

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 EstadoCodigo Postal

Email Address _____

Home Phone (_____) _____ Cell Phone (_____) _____
Telefono del Hogar Telefono Celular

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 _____
Compañía de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado Relación

Policy # _____ Group # _____ Phone (_____) _____
Numero de Póliza Numero de Grupo Telefono

Secondary Insurance Information - Información del Seguro Secundario

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

Insurance company _____
Compañía de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado Relación

Policy # _____ Group # _____ Phone (_____) _____
Numero de Póliza 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 EstadoCodigo Postal

Sex _____ Date of Birth _____ / _____ / _____
Sexo Fecha de Nacimiento

Daytime Phone (_____) _____
Telefono durante el dia

Employer _____
Empleo

Address _____
Direccion

City _____ State _____ Zip _____
Ciudad EstadoCodigo Postal

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 compañía 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 compañía 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

Welcome to Adv OBGYN Institute, 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



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 after payment has been made by my insurance carrier.

Signature of Patient or Guardian

Date



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: _____



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

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: _____

Notice of Privacy Practices

Adv OBGYN Institute

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE HEALTH

INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:

We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:

We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:

We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act, HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Adv OBGYN Institute
601 N Flamingo RD
Pembroke pines, FL

Office: 954-499-4570
Fax: 954-889-0027

Attn: Compliance Contact

Please sign the accompanying
"Acknowledgement" form

Aviso De Prácticas De Privacidad

Adv OBGYN Institute

ESTE AVISO DESCRIBE CÓMO LA INFORMACIÓN MÉDICA SOBRE USTED PUEDE USAR Y DIVULGADA Y CÓMO USTED PUEDE OBTENER ACCESO A ESTA INFORMACIÓN. POR FAVOR, LÉALA CON ATENCIÓN.

Cómo podemos usar y divulgar su información médica: Se describe como sigue es las maneras en que podemos usar y divulgar información de salud que le identifica a usted (información de salud). Excepto para los siguientes propósitos, vamos a utilizar y divulgar su información médica sólo con su permiso por escrito. Usted puede revocar tal autorización en cualquier momento por escrito a nuestra práctica.

Tratamiento:

Podemos usar y divulgar su información médica para su tratamiento y para proporcionarle los servicios de salud relacionados con el tratamiento. Por ejemplo, podemos divulgar información médica a doctores, enfermeras, técnicos y otro personal, incluyendo personas fuera de nuestra oficina, que participan en su atención médica y necesitan la información para proporcionarle atención médica.

Pago:

Podemos usar y divulgar su información médica para que nosotros u otros podamos facturar y recibir pago de usted, una compañía de seguros o un tercero para el tratamiento y los servicios que recibió. Por ejemplo, podemos dar su información de plan de salud para que pagaran por su tratamiento.

Operaciones de atención médicos:

Podemos utilizar y divulgar información médica para fines de atención médica de la operación. Estos usos y divulgaciones son necesarios para asegurarse de que todos nuestros pacientes reciban atención de calidad y para operar y administrar nuestra oficina. Por ejemplo, podemos utilizar y divulgar información para asegurarse de que el cuidado médico que recibe es de la más alta calidad. También podemos compartir información con otras entidades que tienen una relación con usted (por ejemplo, su plan de salud) para sus actividades de atención médica de la operación.

Recordatorios de citas, salud y alternativas de tratamiento, beneficios y servicios relacionados. Podemos utilizar y divulgar información médica para contactarle y recordarle que usted tiene una cita con nosotros. También podemos usar y divulgar información médica para informarle sobre alternativas de tratamiento o beneficios relacionados con la salud y servicios que puedan ser de su interés.

Individuos involucrados en su cuidado o el pago de su atención. Cuando sea apropiado, podemos compartir información médica con una persona que participa en su atención médica o el pago de su atención, como su familia o un amigo cercano. También podemos notificar a su familia sobre su ubicación o condición general o divulgar dicha información a una entidad en un esfuerzo de alivio de desastre.

Investigación. Bajo ciertas circunstancias, podemos usar y divulgar información médica para la investigación. Por ejemplo, un proyecto de investigación puede involucrar comparar la salud de los pacientes que recibieron un tratamiento a aquellos que recibieron otro, para la misma condición. Antes de que usemos o divulguemos información médica para la investigación, el proyecto pasará por un proceso de aprobación especial. Incluso sin autorización especial, podemos permitir los investigadores registros para ayudarles a identificar a los pacientes que pueden incluirse en su proyecto de investigación o para otros propósitos similares, siempre y cuando no retire ni tomar una copia de cualquier información de salud.

Las actividades de recaudación de fondos. Podemos utilizar o divulgar su información médica protegida, según sea necesario, para poder ubicarle para actividades de recaudación de fondos. Usted tiene el derecho de optar por no recibir comunicaciones de recaudación de fondos. (Opcional) Si no quiere recibir estos materiales, por favor envíe una solicitud por escrito al oficial de privacidad.

SITUACIONES ESPECIALES:

Requeridas por la ley. Divulgaremos información de salud cuando así lo requiere la ley internacional, federal, estatal o local.

Para evitar una amenaza grave para la salud o seguridad.

Podemos usar y divulgar su información médica cuando sea necesario para prevenir una amenaza grave a su salud y seguridad o la salud y seguridad del público u otra persona. Revelaciones, sin embargo, se hará sólo a alguien que puede ayudar a prevenir la amenaza.

Asociados de negocios. Podemos divulgar información médica a nuestros asociados de negocios que realizan funciones en nuestro nombre o nos proporcionan servicios si la información es necesaria para dichas funciones o servicios. Por ejemplo, podemos utilizar otra compañía para realizar la facturación de servicios en nuestro nombre. Todos nuestros asociados de negocios están obligados a proteger la privacidad de su información y no se les permite usar o divulgar cualquier información que como se especifica en el contrato.

Violación de datos con fines de notificación. Podemos utilizar su información de contacto para proporcionar avisos requeridos legalmente de adquisición no autorizada, el acceso o la divulgación de su información médica. Podemos enviar aviso directamente a usted o notificar al patrocinador de su plan a través del cual recibe cobertura.

Donación de órganos y tejido. Si usted es un donante de órganos, podemos utilizar o divulgar información de salud a organizaciones que manejan la adquisición de órganos u otras entidades que participan en licitaciones; banca o transporte de órganos, ojos o tejidos para facilitar de órganos, ojos o tejidos donación; y trasplante.

Militares y veteranos. Si usted es un miembro de las fuerzas armadas, podemos divulgar información médica según lo requerido por las autoridades de comando militar. También podemos divulgar información médica a la autoridad militar extranjera correspondiente si eres un miembro de un ejército extranjero.

Compensación. Podemos divulgar información de salud para la compensación de trabajadores o programas similares. Estos programas proporcionan beneficios por accidente de trabajo o enfermedad.

Salud pública riesgos. Podemos divulgar información médica para actividades de salud pública. Estas actividades generalmente incluyen revelaciones para prevenir o controlar enfermedades, lesiones o incapacidades; nacimientos de informe y muertes; abuso de informe o negligencia; reacciones de informe a medicamentos o problemas con productos; notificar a las personas retiradas de productos que pueden estar usando; una persona que han estado expuesta a una enfermedad o puede estar en riesgo de contraer o propagar una enfermedad o condición; y la autoridad de gobierno apropiada si creemos que un paciente ha sido víctima de abuso, negligencia o violencia doméstica. Solamente haremos esta divulgación si usted está de acuerdo o cuando lo requiera o autorice la ley.

SUS DERECHOS:

Usted tiene los siguientes derechos con respecto a la información médica que tenemos sobre usted:

Acceso a registros electrónicos. La tecnología de la información de salud para la salud económica y clínica. Ley de alta tecnología permite a las personas para pedir copias electrónicas de su PHI contenida en registros electrónicos de salud o solicitar por escrito o electrónicamente otra persona reciba una copia electrónica de estos registros. Las reglas finales de omnibus amplían el derecho de una persona para acceder a los registros electrónicos o dirigir que ser enviado a otra persona para incluir no sólo registros electrónicos de salud sino también todos los registros en uno o más conjuntos de registros designados. Si la persona solicita una copia electrónica, deben ser proporcionados en el formato solicitado o en un formato de acuerdo mutuo. Entidades cubiertas pueden cobrar a individuos por el costo de cualquier medio electrónico (como una unidad flash USB) utilizado para proporcionar una copia de la PHI de la electrónica.

Derecho a inspeccionar y copiar. Usted tiene el derecho de inspeccionar y copiar información de salud que pueden utilizarse para tomar decisiones sobre su cuidado o el pago de su atención. Esto incluye registros médicos y de facturación, excepto las notas de psicoterapia. Para inspeccionar y copiar esta información de salud, debe hacer su petición, por escrito.

Derecho a enmendar. Si usted cree que la información de salud que tenemos es incorrecta o incompleta, puede pedirnos que enmendemos la información. Usted tiene el derecho de pedir una enmienda mientras la información se mantiene por o para nuestra oficina. Para solicitar una enmienda, usted debe hacer su petición, por escrito.

Derecho a una contabilidad de accesos. Usted tiene el derecho de solicitar una lista de ciertas revelaciones que hicimos de información médica para fines que no sean de tratamiento, pago y operaciones de atención médica o que proporcionaste autorización por escrito. Para solicitar una contabilidad de accesos, usted debe hacer su petición, por escrito.

Derecho a solicitar restricciones. Usted tiene el derecho a solicitar una restricción o limitación en la información médica que utilizamos o revelamos para tratamiento, pago u operaciones de atención médica. Usted también tiene derecho a solicitar un límite en la información de salud que divulguemos a alguien involucrado en su cuidado o el pago de su atención, como un familiar o amigo. Por ejemplo, usted puede pedir que no compartamos información sobre un determinado diagnóstico o tratamiento con su cónyuge. Para solicitar una restricción, usted debe hacer su petición, por escrito.

No estamos obligados a aceptar su petición. Si estamos de acuerdo, cumpliremos con su petición a menos que la información es necesaria para proporcionar tratamiento de emergencia.

Derecho a la comunicación mediante solicitud confidencial. Usted tiene el derecho a solicitar que nos comuniquemos con usted acerca de asuntos médicos de una cierta manera o en cierto lugar. Por ejemplo, usted puede solicitar que sólo te contactamos por correo o en el trabajo. Para solicitar comunicación confidencial, usted debe hacer su petición, por escrito. Su petición debe especificar cómo o dónde desea ser contactado. Acomodamos las peticiones razonables.

Derecho a una copia impresa de esta notificación. Usted tiene el derecho a una copia impresa de esta notificación. Usted puede pedirnos que le dará una copia de este aviso en cualquier momento.

CAMBIOS A ESTE AVISO:

Nos reservamos el derecho de cambiar este aviso a la nueva notificación se aplica a la información de salud que ya tenemos así como cualquier información que recibamos en el futuro. Publicaremos una copia de nuestra notificación actual en nuestra oficina. La notificación contendrá la fecha de vigencia en la primera página, en la esquina superior derecha.

QUEJAS:

Si usted cree que sus derechos de privacidad han sido violados, puede presentar una queja con nuestra oficina o con el Secretario del Departamento de salud y servicios humanos. Todas las quejas deben hacerse por escrito. Usted no será penalizado por presentar una queja.

Adv OBGYN Institute
601 N.Flamming Rd
Pembroke Pines, FL

Office: 954-499-4570
Fax: 954-889-0027

Atención: Compliance Contact

Por favor firmar el "Reconocimiento"



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.ECLINICALWEB.COM/P
ORTAL6145/JSP/LOGIN.JSP**