FemCare Ob-Gyn, LLC *Geoffrey N. James, MD, Jason S. James, MD, Jila Senemar, MD, Karen Salazar Valdes, MD, Ingrid Paredes, MD*

PATIENT REGISTRATION

PATIENT INFORMATION

Social Security # _____ Home Address _____ Apt _____

First Name _____ City _____ State _____ Zip _____

Last Name _____ Email address _____

Sex _____ Date of Birth _____ Home Phone (____) _____

(Check One) ☐Employed ☐Retired ☐Full-Time Student Cell Phone (____) _____

☐Other _____ Work Phone (____) _____

Occupation _____ Pharmacy Number (____) _____

Employer _____ Primary Physician _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed Referred By _____

Spouse's Name _____ Primary Language _____

INSURANCE INFORMATION – *Please provide your insurance card and Driver's License to the receptionist*

Primary Insurance _____ Secondary Insurance _____

Name of Subscriber _____ Name of Subscriber _____

Policy # _____ Group # _____ Policy # _____ Group # _____

EMERGENCY CONTACT

Name _____ Relationship _____ Sex _____

Home Phone (____) _____ Work Phone (____) _____

I allow Doctor/Staff to leave messages/fax results at: ☐Home ☐Work ☐Cell ☐Fax ☐None

I authorize FemCare Ob-Gyn, LLC to disclose certain protected health information (PHI) about me to the parties listed below:

1._____ 2._____

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, I authorize said attorney to obtain my credit report and I understand that I will be liable for any charges incurred, including reasonable attorney's fees, court costs and collection expenses.

Malpractice Insurance Notification

We have elected not to carry Medical Malpractice Insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments 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 judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law.

Physician's Release and Assignment

I hereby authorize payment directly to FemCare Ob-Gyn, LLC ("Physician") of all benefits applicable and otherwise payable to me from my insurance carrier 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 release of my medical records as deemed necessary for payment of benefits.

HIPAA Acknowledgement

By signing below, I acknowledge that I have read and understand the Notice of Privacy Practices of the Federal HIPAA Privacy Rule.

Patient's/Guarantor's Signature _____ Date _____

FEMCARE OB-GYN, LLC
Geoffrey N. James, M.D.
Jason S. James, M.D.
Jila Senemar, M.D.
Karen Salazar Valdes, M.D.
Ingrid Paredes, M.D.

Snapper Creek Professional Center
7800 S.W. 87th Avenue, Suite A-120
Miami, Florida 33173
Telephone (305) 412-6004
Fax (305) 412-3007
www.femcare-obgyn.com

Questionnaire for COVID-19

1. Have you had any recent fever, chills or abnormal coughs in the last week? YES NO

2. Have you traveled outside the USA since January? If so where? _____

3. Have you been in contact with anybody with **COVID-19** or suspected for **COVID?** YES NO

4. Have you been tested for **COVID-19** or antibody? YES NO

   a. If so when and what was the results? _____

Patient's Name:_____ Date:_____

Patient's Signature:_____ Temperature:_____

FEMCARE OB-GYN

FEMCARE OB-GYN, LLC
Geoffrey N. James, M.D.
Jason S. James, M.D.
Jila Senemar, M.D.
Karen Salazar Valdes, M.D.
Ingrid Paredes, M.D.

Snapper Creek Professional Center
7800 S.W. 87th Avenue, Suite A-120
Miami, Florida 33173
Telephone (305) 412-6004
Fax (305) 412-3007
www.femcare-obgyn.com

Cuestionario para COVID-19

1. Ha tenido fiebre recientemente, escalofrios o tos nueva en las ultimas semanas? SI NO

2.Ha viajado fuera de los estados Unidos en estos ultimos tres meses? A donde? _____

3.Ha estado en contacto con alguien con el **COVID-19** o con sospechas del **COVID**? SI NO

4. Le han hecho el examen del **COVID-19** recientemente para el virus o anticuerpos? SI NO

   a. De ser si la repuesta anterior cual fue el resultado? _____

Nombre del Paciente: _____ Fecha:_____

Firma del Paciente: _____ Temperatura: _____

FEMCARE OB-GYN, LLC
Geoffrey N. James, M.D.

Jason S. James, M.D.
Jila Senemar, M.D.
Karen Salazar Valdes, M.D.
Ingrid Paredes, M.D.

Snapper Creek Professional Center
7800 S.W. 87th Avenue, Suite A-

Miami, Florida 33173
Telephone (305) 412-6004
Fax (305) 412-3007
www.femcare-obgyn.com

NOTICE TO OBSTETRIC PATIENT

(See Section 766.316, Florida Statutes)

I have been furnished information by Dr. Geoffrey N. James, Dr. Jason S. James, Dr. Jila Senemar, Dr. Karen Salazar Valdes, and/or Dr. Ingrid Paredes prepared by the Florida Birth-Related Neurological Injury Compensation Association (NICA), and have been advised that Dr. Jason S. James, Dr. Jila Senemar, Dr. Karen Salazar Valdes, and Dr. Ingrid Paredes are participating physicians in that program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor, delivery or resuscitation. For specifics on the program, I understand I can contact:

Florida Birth-Related Neurological Injury
Compensation Association
P.O. Box 14567
Tallahassee, Florida 32317-4567
1-800-398-2129.

I further acknowledge that I have received a copy of the brochure prepared by NICA.

In addition, I acknowledge that I have been advised and agree that occasionally I may be cared for by covering physicians who are also participating physicians in the NICA program and include, among others, Dr. Cesar Vinueza and Dr. Wilfredo Alvarez as well as Baptist Hospital employed physicians from OB Hospitalist Group.

DATED this _____ day of _____, 20___.

_____
Signature of Patient

_____
Printed Name of Patient

Witness:

_____
Social Security Number

_____
Signature

_____
Name

Date: _____

FEMCARE OB-GYN

FEMCARE OB-GYN, LLC
Geoffrey N. James, M.D.
Jason S. James, M.D.
Jila Senemar, M.D.
Karen Salazar Valdes, M.D.
Ingrid Paredes, M.D.

Snapper Creek Professional Center
7800 S.W. 87th Avenue, Suite A-120
Miami, Florida 33173
Telephone (305) 412-6004
Fax (305) 412-3007
www.femcare-obgyn.com

Obstetric Call Schedule Acknowledgment

FemCare Ob-Gyn's physicians who preform deliveries are: Jason James MD, Jila Senemar MD, Karen Salazar Valdes MD, and Ingrid Paredes MD. These four physicians cover Baptist Hospital on a rotating basis throughout the week and weekends. Under most normal circumstances, deliveries will be performed by one of these four physicians. Two additional physicians provide occasional call coverage on some weekends and holidays: Cesar Vinueza MD and Wilfredo Alvarez MD. In addition, Baptist Hospital employs a group of emergency obstetricians who staff the hospital 24 hours a day and provide emergency coverage- this group is called OB Hospitalist Group and comprise multiple physicians who provide call to the hospital.

By signing below, I acknowledge that my obstetrical care may be provided by any of the above physicians depending on scheduling, availability and potential emergencies.

_____

Name (Print)

_____

Signature

_____

Date

FEMCARE OB-GYN, LLC
Geoffrey N. James, M.D.
Jason S. James, M.D.
Jila Senemar, M.D.
Karen Salazar Valdes, M.D.
Ingrid Paredes, M.D.

Snapper Creek Professional Center
7800 S.W. 87th Avenue, Suite A-120
Miami, Florida 33173
Telephone (305) 412-6004
Fax (305) 412-3007
www.femcare-obgyn.com

Prenatal Genetic Screen

	YES	NO
1. Will you be 35 years or older when the baby is due?	___	___
2. Have you, the baby's father; or anyone in either if your families ever had any of the following disorders:		
Down Syndrome (mongolism)	___	___
Neural tube defect (spina bifida, meningomyelocele, Open spine, anencephaly)	___	___
Hemophilia	___	___
Muscular dystrophy	___	___
Cystic fibrosis	___	___
If yes, indicate the relationship of the affected person to you or the baby's father: _____		
3. Do you or the baby's father have a birth defect? If yes, who has the defect and what is it? _____	___	___
4. In any pervious marriages, have you or the baby's father has a child born dead or alive with a birth defect not listed in question 2?	___	___
5. Do you or the baby's father have any close relatives with mental retardation?	___	___
6. Do you, the baby's father, or close relative in either of your families have a birth defect, any familial disorder, or a chromosomal abnormality not listed above?	___	___
7. In any previous marriages, have you or the baby's father has a stillborn child or three or more first trimester spontaneous pregnancy losses (miscarriages)?	___	___
8. Are you or the baby's father of Jewish ancestry?	___	___
If yes, have you been tested for Tay Sach's disease?	___	___
9. Are you or the baby's father African American or African American descent?	___	___
If yes, have you been screened for sickle cell trait disease background?	___	___
If yes, have either of you been rested for B-Thalassemia?	___	___
10. Are you or the baby's father of Philippine or Southeast Asian ancestry?	___	___
11. Do you have any religious or personal reasons that would make you unwilling to accept blood transfusions in case of life- threatening emergency?	___	___
12. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period (including non-prescription or alternative medications)?	___	___
If yes, give name of medication and when taken:		

_____

_____

Name (Print): _____ Date: _____