OBGYN By the Sea

The doctors would like you to know a couple things:

- We ***will*** be notifying you with all results whether they are good or bad.
- We post all ***normal results*** to our ***patient portal***. You ***will not*** receive a call with normal results.
- You will receive a phone call with any abnormal results. Please make sure your ***voicemail is set up and not full***, that way we can leave you a message to call us back or a detailed message with results.
- If you prefer that we do not leave your results on your voicemail, we will call the number below and leave a message for you to call the office back.

Please provide the best number to contact you

Name: ______________________________ Date: ________________

Number: ______________________________

☐ Leave detailed message on voicemail if applicable

☐ Do not leave detailed message

If you have not heard anything from the office within two weeks (via phone or patient portal) regarding your results please contact the office via patient portal.

If you need non urgent assistance please use the portal. We check the portal once a day Monday- Friday. We get back to you within 36 hours (unless it's over the weekend then we will get back you on the next business day)

Reasons for portal use:

- Access results
- Request refills
- Medical questions
- Request someone to call you back to schedule an appt

The portal ***should not*** be used for any medical emergencies.

If you have an ***Urgent matter*** or need to schedule an appt, please call the office.

OBGYN By the Sea, LLC

Patient Registration form

Patient information

First Name______________________ Last Name________________________ MI___

Maiden Name__________________ Marital status________ Social Security #_________

Date of Birth________ Age_____

Address____

City____________________________ State______ Zip Code__________________

E-Mail Address ____

Home Phone_______________ Cell phone______________ work phone____________

Occupation______________________ Language spoken_______________________

REFERRING PROVIDER: ____

REFERRAL SOURCE: ____

Emergency Contacts : we may contact in case of an emergency or if we cannot reach you

Full Name________________________ Relationship___________ Telephone________

Full Name________________________ Relationship___________ Telephone________

Pharmacy information

Name and Address____

Phone number_____________________ Fax Number___________________________

Name and Address____

Phone number_____________________ Fax Number___________________________

OBGYN By the Sea, LLC

Thank you for choosing OBGYN By the Sea, LLC as your health care provider. We are committed to your treatment being successful. Please understand that your payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require for you to read and sign prior to any treatment.

ALL COPAYMENTS AND/OR DEDUCTIBLES ARE DUE PRIOR TO YOU VISIT

We accept: cash, check, major credit cards: Visa, MasterCard, and Discover Card

INSURANCE: *we will bill your insurance company for your visit AS COURTESTY TO YOU. Due to the difficulty obtaining payment from your insurance plans, we may ask for your assistance in getting your claim paid. Please be advised that it is the patient's responsibility to verify that we are a participating provider with your insurance plan.*

HMO/ REFERRALS: *it is your responsibility to obtain a referral from your primary care physician if you insurance carrier requires it for your visits. It is the patient's responsibility to know and understand the requirements of their insurance plan. Our office is not responsible to obtain referrals for patients on HMO plans.* ***If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.***

MINOR PATIENTS: *the parent or guardian accompanying the minor is responsible for payment of the bill.*

RETURNED CHECKS: *checks returned for any reason will be subject to all bank fees charged to us along with 5% of the face value of the check or $25.00 administrative fee (Whichever greater).*

COLLECTIONS: *should your account become a collection problem, the patient/ debtor assumes all costs of the 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.*

NON-COVERED SERVICES: *You will be responsible for your payment of services "NOT COVERED" by your insurance plan. It is your responsibility to understand your insurance plan's benefits and/or limitations.*

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY. I herby agree to render payment in the accordance with the terms and conditions set forth.

Patient/Responsible party signature ______________________________ ***Date:*** ____________

Print Patient Name: ____

OBGYN By The SEA, LLC

Insurance company information

Primary Insurance Company____

Name of Insured Party_________________________ Relationship__________________

Payment of Benefits

I understand the doctor does not carry malpractice insurance as stated in the sign posted in the reception area. I authorize payment of benefits, as determined by the company, directly to the physician. I understand that I may still be responsible for any amount not paid by my insurance company.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the release of any medical information necessary to process my health insurance claim form.

Patient or authorized (print):

____

Patient or authorized signature:

____

OBGYN By The Sea, LLC

Notice of privacy acknowledgement

I understand that under the 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 Privacy Practices.

____ __________________

Patient Name or Legal Guardian (print) *Date*

____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

*Date*______________ *Attempt:*____

*Staff Name*____

NO-SHOW Policy

- In order to be respectful of the medical needs of our patients, please notify us if you are unable to attend your appointment.
- This opens up availability to those who need to be seen and helps us decrease your waiting times for scheduled appointments.
- Please give us at least 24 hours advanced notice. ______ **Initial**

How to cancel/reschedule your appointment

To cancel/reschedule your appointment please call the office and leave a detailed message

- *954-772-3960*
- *954-467-2013*

If you do not give **24-Hour** notice to cancel or reschedule your appointment, this is considered a **NO-SHOW** and you **will be billed**.

- 50.00 dollars for a visit
- 75.00 dollars for a procedure

______ **Initial**

You will not be allowed to make another appointment until the no-show fee is paid in full. _____ Initial

Name: ______________________________ **Date:** ____________

Signature: ____________________________

We are excited about our New Patient Portal.

Here is why..

1. It is quick and easy
2. You can see your **normal Lab results**
3. You can request **prescription refills**
4. You can ask the staff a **question**

Here are some things you should know

1. This does not replace your office visits or consultations with your Doctor, but it improves communication with the office and thus your overall experience.

2. We do not post all results to the portal. It is up to the Doctor what is posted

3. If there is any abnormality you will receive a phone call.

And most importantly

4. This should **not** be used for any **medical emergency or urgency** as these questions will be answered within **48 hours.**

We hope you are as excited as we are!
Please make sure your **email address** is correct and look out for a welcome email to get started!

If you prefer not to use this portal please let the front desk know.

Patient name: ______________________ Date: ____________
Patient Signature: ______________________________________

OBGYN By the Sea

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS.

I understand that I am consenting that OBGYN By the SEA LLC, it's Physicians, Nurse Practitioners, Medical Assistants, Ultrasound Technicians, or Medical Students (when applicable) can provide and perform medical care, tests, blood draws, procedures, breast examinations, or any medically indicated physical examination which may include, but may not be limited to the following:

- A female Gynecological Exam, which may include a Pelvic Exam and a Rectal Exam.
- A Pelvic/ Transvaginal Ultrasound Examination which will include a probe placed into the vagina.
- A rectal exam
- Examination of external genitalia

These examinations are agreed upon and in the best interest of my health.

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

Name: ______________________________ Date: ______________

Signature of Patient or Patient's Representative if under 18:

____

CANCER FAMILY HISTORY QUESTIONNAIRE

Patient Name: ______________________________ Date of Birth: ____________________

Physician seeing: ______________________________ Today's Date: ____________________

This is a screening tool for cancers that run in families. Please INCLUDE these family members:
Mother/Father/Sister/Brother/Children
Aunt/Uncle/Grandparent/Niece/Nephew/ 1st Cousin

Please only circle YES if your history exactly matches the questions on this form

		Cancer Family History	SELF	Please list your FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Breast cancer diagnosed at age 49 or less				
Y	N	TWO relatives on the same side of the family with breast cancer, one diagnosed at age 50 or younger				
Y	N	Ovarian cancer at any age				
Y	N	THREE relatives on the same side of the family diagnosed with breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with a breast, ovarian, prostate or pancreatic cancer in the family				
Y	N	Male breast or metastatic prostate cancer at any age				
Y	N	Pancreatic cancer at any age				
Y	N	Endometrial/ uterine or colon cancer diagnosed before age 50				
Y	N	THREE or more of the following cancers on the same side the family at any age: colon, endometrial, ovarian, gastric/stomach, pancreatic, brain, small bowel, renal/pelvic				
Have you ever been tested for BRCA or Lynch Syndrome before?						

Patient is appropriate for testing: Y / N

Patient accepted genetic testing: Y / N

Patient Signature: ____________________

Provider Signature: ____________________