evaluation of symptoms affecting the female reproductive and urinary tract, such as pain, bleeding, discharge, urinary incontinence, or trauma (e.g sexual assault.) It can also be used to assess a woman's anatomy in preparation for a procedure. The exam can be done awake in the clinic.

I understand that this examination is performed by observing, palpitating, or inserting a gloved finger into the perineal region including the vagina and/or rectum. And the full pelvic exam consists of the following three elements:

1) External exam to evaluate the external genitalia, pubic, perineal, and peri-anal areas.
2) Speculum exam, introduction of a speculum into the vaginal canal, to view the vaginal walls and cervix, as well as to complete screening procedures for sexually transmitted infections or cancer.
3) Bimanual exam, the placing of one or two fingers inside the vagina to assess for uterine mobility and tissue tenderness.

I understand that if I consent to the pelvic exam, I will have the opportunity to revoke my consent at any time during the examination.
I understand that my physician will have a female assistant present during the examination to accompany me, and that the exam will have a female assistant accompany me, and that the exam will occur in clean, private, and secure area.

I understand that I will be required to disrobe for the exam and that appropriate draping and coverings will be provided.

I will communicate relevant medical history information to the physician including but not limited to, medication use, IUDs (or other implants), pre-existing urogenital infection or known sexually communicable diseases. Potential risks/benefits : I may experience discomfort during the examination and/ or minor bleeding afterwards. These effects are usually temporary; if they do not subside in 1-3 days, I agree to contact my physician. Benefits include identifying possible signs if ovarian cyst, sexually transmitted infections, uterine fibroids of early stage cancer or improvement in my symptoms.

By signing below I acknowledge that I have read and understood the above information.

✘ _____ ✘ _____ ✘ _____
Patient Name Signature Date

By signing this consent form, I am authorizing and giving my full permission to a "A MEDICALLY INDICATED EXAMINATION INCLUDING BUT NOT LIMITED TO A PELVIC EXAM"

✘ _____ ✘ _____ ✘ _____
Patient Name Signature Date

Beatrice Hecker MD LLC

8955 SW 87th CT Suite 115
Miami, Florida 33176

Financial Agreement for Deductibles and Coinsurance

I, ✘_____ agree to have a pelvic ultrasound and/or procedure at Dr. Beatrice Hecker's office, as per the doctors recommendations. Dr Hecker's office has verified my eligibility and has deemed that my financial responsibility for such should be solely a copay of $____. However, I understand that if my insurance fails to pay for any reason, I will then be responsible for such payment. My signature below automatically enters myself into a payment plan agreement.

If total charges are under $250: Monthly payments of $50 must be received and initial payment is due within 30 days from the date of service.

If total charges exceed $250: Monthly payments of $75 must be received and initial payment is due within 30 days from the date of service.

The undersigned also agrees that she hereby obligates herself to pay the account in full. Should the account be referred over to an attorney for collection, I authorize attorney to obtain my credit report; and the undersigned shall pay reasonable attorney's fees and collection expenses. Failure to comply with this financial agreement in its entirety will result in automatic turnover the Law Office of NEWMAN MARQUEZ P.A. for formal collections.

Patient Name: ✘_____

Patient Signature: ✘_____

Date: ✘_____

Beatrice Hecker MD LLC

8955 SW 87th CT Suite 115
Miami, Florida 33176

Missed Appointment Policy

We're glad you have chosen us to provide your medical care, but if you miss your appointments, you compromise that care. It is very important that you understand our office policies with respect to missed appointments.

A missed appointment is when you fail to show up for an appointment without a phone call cancellation with a 24 hour prior notice.

Our missed appointment policies are outline below

Failure to show up to your scheduled appointment
Or
Failure to call to cancel said appointment with 24 hour notice
Doing either will result in a $25 fee added to your account.

I have read, understand, and accept all of the above mentioned policy explanations with regards to missed appointments and their fees, if applicable.

✘ _____
Patient Name

✘ _____
Signature

✘ _____
Date

Beatrice Hecker MD LLC
8955 SW 87th CT Suite 115
Miami, Florida 33176

Notice Regarding Malpractice

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 physician has decided not to carry medical malpractice insurance. This is permitted under Florida Law subject to certai conditions. Florida law imposes strict penalties against non-insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

I acknowledge that I have been duly informed of the above

✘_____ ✘_____ ✘_____

Patient Name Signature Date

Beatrice Hecker MD LLC

8955 SW 87th CT Suite 115
Miami, Florida 33176

Notice of Privacy Practice Acknowledgement

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 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 Privacy Practices.

✘ _____ ✘ _____ ✘ _____

Patient Name Signature Date

*** Office Use Only ***

We have made the following attempt to obtain the patients signature acknowledging receipt of Notice of Privacy Practices

Date: _____ Staff Name: _____

Attempt: _____

Beatrice Hecker MD LLC
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Review of Systems

General

Have you had fever, chills, or sweats?	Y	N
Have you gained/lost weight recently?	Y	N
How many pounds?		

Eyes

Blurred Vision	Y	N
Double vision	Y	N
Have you ever lost vision?	Y	N

Allergic/ Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Infections	Y	N

Neurological

Seizures	Y	N
Trouble Sleeping	Y	N
Headaches	Y	N

Endocrine

Excessive Thirst	Y	N
Too hot/ too cold	Y	N
Tired/ Sluggish	Y	N

Gastrointestinal

Abdominal pain	Y	N
Nausea/ vomiting	Y	N
Diarrhea	Y	N

Cardiovascular

Chest Pain	Y	N
Palpitations	Y	N
High Blood Pressure	Y	N

Ear/ Nose/ Mouth

Ear Pain	Y	N
Sore Throat/ Hoarse	Y	N
Sinus Problem	Y	N

Genitourinary

Blood in the urine	Y	N
Painful/ Frequent Urination	Y	N
Irregular Menstruatuion	Y	N
Vagina Discharge/ Itching	Y	N
Pain during/ after sex	Y	N

Respiratory

Asthma	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N

Hematologic/ Lymphatic

Anemia	Y	N
Swollen Glands	Y	N
Blood Clotting Problem	Y	N

Psychiatric

Are you unhappy with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Musculoskeletal

Joint Pain	Y	N
Swelling in your joints	Y	N
Arthritis	Y	N

Integumentary

Skin Rash	Y	N
Nipple Discharge	Y	N
Persistent Itch	Y	N

Name: _____

Pelvic Health Survey

Today's Date: _____

Patient's Name: _____ 1. Age: ____ 2. Sex: □Female □Male

Bladder (check one):

3. How often do you leak urine (check one box)?
   - 0 □ Never
   - 1 □ About once a week or less often
   - 2 □ Two or three times a week
   - 3 □ About once a day
   - 4 □ Several times a day
   - 5 □ All the time

4. We would like to know how much urine you think leaks. How much urine do you usually leak (whether you wear protection or not)? Check one box.
   - 0 □ None
   - 2 □ A small amount
   - 4 □ A moderate amount
   - 6 □ A large amount

5. Overall, how much does leaking urine interfere with your everyday life? Please circle a number between 0 (not at all) and 10 (a great deal).

0	1	2	3	4	5	6	7	8	9	10
Not at all										A great deal

ICIQ score: sum 3+4+5= _____

6. When does urine leak? (Please check all that apply to you.)
   - □ Never—urine does not leak
   - □ Leaks before you can get to the toilet
   - □ Leaks when you cough or sneeze
   - □ Leaks when you are asleep
   - □ Leaks when you are physically active/exercising
   - □ Leaks when you have finished urinating and are dressed
   - □ Leaks for no obvious reason
   - □ Leaks all the time

Do you wear diapers, pads, or panty liners because of leaking? □Yes □No

Are you bothered by the number of times per day you have to empty your bladder? □Yes □No

Do you wake up at night to empty your bladder? □Yes □No

If Yes, How many times? _____

Do you feel you have to rush to the toilet to avoid an accidental leak? □Yes □No

Bowel:

1) Do you accidentally leak stool? □Yes □No
2) Do you have to strain to have bowel movements? □Yes □No
3) Do you pass gas when you do not want to? □Yes □No

Gynecological:

1) Do you experience pelvic pain? □Yes □No
2) Do/did you experience pain with intercourse? □Yes □No
3) Do you have a feeling of a "ball" in your vagina? □Yes □No
4) Hysterectomy? □Yes □No
5) Vaginal Dryness? □Yes □No
6) # of Vaginal Deliveries _____
7) # of Cesarean Sections _____