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*

Race/Ethnicity _____
Raza/Etnia

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

☐ Other _____
Otro

Employer _____
Empleador

Work Phone (_____) _____
Telefono de Trabajo

Home Address _____
Direccion del Hogar

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

Email Address _____

Home Phone (_____) _____ Cell Phone (_____) _____
Telefono del Hogar *Telefono Cellular*

I was referred to: _____ by / *por*
Fui recomendado por

☐ Friend _____ ☐ Relative _____
Amigo *Familiar*

☐ Physician _____ ☐ Insurance _____
Médico *Seguro*

☐ Reputation of the LLC's Physicians _____
Reputación de los Médicos del LLC

☐ Existing Patient of the LLC _____
Paciente Existente de la LLC

☐ Other _____
Otro

Insurance Information - *Información del Seguro*

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

☐ 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*

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

Pharmacy - *Farmacia*

Pharmacy _____
Farmacia

Pharmacy Phone _____
Numero de telefono de la farmacia

Pharmacy Address _____
Direccion de la farmacia

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 ____/____/____
Sexo *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 mira al Dorso

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept most major credit cards. 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 ciertas tarjetas de credito. Su seguro medico es un contrato entre usted y su compañia de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsable de los gastos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate 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 judgements arising from claims of medical malpractice. This notice is pursuant to Florida law.

Hemos elegido no llevar seguro de negligencia medica o no demostrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (la ley 5) (g). Florida impone penas contra los medicos de los no-asegurado que no pueden satisfacer los juicios adversos que se presentan de demandas de la 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 carrier, 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 transferir 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 _____

Patient: _____ Date: _____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle **Yes** or **No**

Constitutional Systems

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other _____		

Allergic/Immunologic

Hay fever	Y	N
Drug allergies	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/Tingling	Y	N
Other _____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other _____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other _____		

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other _____		

Musculoskeletal

Joint pain	Y	N
Knee pain	Y	N
Back pain	Y	N
Other _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problem	Y	N
Other _____		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other _____		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other _____		

Psychiatric

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

Kompal Gadh, MD, LLC
601 N Flamingo Rd, Suite 307, Pembroke Pines, FL, 33028
(954) 499-4570

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I – Authorization

I,_____, give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II - Health Information

I would like to give the above healthcare organization permission to:

- ☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

- ☐ Disclose my complete health record except for the following information:
  - ☐ Mental health records
  - ☐ Communicable diseases including, but not limited to, HIV and AIDS
  - ☐ Disclose Alcohol/drug abuse treatment records
  - ☐ Genetic information
  - ☐ Other: _____

_____

_____

Form of Disclosure:

- ☐ Electronic copy or access via a web-based portal
- ☐ Hard copy

Section III – Reason for Disclosure

Please detail the reason(s) why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

_____

_____

This document will be retained by the providing organization for seven years.

Rompal Gaon, MD, LLC
601 N Flamingo Rd, Suite 307, Pembroke Pines, FL, 33028
(954) 499-4570

AUTORIZACIÓN PARA REVELAR INFORMACIÓN DE SALUD

Por favor complete todas las secciones de este formulario de liberación de HIPAA. Si alguna sección se deja en blanco, este formulario no será válido y no será posible que su información de salud se comparta según lo solicitado.

Sección I - Autorización

Yo, _____, doy mi permiso para _____ compartir la información que figura en la Sección II de este documento con la (s) persona (s) u organización (s) que he especificado en la Sección IV de este documento.

Sección II - Información de Salud

Me gustaría dar permiso a la organización de salud anterior para:

☐ Revelar mi registro de salud completo, que incluye, entre otros, diagnóstico, resultados de pruebas de laboratorio, tratamiento y registros de facturación para todas las condiciones.

O

☐ Revelar mi historial médico completo, excepto por la siguiente información:

- ☐ Registros de salud mental
- ☐ Enfermedades transmisibles que incluyen, pero no se limitan a, VIH y SIDA
- ☐ Revelar registros de tratamiento de abuso de alcohol / drogas
- ☐ Información genética
- ☐ Otro: _____

_____

_____

Forma de revelación de información:

☐ Copia electrónica o acceso a través de un portal en el internet.
☐ Copia en papel.

Sección III - Motivo por el cual se está revelando la información

Por favor, detalle las razones por las que se comparte la información. Si está iniciando la solicitud de compartir información y no desea enumerar las razones para compartirla, escriba "solicitud propia".

_____

_____

_____

_____

Este documento será retenido por la organización proveedora por siete años.

Kompal Gadh, MD, LLC
601 N Flamingo Rd, Suite 307, Pembroke Pines, FL, 33028
(954) 499-4570

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s):

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s)listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

- ☐ From _____ to _____

Or

- ☐ All past, present, and future periods

Or

- ☐ The date of the signature in section VI until the following event: _____

_____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

This document will be retained by the providing organization for seven years.

AUTORIZACIÓN PARA REVELAR INFORMACIÓN DE SALUD

Sección IV - Quién puede recibir mi información de salud

Doy mi autorización para que la información de salud que se detalla en la sección II de este documento se comparta con la (s) siguiente (s) persona (s) u organización (es):

Nombre: _____

Organización: _____

Dirección: _____

Entiendo que la (s) persona (s) / organización (es) enumerada (s) arriba puede no estar cubierta por las reglas estatales / federales que rigen la privacidad y seguridad de los datos y se le puede permitir compartir más la información que se les proporciona.

Section V – Duración de esta Autorización

Esta autorización para compartir mi información de salud es válida:

☐ Desde _____ hasta _____

O

☐ Todos los períodos pasados, presentes y futuros.

O

☐ La fecha de la firma en la sección VI hasta el siguiente evento.: _____

_____

Entiendo que puedo revocar esta autorización para compartir mis datos de salud en cualquier momento y puedo hacerlo mediante el envío de una solicitud por escrito a:

Nombre: _____

Organización: _____

Dirección: _____

Entiendo que:

- En el caso de que mi información ya haya sido compartida para cuando se revoque mi autorización, puede ser demasiado tarde para cancelar el permiso para compartir mis datos de salud.
- Entiendo que no necesito dar ningún otro permiso para que la información detallada en la Sección II se comparta con la (s) persona (s) u organización (s) enumerada (s) en la Sección IV.
- Entiendo que no firmar o enviar esta autorización o la cancelación de esta autorización no me impedirá recibir ningún tratamiento o beneficios a los que tengo derecho, siempre que esta información no sea necesaria para determinar si soy elegible para recibir esos tratamientos. o beneficios o para pagar los servicios que recibo.

Este documento será retenido por la organización durante al menos [illegible] años

Kompal Gadh, MD, LLC
601 N Flamingo Rd, Suite 307, Pembroke Pines, FL, 33028
(954) 499-4570

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section VI – Signature

_____ _____
Print Patient Name Date

_____
Signature

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form: _____

_____

_____

This document will be retained by the providing organization for seven years.

Kompal Gadh, MD, LLC
601 N Flamingo Rd, Suite 307, Pembroke Pines, FL, 33028
(954) 499-4570

AUTORIZACIÓN PARA REVELAR INFORMACIÓN DE SALUD

Sección VI - Firma

_____ _____

Nombre del Paciente (Escriba) Fecha

_____

Firma

Si una persona con autoridad legal está completando este formulario para actuar en nombre de una persona, como un padre o tutor legal de un menor o un agente de atención médica, complete la siguiente información:

Nombre de la persona que completa este formulario: _____

Firma de la persona que completa este formulario: _____

Describa a continuación cómo esta persona tiene autoridad legal para firmar esto: _____

_____

_____

Este documento será retenido por la organización proveedora por siete años.

KOMPAL GADH, M.D.

ADVANCED OB/GYN INSTITUTE

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS

I understand the planned procedure and I consent to a 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

An Ultrasound Exam which may include a probe placed in the vagina.

Other procedures as listed _____-

This examination will be performed by any provider from **KOMPAL GADH, M.D.**, LLC.

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

Name of Patient

_____

Signature of Patient or Patient's Representative if under 18

_____

Date _____

601 N. Flamingo Road, Suite 307 • Pembroke Pines, FL 33028
1040 Weston Road, Ste 105 • Weston, FL 33326
Phone: (954)-499-4570 • Fax: (954)-889-0027

KOMPAL GADH, M.D.

ADVANCED OB/GYN INSTITUTE

PATIENT FINANCIAL RESPONSIBILITY FORM

PATIENT NAME: _____ **DOB:** _____

Thank you for choosing Dr. Kompal Gadh (Advanced OB/GYN Institute) as your health provider. We are honored by your choice and are committed to providing you with the highest quality health care.
We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

- The patient (or patient's guardian, if minor) is ultimately responsible for the payment for her treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated.
- We will verify your insurance prior to your appointment. If you are coming in for a well women appointment, and are seen on the same day for a problem, if your insurance bills for a copay, you will then be responsible for that copay. Your insurance may require a copay that you will be responsible to pay on the day of the service.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatments not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check and most major credit cards at our office.
- Patients may incur, and are responsible for the payment of additional charges at the discretion of Dr. Kompal Gadh (Advanced OB/GYN Institute). These charges may include (but are not limited to):
    - Charge for returned check_____(initial)
    - Any costs associated with turning unpaid accounts over to our collection agency.-_____(initial)
    - If unable to keep your appointment, please notice us **24 hours** in advance so that we may offer that time to another patient. A patient of repetitive "**no show**" or **late cancellations may regretfully result in an assessment of a cancellation/no show fee of $50.00 each incident. _____(initial)**

I have read the policy regarding my financial responsibility to the Practice, for providing medical services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits; or, if applicable any amount due alter payment has been made by my insurance carrier.

_____

Signature of Patient or Guardian Date

601 N. Flamingo Road, Suite 307 • Pembroke Pines, FL 33028
1040 Weston Raod, Suite 105 • Weston, FL 33331
Phone: (954)-499-4570 • Fax: (954)-889-0027

KOMPAL GADH, M.D.

ADVANCED OB/GYN INSTITUTE

Welcome to Kompal Gadh, M.D., LLC. For those of you who have been to our practice before, we appreciate your support and confidence you have in our practice. For those of you who are a new patient to our office, we will strive to meet your expectations.

Please be advised that we only deliver and work out of Memorial Hospital West. If you seek care at any other hospital than Memorial Hospital West, we will be unable to care for you while you are in the hospital.

Please note that Dr. Gadh, Dr. Danastor, Dr. Mignacca and Ilona Blumberg, CNM will provide On-Call coverage. They will also be available in case of any unforeseen emergency, vacation, seminar, etc.

Once again, we welcome you to our practice. Please do not hesitate to ask any questions or voice any concerns.

_____ _____

Patient's Name (Please Print) Patient's Signature

_____ _____

Witness Date

601 N. Flamingo Road, Suite 307 • Pembroke Pines, FL 33028
1040 Weston Road, Suite 105 • Weston, FL 33326
Phone: (954)-499-4570 • Fax: (954)-889-0027