DATE_____

NAME_____

(PLEASE PRINT)

PLEASE TELL US THE REASON FOR YOUR VISIT TODAY_____

_____

Your insurance will be billed accordingly with the proper procedure and diagnosis codes. We are unable to change any codes after the insurance is filed.

SIGNATURE_____

* *PLEASE NOTE: THERE WILL BE A SEPARATE CHARGE FROM THE LABORATORY FOR ANY SPECIMENS SENT FROM THIS OFFICE. *ie: Pap Smears, biopsies and cultures*

PLEASE PRINT

Patient Registration

Date _____

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

Patient Information

Social Security # _____

First Name _____ Middle _____

Last Name _____

Sex _____ Date of Birth ____ / ____ / ____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race/Ethnicity _____

☐ Employed ☐ Retired ☐ Full-Time Student ☐ Other _____

Employer _____

Address _____
Street City State Zip

Home Address _____

City _____ State _____ Zip _____

Email Address _____

Home Phone (____) _____

Cell Phone (____) _____

Preferred Phone ☐ Home ☐ Cell OK to leave message? Y / N

I was referred by: _____

Work Phone (____) _____

Emergency Contact _____ Relationship _____ Phone (____) _____

Primary Insurance Information

Please fill in your insurance information below

☐ Commercial ☐ Medicare ☐ Other _____

Insurance company _____

Insured / Card Holder's Name _____ Date of Birth ____ / ____ / ____ Relationship _____

Policy # _____ Group # _____ Phone (____) _____

Employer _____

Subscriber's Address: _____
Street City State Zip

Secondary Insurance Information

☐ Commercial ☐ Medicare ☐ Other _____

Insurance company _____

Insured / Card Holder's Name _____ Date of Birth ____ / ____ / ____ Relationship _____

Policy # _____ Group # _____ Phone (____) _____

Employer _____

Subscriber's Address: _____
Street City State Zip

Spouse / Guarantor / Responsible Party

Social Security # _____

Relationship _____

First Name _____ Middle _____

Last Name _____

Address _____

City _____ State _____ Zip _____

Sex _____ Date of Birth ____ / ____ / ____

Daytime Phone (____) _____

Employer _____

Address _____

City _____ State _____ Zip _____

Signature Required Please See Reverse Side

09/15

NAME: _____

DATE: _____

REASON FOR VISIT

PAST MEDICAL & FAMILY HISTORY - *PLEASE CHECK (✓) IF YOU (PERS) OR ANY BLOOD RELATIVE (FAM) HAD ANY OF THE FOLLOWING CONDITIONS*

	PERS	FAM		PERS	FAM
1. WT LOSS-GAIN	☐	☐	13. URINARY INCONTENANCE	☐	☐
2. APPETITE	☐	☐	14. URINARY INFECTIONS	☐	☐
3. HEADACHES / MIGRAINE	☐	☐	15. BLOOD TRANSFUSIONS	☐	☐
4. HEART DIS ☐ VALVULAR DIS. ☐ RHEUMATIC DIS.	☐	☐	16. ANEMIA / BLOOD DISORDER	☐	☐
5. HYPERTENSION	☐	☐	17. VARICOSE VEINS / PHLEBITIS	☐	☐
6. RESPIRATORY DISEASE	☐	☐	18. SKIN DISEASE	☐	☐
7. BREAST DISEASE	☐	☐	19. DIABETES	☐	☐
8. JAUNDICE / HEPATITIS	☐	☐	20. NIGHT SWEATS	☐	☐
9. GALL BLADDER DISEASE	☐	☐	21. THYROID DISEASE	☐	☐
10. H. HERNIA / PEPTIC ULCER	☐	☐	22. CANCER	☐	☐
11. BOWEL DISORDERS	☐	☐	23. EPILEPSY / NEUROLOGICAL DIS.	☐	☐
12. KIDNEY DISEASE	☐	☐	24. ARTHRITIS	☐	☐

HOSPITAL ADMISSIONS - *LIST THOSE OPERATIONS & SERIOUS ILLNESS WHICH REQUIRED HOSPITALIZATION (EXCLUDING PREGNANCY)*

YEAR	REASON FOR ADMISSION / HOSPITAL	YEAR	REASON FOR ADMISSION / HOSPITAL

MEDICATIONS - *LIST ALL MEDICATIONS - YOU ARE CURRENTLY TAKING (DOSAGE - FREQUENCY) - INCLUDE OVER THE COUNTER DRUGS*

DRUG ALLERGIES

MENSTRUAL HISTORY

AGE AT FIRST PERIOD

DATE OF LAST PERIOD (1st DAY)

PERIOD INTERVAL (1st Day to 1st Day) # DAYS

DURATION OF BLEEDING

CRAMPS [Y] [N] - [MILD] [MOD] [SEVERE] ALWAYS PRESENT [Y] [N]

CRAMPS - START [BEFORE] [DURING] [AFTER] BLEEDING

MEDICATIONS FOR CRAMPS [Y] [N] TYPE?

HOW MANY PERIODS IN LAST YEAR?

BLEEDING (SPOTTING) BETWEEN PERIODS? [Y] [N]

VAGINAL INFECTIONS -*HISTORY OF* ☐ YEAST ☐ TRICHOMONAS ☐ CHLAMYDIA ☐ HERPES ☐ GONNORHEA

PAP TEST DATE OF LAST TEST ☐ NORMAL ☐ ABNORMAL

MAMMOGRAM DATE OF LAST TEST ☐ NORMAL ☐ ABNORMAL

CONTRACEPTIVE HISTORY CURRENT METHOD

PAST METHODS

OBSTETRICAL HISTORY

NUMBER (OF TIMES) PREGNANT | PREMATURE BABIES | MISCARRIAGES | ABORTIONS | LIVING CHILDREN

BORN YR / MOS	WEEKS PREG.	WEIGHT	SEX	TYPE OF DELIVERY	REMARKS	BORN YR / MOS	WEEKS PREG.	WEIGHT	SEX	TYPE OF DELIVERY	REMARKS
1)						4)					
2)						5)					
3)						6)					

MENOPAUSAL HISTORY *IF APPLICABLE* -HOT FLASHES / SWEATS [Y] [N] TREATMENT

SEXUAL HISTORY ☐ SATISFACTORY ☐ UNCOMFORTABLE ☐ WISH TO DISCUSS

SOCIAL HISTORY SMOKING | CIG / DAY YRS | ALCOHOL | OZ / WK | COFFEE | CUPS / DAY | STREET DRUGS

John A. White, M.D.
Obstetrics and Gynecology
533 North Clyde Morris Boulevard
Daytona Beach, Florida 32114
(386) 255-0901

WITH WHOM MAY WE DISCLOSE ANY OF YOUR MEDICAL INFORMATION.
(Future appointments, test results, medical status, billing)

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____

NAME:_____RELATIONSHIP:_____

X_____**DATE**:_____

We are part of a large group of doctors **Vital MD Group Holding, LLC**. Your insurance will send all payments and Explanation of Benefits for services rendered in this office to **Vital MD Group Holding, LLC**, in Miami, Florida. Our office **does not receive checks or explanations** from your insurance company.

If there is any discrepancy on the bill you receive from this office regarding insurance payments and adjustments, we ask that you send us a copy of the Explanation of Benefits you receive from your insurance company so we may make sure your account is properly credited.

X_____

Due to insurance purposes, have you seen any of the doctors, listed below, since 2011.
Please circle.

Desai Robertson Tapia Bagwell Haddox

Vagovic

Meyers DaSilva Gilmore

Dr. Whitney Shoemaker

Medication and Doctor List

Please list ALL medications you currently are taking, prescription & over the counter, including dosage.

	Name of Medication	Name of Doctor
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Notice of Privacy Acknowledgement

John A. White, MD Obstetrics & Gynecology, 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 your 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.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

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

Date: _____ Attempt: _____

Staff Name: _____

Notice of Privacy Practices
John A. White, MD Obstetrics & Gynecology, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES 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 w 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 b 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 a 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.

533 N. Clyde Morris Blvd, Suite A,
Daytona Beach, FL, 32114

Office: (386) 255-0901
Fax: (386) 255-4454

Attn: Compliance Contact

Please sign the accompanying "Acknowledgement" form

Insurance policy – John A. White, MD, Obstetrics and Gynecology, LLC

If the insurance information I provide to John A. White, MD, Obstetrics and Gynecology, LLC is incorrect and I do not provide the correct insurance information in a timely manner, I understand that I will be responsible for all charges for all services rendered to me.

I have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

Signed Date

John A. White, M.D., L.L.C.
Office Policies and Consent
****Initial after each Policy & Consent.****

1. **Insurance Benefits:** Payment is expected at the time of service. This includes copays, co-insurance, and any remaining deductibles. **Please note,** all benefit information is provided to us by your insurance company. If there are any discrepancies with your benefits, we ask that **you** contact your insurance company. _____**initial.**

2. **Financial Responsibility:** Upon checking in, our staff will inform you of your financial obligation for your appointment as well as any past due balances. Payment at this time will be requested. _____ **initial.**

3. **Delinquent Accounts:** Our office makes reasonable financial arrangements with our patients. These arrangements must be made with our billing/insurance department. If you have not made a financial arrangement and/or have not made an attempt to pay your obligation, your account will be placed in a collection status. Your account will be turned over by the practice to a debt collector. A fee, in the amount of **35% of the total amount due,** will be added to your outstanding balance. _____ **initial.**

4. **No Show Policy:** Our office enforces a "No Show" policy. We ask that if you must cancel your appointment that you kindly give us a 24-hour notice. **New Patient Appointment** "no show" fee is $50.00. **Established Patient appointments** "No Show" fee is $50.00. The "No Show" fee is required to be paid before another appointment can be scheduled. _____ **initial.**

5. **Surgical fees:** At the time your procedure/surgery is scheduled, our office will notify you your estimated financial obligation. Your obligation is expected to be paid no later than your pre-op visit. Failure to pay your portion may result in your procedure/surgery being rescheduled. _____ **initial.**

6. **Insurance Processing:** Our office will file primary insurance plans ONLY. If you are submitting your own claim, you will be given the information needed when you check out to forward to your insurance company. _____ **initial.**

7. **Medical Records:** There is a $1.00 per page fee for the first 25 pages, and $0.25 for each additional page. Allow 72 hours for your request to be fulfilled. Medical Record requests can be printed from our website. _____ **initial.**

8. **Consent:** I hereby consent to a medically indicated physical examination. This may include but is not limited to a pelvic examination. This consent will remain Active until I withdraw my consent in writing. _____ **initial.**

I certify that I have read and understand the above office policies and Consent.

_____ _____
Patient/Guardian Signature Date

_____ _____
Patient/Guardian Printed Name Patient DOB