Patient Registration
Registracion del Paciente

Date: ________

Patient Information/*Informacion del Paciente***:**

Social Security#: ___________________________
Numero de Seguro Social

First Name: _______________________________
Primer Nombre

Last Name: _______________________________
Apellido

Date of Birth: _____/_____/________
Fecha de nacimiento

Race/Ethnicity: ____________________________
Nacionalidad

Marital Status: ____________________________
Estado Civil

Employer: _______________________________
Empleador

Email Address/***Direccion Electronica***
____

Home Address/ *Direccion De Hogar*:
____

City: __________ State: ________ Zip: ______
Cuidad ***Estado*** ***Codigo Postal***

Home Phone: (_____) ______________________
Telefono del Hogar

Cellular Phone: (______) __________________
Telefono de Celular

Work Phone: (_______) ___________________
Telefono del Trabajo

Allergies to Meds/ *Allergias a Medicinas*:
____

Pharmacy Name & Phone / *Farmacia*:
____

Referred By/ *Referido Por:*
____

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST- POR FAVOR ENTREGUE SU TARJETA DE SEGURO A LA RECEPCIONISTA.

Insurance Information / Informacion de Seguro:
____ Commercial ____ Medicare ____ Other ____

Insurance Company: ______________________
Compania de Seguro

Insured/Card Holder's Name:______________________
Nombre del Asegurado

Relationship: ____________________________
Relacion

Policy#: ____________________________________
Numero de Poliza

Insurance Phone #: (____) ________________

Group#: ____________________________________

Primary Insurance Holder / *Primario de Seguro:*

Social Security#: __________________________
Numero de Seguro Social

Date of Birth: _____/_____/______
Fecha de Nacimiento

Relationship: _____________________________
Relacion

Daytime Phone: (______) ____________________
Telefono durante el dia

First Name: ______________________________
Primer Nombre

Employer: _________________________________
Empleo

Last Name: ______________________________
Apellido

Address: ___________________________________
Direccion
City: __________State: _______Zip:__________

Emergency Contact / *Contact de Emergencias,*

First Name: ______________________________
Primer Nombre

Home Phone: (_____) ______________________
Telefono del Hogar

Last Name: ______________________________
Apellido

Work Phone: (_____) ______________________
Telefono del Trabajo

Relationship to patient: ____________________
Relacion al paciente

Cellular Phone: (_____)____________________
Telefono de celular

7300 S.W. 62nd Place, 3rd Floor
South Miami, Florida 33143
Tel: (305) 665-1133
Fax: (305) 666-0258
www.southmiamiobgyn.com

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept Visa, Master Card and American Express. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos Visa, Master card and American Express. Su seguro medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su reponsabilidad. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsable de los gastos legales.

We have elected no to carry Medical Malpractice insurance or otherwise demostrate financial responsibility. However, we agree to satisfy any adverse judgements up to the minimum amounts pursuant to S.458.320(5)(g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida Law.

Hemos elegido para no llevar seguro de negligencia medica o para no demostrar de otra manera resposabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (laley 5) (gla ley de la Florida impone penas contra los medicos no-asegurados que no pueden satisfacer los juicios adversos que se presentan por demanda de negligencia medica. Este aviso esta conforme a la ley de la Florida.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carier, HMO or other third party, payor, for services rendered by the physician. I understand that I am financially responsible to the physician for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a el medico todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo tranferir documentos relacionados a mi tratamiento medico a mi compañia de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico

________________________________ ________________

PATIENT'S / GUARANTOR'S SIGNATURE DATE

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FOR YOUR INFORMATION

There are times when our physicians will recommend laboratory tests or diagnostic ultrasound for management of your care. Some insurance companies may consider the test to be "screening" and not fit within their reimbursement guidelines and will not pay. Therefore, please be aware that should your insurance company deny the claim, you will be responsible for payment to the laboratory and/or office.

____ Yes, I understand I may be financially responsible.

EXCLUDED TESTS MAY INCLUDE GC & CHLAMYDIA SCREENING

Name: ______________________________ Date: ______________________

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Dear Patient:

Physicians have always protected the confidentiality of health information and have refused to reveal such information. Today, state and federal laws are also attempting to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. This "privacy rule"protects health information that is maintained by physicians, hospitals and other health care providers and plans.

The new regulation, effective April 14, 2003, protects virtually all patients, regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to a hospital, fill a prescription or send a claim to a health plan, those professionals will need to consider the privacy rule. All health information, including paper records, oral communication and electronic formats (such as E-mail and electronic claim filing) are protected by the privacy rule.

The *Notice of Privacy Practices,* which is available in our waiting room, contains information about how your confidential health information is protected by this office and describes how you can exercise your rights with regard to your health information. The privacy rule provides you certain rights, such as the right to have access to your medical records; however, because there are exceptions to these rights, they are not absolute. We encourage you to read the *Notice of Privacy Practices* as your signed consent is required.

Please let us know if you have any questions about the *Notice of Privacy Practices.* To contact our Privacy Officer, Call (305) 665-1133.

PRIVACY ACKNOWLEDGMENT

_____ I have read and understand the *Notice of Privacy Practices.*

______________	______________	______________
Date	Printed Name	Signature

Patient Financial Agreement

PLEASE READ THOROUGHLY AND SIGN BELOW

Upon receiving services from South Miami OB/GYN Associates, you agree:

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our billing department. We are dedicated to providing the best possible care and service to you. We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract.
- We will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable length of time (within 90 days), you may be responsible.
- All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**
- Upon check-out, we will collect your deductible, co-pay, and payment for any uncovered services as well as the patient's portion as determined by insurance. We accept cash, check, and credit card of Master Card, Visa, Discover, American Express, and Care Credit.
- If your account is more than 90 days past due, you will receive a letter stating that you have 14 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, it may be sent to a collection agency. If an account is sent to collections, it is the policy of this office to refrain from providing further medical care until the balance is paid in full.

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines.

X ____ Date____________________

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY

X ____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY