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 _____

ADVANCED OBGYN 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 Road, Suite 105 • Weston, FL 33331
Phone: (954)-499-4570 • Fax: (954)-889-0027

ADVANCED OBGYN INSTITUTE

Pap Smear

A **Pap smear**, also called a **Pap test**, is a procedure to **test** for **cervical** cancer in women. A **Pap smear** involves collecting cells from your cervix — the lower, narrow end of your uterus that's at the top of your vagina. Detecting **cervical** cancer early with a **Pap smear** gives you a greater chance at a cure.

Our provider advises Pap smear to be done yearly but some insurances don't cover the charges for Pap smear done yearly. So, you may receive a bill for your pap which you will be responsible.

I _____ DOB_____ give my **consent/ refuse** to

Dr._____ to do a Pap smear on me. I have been informed about the financial

responsibilities regarding the same.

Laboratories

We routinely send our laboratory testing to third-party laboratory companies (Quest Diagnostics, LabCorp & Aurora). Please be aware that those labs will be charging your insurance. Some tests might not be covered by your insurance carrier and Advanced ObGyn Institute cannot be held responsible. Please contact your health insurance to verify your coverage.

Signature of the patient: _____Date: _____

Name of the patient: _____

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

ADVANCED OBGYN INSTITUTE

General Consent for Comprehensive Examination involving Pelvis

I understand the planned procedure and I consent to a medically indicated physical examination which may include, but not limited to the following:

A female Gynecological exam which may include a pelvic exam,

An Ultrasound exam which may include a probe placed in vagina,

Other procedure as listed _____

This examination will be performed by any provider Advanced OBGYN Institute.

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

_____ _____

Signature of patient or Patient's representative if minor Date

_____

Print Name

601 N. Flamingo Road, Suite 307 • Pembroke Pines, FL 33028
1040 Weston Road, Suite 105 • Weston, FL 33326
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Advanced OBGYN Institute
601 N. Flamingo Rd, Pembroke Pines, FL, 33028
9544994570

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.

Advanced OBGYN Institute
601 N. Flamingo Rd, Pembroke Pines, FL, 33028
9544994570

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.

Advanced OBGYN Institute
601 N. Flamingo Rd, Pembroke Pines, FL, 33028
9544994570

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.

ADVANCED OBGYN INSTITUTE

PATIENTS CAN NOW ACCESS THEIR LABS THROUGH OUR PORTAL. PLEASE LET THE STAFF KNOW YOUR EMAIL ADDRESS. PLEASE ACTIVATE YOUR ACCOUNT WHEN LOGIN IS RECEIVED.

LOGIN URL: HEALOW

CODE: BECECA

HTTPS://MYCW52.ECLINCALWEB.COM/PORTAL6145/JSP/LOGIN.JSP

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