Date _____ E-mail: _____
Direccion Electronica

Home _____ Work#:_____Cell#: _____
Telefono del Hogar *Telefono del Trabajo* *Telefono Celular*

First Name:_____ Middle Initial: _____ Last Name: _____
Primer Nombre *Segundo Nombre* *Apellido*

Home Address: _____
Direccion del Hogar

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

Social Security #: _____Date of Birth**:** _____Marital Status: _____
Numero de Seguro Social *Fecha de Nacimiento* *Estado Civil*

Employer_____**Occupation**_____
Empleador *Ocupacion*

Primary Language_____**Race:**_____**Referred by**_____
Idioma Primario *Referido por*

PHARMACY NAME:_____/PHONE #_____

Spouse/Guarantor/Responsible Party/Emergency Contact
(Esposo (a)/Persona Responsable)

Name_____ Relationship_____ Date of Birth_____
Nombre *Relacion al paciente* *Fecha de Nacimiento*

Social Security#_____ E-mail_____
Numero de Seguro Social *Direccion Electronica*

Home #_____ Work #_____Cell #_____
Telefono del Hogar *Telefono del Trabajo* *Telefono Celular*

Employer_____ Occupation_____
Empleador *Ocupacion*

Insurance Information: Please provide your insurance card and photo I.D. to the receptionist

All fees are payable at the time services are rendered. We accept Visa and Master Card.
Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos Visa y Master Card

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 the attorney to obtain my credit report; and the undersigned shall pay reasonable attorney's fees and collection expenses.

PHYSICIAN'S RELEASE AND ASSIGMENT

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or the other third party payer, 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.

Malpractice Statement

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments 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.

Notice of Privacy Practices

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) 665-9644.

Consent for Treatment

Effective July 1, 2020 Per Florida Senate Bill 698 we are now required to obtain your consent for pelvic examinations.

I hereby consent to the provision of care, diagnosis and/or treatment and/or a medically indicated examination including but not limited to a pelvic and digital rectal exam by the physicians and nurse practitioners of South Miami Women's Health

ACKNOWLEDGMENT

I have read and understand the financial responsibility agreement
I have read and understand the Physician's release and assignment
I have read and understand the Malpractice Statement
I have read and understand the Notice of Privacy Practices
I have read and understand the Consent for Treatment
I hereby acknowledge that such consents will remain in effect until I cancel such consent in writing.

Signature_____Date_____

South Miami Women's Health
7000 SW 62 Avenue, Suite 350 South Miami, Fl. 33143

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name: _____ DOB:_____

Please select all that apply:

☐ You have my permission to leave a detailed message or via **unencrypted** email test results:
Tel_____ - Email:_____

☐ Please **DO NOT** release **ANY** medical information to anyone other than myself.

☐ I authorize this office to discuss my medical care with the following:

Name_____ Relationship_____

Tel: _____

Name_____ Relationship_____

Tel: _____

HIPAA ACKNOWLEDGEMENT

By signing below, I acknowledge that I have read and understood the Notice of Privacy Practices of the Federal HIPAA Privacy Rule.

_____ _____ _____ / **Date_____**

Patient Signature

YEARLY APPPOINTMENT REMINDER

****your appointment reminder will be emailed and texted****
If this is NOT OK please advise front desk

DATE: _____

NAME:_____

DATE OF BIRTH: _____

EMAIL: _____

PAP SMEAR RESULTS

****your pap result will be emailed and texted****
If this is NOT OK please advise front desk

DATE: _____

NAME:_____

DATE OF BIRTH: _____

EMAIL: _____

MEDICAL TEST RESULTS POLICY

We appreciate your confidence in us and we strive to make every effort to inform you of your test results in a timely manner. Our practice is to advise you of any test results (blood work, imaging exams, diagnostic procedures, etc.), within two weeks of the tests being done. In some rare instances the test may not be processed or the results may be misdirected or misplaced. That is why it is important for you to call our office if you have not received your test results within two weeks of the testing being done. **It is your responsibility to inform us if you have not received your results within two weeks of any tests or diagnostic procedures being performed.**

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, South Miami Women's Health reserves the right to charge a fee of $75.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand BOTH policies.

_____ *Date*_____

Printed Name

_____

Signature