*FemCare Ob-Gyn, LLC*

*Geoffrey N. James, MD, Jason S. James, MD, Jila Senemar, MD, Karen Salazar Valdes, MD, Ingrid Paredes, MD*

## PATIENT INFORMATION

Social Security # ______________________

First Name ______________________

Last Name ______________________

Sex _______ Date of Birth ______________

(Check One) ☐Employed ☐Retired ☐Full-Time Student

☐Other ______________________

Occupation ______________________

Employer ______________________

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Spouse's Name ______________________

Home Address ______________________ Apt _____

City ______________ State _____ Zip _________

Email address ______________________

Home Phone (_____) ______________________

Cell Phone (_____) ______________________

Work Phone (_____) ______________________

Pharmacy Number (_____) ______________________

Primary Physician ______________________

Referred By ______________________

Primary Language ______________________

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

Primary Insurance ______________________

Name of Subscriber ______________________

Policy # ________________ Group # _________

Secondary Insurance ______________________

Name of Subscriber ______________________

Policy # ________________ Group # _________

## EMERGENCY CONTACT

Name ______________________

Home Phone (_____) ______________________

Relationship ________________ Sex _________

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.

**Consent to Treat**

By signing below, I acknowledge that I consent to treatment by the physicians and other healthcare providers of FemCare Ob-Gyn, LLC, including performance of a medically necessary examination including, but not limited to, a pelvic examination.

Patient's/Guarantor's Signature ______________________ Date ___________

FEMCARE OB-GYN, LLC
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Karen Salazar Valdes, M.D.
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# GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

This consent form is being requested pursuant to Florida law.

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

- A female Gynecological Exam which may include a rectal exam and a pelvic examination
- An Ultrasound Exam which may include a probe placed in the vagina.
- Examination of external genitalia

This examination will be performed by any provider from FemCare Ob-Gyn, LLC.

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

Name of Patient:

________________________________________

Signature of Patient or Patient's Representative if under 18:

________________________________________

Date ________________