Bendayan LLC
Obstetrics & Gynecology

TopLine MD Alliance

Patient's Name _____DOB: _____/_____/_____

Phone: _____ Email: _____

Marital Status: Single ( ) Married ( ) Divorced ( ) Widowed ( )

Race/Ethnicity: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Emergency contact (Name): _____

Relation to patient: _____ Phone: _____

Insurance: _____

Policy ID: _____ Group: _____

Primary Doctor: _____ Phone: _____

Allergies: _____

Medications: _____

Last Pap smear date: _____ Last menstrual period date: _____

Pharmacy name: _____ Phone: _____

Reason for visit: _____

Referred by: _____

Patient's Signature: _____ Date: _____/_____/_____

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CONTACT WITH THE OFFICE

I) I AGREE TO BE CONTACTED BY EMAIL: I give my written express consent to Bendayan, LLC to leave detailed messages on my email about my normal lab results, diagnostic and/or imaging results, prescription information, or appointment reminders. No abnormal results will be communicated via our automated system or email.

YES _____ NO _____

II) I AGREE TO BE CONTACTED BY TEXT MESSAGE and/or WHATSAPP: I give my written express consent to Bendayan, LLC to leave detailed text messages or WhatsApp about my normal lab results, diagnostic and/or imaging results, prescription information, or appointment reminders. No abnormal results will be communicated via our automated system or text message or WhatsApp.

YES _____ NO _____

III) I AGREE TO RECEIVE VOICE MESSAGES: I give my written express consent to Bendayan, LLC to leave detailed messages on my voicemail/answering machine about my normal lab results, diagnostic and/or imaging results, prescription information, or appointment reminders. No abnormal results will be communicated via our automated system or voice message.

YES _____ NO _____

Patient's Name: _____

Patient's Signature: _____ Date: _____ /_____ /_____

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1. RISKS OF USING E-MAIL, TEXT OR WHATSAPP TO COMMUNICATE:

Bendayan, LLC offer patients the opportunity to communicate by e-mail, text or WhatsApp. Transmitting patient's information through these platforms has a number of risks to consider. These include, but are not limited to: a. They can be circulated, forwarded, and stored in numerous paper and electronic files. b. They can be immediately broadcast worldwide and be received by unintended recipients. c. Senders can easily type-in the wrong email address or phone number. d. They are easier to falsify than handwritten or signed documents. e. Backup copies may exist even after the sender or recipient has deleted his or her copy. f. Employers and on-line services have a right to archive and inspect e-mails, texts or WhatsApps transmitted through their system. g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection. h. E-mail can be used to introduce viruses into the computer system. i. They can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL, TEXT OR WHATSAPP TO COMMUNICATE:

Bendayan, LLC will use reasonable means to protect the security and confidentiality of e-mail, texts and WhatsApp message information sent and received. However, because of the risks outlined above, Bendayan, LLC cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Bendayan, LLC intentional misconduct. Thus, the patients must consent to the use of these means for patient information. Consent to the use of e-mail, text and WhatsApp messages includes agreement with the following conditions: a. All e-mails, text and WhatsApp messages to or from the patient concerning diagnosis or treatment will be made as part of the patient's medical record. Because they are part of the medical records, other individuals authorized to access the medical records will have access to those e-mails, texts and WhatsApps. b. Bendayan, LLC may forward e-mails, texts and WhatsApp internally to Bendayan, LLC staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Bendayan, LLC will not, however, forward emails, texts and WhatsApps to independent third parties without the patient's prior written consent, except as authorized or required by law. c. The patient is responsible for protecting his/her password or other means of access to email. Bendayan, LLC is not liable for breaches of confidentiality caused by the patient or any third party. d. Bendayan, LLC shall not engage in e-mail, text or WhatsApp communication that is unlawful, such as unlawfully practicing medicine across state lines. e. It is the patient's responsibility to follow-up and/or schedule an appointment.

3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS:

To communicate by e-mail, text or WhatsApp the patient shall: a. Limit or avoid using his/her employer's computer or phone. b. Inform our offoce of changes in e-mail address or phone number. c. Confirm that he/she has received and read the e-mail, text or WhatsApp message from Bendayan, LLC. d. Put the patient's name in the body of the e-mail. e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions). f. Take precautions to preserve the confidentiality of e-mail, text and WhatsApp such as using screen savers and safeguarding his/her computer and phone passwords. g. Withdraw consent only by e-mail, text or WhatsApp or other written communication to Bendayan, LLC.

4. TERMINATION OF THE E-MAIL, TEXT OR WHATSAPP RELATIONSHIP:

Bendayan, LLC shall have the right to immediately terminate the e-mail, text and/or WhatsApp relationship with you if determined in the sole Bendayan, LLC discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which Bendayan, LLC determines to be unacceptable.

HOLD HARMLESS

I agree to indemnify and hold harmless Bendayan, LLC, and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet or phone to communicate with the Bendayan, LLC, and any breach by me of these restrictions and conditions.

Patient's Name: _____ Date: _____ /_____ /_____

Patient's Signature: _____ DOB: _____ /_____ /_____

This disclosure is effective as of July 1, 2020 following the guidelines of our Corporate Office VitalMD/Femwell

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OFFICE POLICIES

I) We understand that emergencies and inconveniences arise, but if you need to reschedule or cancel your appointment, please call 24 hours ahead of time to avoid a $50 charge fee for **"No Show"** that will be billed directly to you.

INITIALS _____

II) All copays and coinsurances are due at the time of your visit. If there is an extra charge that the insurance did not cover, we will notify you. You may call your insurance to dispute the charge. The benefits given to us are not a guarantee of payment and you may receive a bill after your visit. It is NOT Dr. Bendayan or the office's decision. Please be respectful to our staff who are only doing their job. Failure to pay the balances will result in a report to the collections agency.

INITIALS _____

III) Doctor Bendayan can be called to attend a delivery at any time of day or night. We will contact you ahead of time as permitted and you may choose to reschedule or see Dr. Placencia.

INITIALS _____

IV) As per OSHA regulations, please refrain from bringing any food or drinks to our office.

INITIALS _____

Patient's Name: _____

Patient's Signature: _____ Date: _____ /_____ /_____

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NOTICE OF PRIVACY ACKNOWLEDGEMENT BENDAYAN, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Office Use Only
We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: Staff Name:

I authorize Bendayan, LLC to release and disclose my medical and/or billing information to the following individual(s):

1. _____ Relation: _____ Phone: _____
2. _____ Relation: _____ Phone: _____

Patient Information
I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.
I understand that the information disclosed to any above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient.

Patient's Name: _____

Patient's Signature: _____ Date: _____ /_____ /_____

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MALPRACTICE INSURANCE INFORMATION

Under Florida Law, physicians are required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE

This is permitted under Florida Law and subject to certain conditions. Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgement arising from claims of medical malpractice up to a minimum amount pursuant to Florida Statute s.458.320 (5) (g) 1 or Florida Statute s.459.008 s (5) (g) 1

Physicians who elect not to carry malpractice insurance must either post notices in the form of a sign prominently displayed in the reception area of the physician's office or provide a written statement to any person to whom medical services are being provided.

PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have read and understood that Dr. Jose Bendayan has elected not to carry malpractice insurance as stated above.

Patient's Name: _____

Patient's Signature: _____ Date: _____ /_____ /_____

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CONSENT FOR COMPREHENSIVE EXAM INVOLVING PELVIS AND/OR RECTUM

As per new Florida Law in effect July 1, 2020

I understand and 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 the vagina.

( ) Examination of external genitalia.

This examination will be performed by Dr. Jose Bendayan and/or Yuleima Placencia APRN.

This consent can only be withdrawn in writing

Patient's Name: _____ Date: _____ /_____ /_____

Patient's Signature: _____ DOB: _____ /_____ /_____

Legal Guardian's Signature if under 18: _____

Office Use Only
Signature of Witness: _____

Date: Staff Name:

This disclosure is effective as of July 1, 2020 following the guidelines of our Corporate Office VitalMD/Femwell