<u>FINANCIAL POLICY</u>

Thank you for choosing OBGYN Specialists of Fort Lauderdale, LLC as your health care provider. We are committed to building a successful physician-patient relationship. The following is a statement of our Financial Policy. Our office will be happy to answer any questions or concerns you may have.

PAYMENT IS DUE AT THE TIME OF SERVICE
ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT

WE ACCEPT: CASH, CHECK, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We are in network with most major insurance carriers. However, it is the patient's responsibility to verify that we are a participating provider of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. As part of the contract with your insurance company, all co-payments, co-insurances and deductibles must be paid at time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

HMO/REFERRALS: It is the patient's responsibility to obtain a referral form from your primary care physician if your insurance carrier requires it for your visits. If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.

MEDICAID: Our office does **NOT** currently accept any Medicaid products as either a Primary **OR** a Secondary. Should you fail to notify us that you have a Medicaid product you will be charged the **Full Fee for Services**.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of services rendered.

MISSED APPOINTMENTS: Unless cancelled 48 hours in advance, there is a $25.00 fee for missed appointments. Please help us serve you better by keeping scheduled appointments.

NONCOVERED SERVICES: Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

RETURNED CHECKS: Any check returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) along with a $50.00 NSF fee from the office.

COLLECTION POLICY: Should your account become past due, the patient/debtor assumes all costs of collection, including but not limited to, collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

RECORDS: There is a flat fee of $20.00 for each full set of medical records requested.

I HAVE READ AND FULLY UNDERSTAND the Financial Policy and all my questions regarding this policy have been answered. I hereby agree to render payment in accordance with the terms and conditions set forth.

Patient Name: ____ Date: _________________

Patient/Responsible Party Signature: ____

Under Florida law, Physicians are generally 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 subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Patient Signature:_______________________________________

Print Name:____

Date:________________________

Rachel Bernstein MD, FACOG ● Patricia Calvo MD, FACOG

6333 North Federal Highway, Suite 285, Fort Lauderdale, Florida 33308 ● 954-770-2141 Fax 754 206 4774

www.ForWomenOnlyOBGYN.com

PATIENT CONTRACT WITH CONSENT TO TREAT

CONSENT TO TREAT

By signing this form I understand that I am consenting that ObGyn Specialists of Fort Lauderdale, it's Physicians, Nurse Practitioners, Medical Assistants, Technicians or Medical Students (when applicable) can provide and perform medical care, tests, procedures or a medically indicated examination including but not limited to a pelvic exam as agreed upon in the best interest of my health. _______ **Patient Initials**

TREATMENT OF STAFF

We take great pride in assisting our patients and providing exceptional patient care. If you or anyone representing you act in an abusive manner to a staff member or a Physician you may be asked to leave and/or discharged from the practice. We have a Zero Tolerance policy for the mistreatment of our staff and Physicians so please be mindful of your behavior. **_______Patient Initials**

CO-PAYMENTS AND EXISTING ACCOUNT BALANCES

Co-Payments are due at the time of service. *No Exceptions*. If you have an existing account balance at the time of your visit, you are expected to pay the balance at your visit or set up an auto-payment plan to make timely payments. See the Front Desk for more information on the auto-payment plan. **________Patient Initials**

FORMS AND LETTER REQUESTS

All forms & letter requests may take up to 10 business days to complete so please be mindful of that timeframe when submitting a request. ALL patient information must be filled out on forms and all letter requests must include ALL information needed for the letter. If incorrect information is provided, there will be a $10 charge for each additional corrected form or letter. **_______Patient Initials**

APPOINTMENT CANCELLATIONS and LATE ARRIVALS FOR APPOINTMENTS

There will be a $25 charge for ANY appointment, (i.e. LAB, Ultrasound, Dr visit, Nurse visit etc.) not cancelled with a 48-hour notice. We have an appointment reminder system that notifies you via email, phone and text so if you must cancel, please use the system. You are considered late if you arrive more than 15 minutes past your scheduled time. We will do our best to see you but you may be asked to wait or reschedule. **_______Patient Initials**

BY SIGNING THIS CONTRACT, I, AS THE PATIENT, AGREE TO BE AN ACTIVE PARTICIPANT IN MY CARE AND THAT I UNDERSTAND THAT I MAY BE DISCHARGED FROM THE CARE OF OBGYN SPECIALISTS OF FORT LAUDERDALE AT THE DISCRETION OF THE PHYSICIANS IF ANY OF THE ABOVE TERMS ARE NOT FOLLOWED.

I FULLY UNDERSTAND AND ACCEPT THE TERMS STATED ABOVE:

Print Patient Name: ____ Patient D.O.B.________________

Patient Signature: ____ Today's Date: ________________

Medicaid Acknowledgment

If you currently have or plan to switch to Medicaid, Secondary Medicaid, Sunshine Health or any Medicaid related products please notify us IMMEDIATELY.

Neglecting to notify the office of your participation in any Medicaid program may result in immediate discharge from our office as well as out of pocket fees that will be your responsibility.

I have read and understand the above statement and agree to notify the office of any current or future changes:

___________________________________ ___________________________

Patient Print Date

____

Patient Signature

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Notice of Privacy Acknowledgement

OB-GYN Specialists of Fort Lauderdale, 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: ___________________________________

REVIEW OF SYSTEMS AND MEDICAL HISTORY FORM

Patient's Name:____ D.O.B. ______________________________

Reason for Visit:______________________________________ Email:_______________________________________

In order for your Physician to complete your exam, it is extremely important to complete this form in its entirety, including ALL PAST MEDICAL HISTORY. **ANY SECTIONS LEFT BLANK WILL RESULT IN A DELAY OF YOUR VISIT.**

CONSTITUTIONAL SYMPTOMS

Good general health lately................................ ☐No ☐Yes
Recent weight change....................................... ☐No ☐Yes
Fever.. ☐No ☐Yes
Fatigue... ☐No ☐Yes
Exercise regularly.. ☐No ☐Yes
Eat a balanced diet.. ☐No ☐Yes

EYES

Eye disease or injury.. ☐No ☐Yes
Wear glasses/contact lenses............................. ☐No ☐Yes
Blurred or double vision.................................... ☐No ☐Yes
Glaucoma... ☐No ☐Yes

EARS/NOSE/THROAT

Hearing loss or ringing....................................... ☐No ☐Yes
Earaches or drainage.. ☐No ☐Yes
Chronic sinus problem or rhinitis...................... ☐No ☐Yes
Nose bleeds.. ☐No ☐Yes
Mouth sores.. ☐No ☐Yes
Bleeding gums... ☐No ☐Yes
Sore throat or voice change............................... ☐No ☐Yes

CARDIOVASCULAR

Heart trouble.. ☐No ☐Yes
Chest pain or angina pectoris............................ ☐No ☐Yes
Palpitation.. ☐No ☐Yes
Shortness of breath with walking...................... ☐No ☐Yes
Swelling of feet, ankles or hands....................... ☐No ☐Yes
Murmur... ☐No ☐Yes
Mitral valve prolapse.. ☐No ☐Yes

RESPIRATORY

Chronic or frequent coughs............................... ☐No ☐Yes
Spitting up blood.. ☐No ☐Yes
Shortness of breath.. ☐No ☐Yes
Asthma or wheezing... ☐No ☐Yes

GASTROINTESTINAL

Loss of appetite.. ☐No ☐Yes
Change in bowel movements............................. ☐No ☐Yes
Nausea or vomiting.. ☐No ☐Yes
Frequent diarrhea.. ☐No ☐Yes
Constipation... ☐No ☐Yes
Rectal bleeding or blood in stool....................... ☐No ☐Yes
Abdominal pain.. ☐No ☐Yes
Peptic ulcer (stomach or duodenal)................... ☐No ☐Yes
Reflux.. ☐No ☐Yes

MUSCULOSKELETAL

Joint pain.. ☐No ☐Yes
Joint stiffness or swelling.................................. ☐No ☐Yes
Weakness of muscles or joints........................... ☐No ☐Yes
Muscle pain or cramps....................................... ☐No ☐Yes
Back pain.. ☐No ☐Yes
Cold extremities... ☐No ☐Yes
Difficulty in walking... ☐No ☐Yes
Sports injury... ☐No ☐Yes

INTEGUMENTARY (SKIN BREAST)

Rash or itching.. ☐No ☐Yes
Change in skin color.. ☐No ☐Yes
Change in hair or nails....................................... ☐No ☐Yes
Varicose Veins.. ☐No ☐Yes
Breast pain... ☐No ☐Yes
Breast lump.. ☐No ☐Yes
Breast discharge... ☐No ☐Yes
Changing mole.. ☐No ☐Yes

NEUROLOGICAL

Frequent or recurring headaches....................... ☐No ☐Yes
Light headed or dizzy... ☐No ☐Yes
Convulsions or seizures...................................... ☐No ☐Yes
Numbness or tingling sensations....................... ☐No ☐Yes
Tremors... ☐No ☐Yes
Paralysis.. ☐No ☐Yes
Stroke.. ☐No ☐Yes
Head injury... ☐No ☐Yes

PSYCHIATRIC

Memory loss or confusion.................................. ☐No ☐Yes
Nervousness... ☐No ☐Yes
Depression.. ☐No ☐Yes
Insomnia... ☐No ☐Yes

ENDOCRINE

Glandular or hormone problem......................... ☐No ☐Yes
Thyroid disease.. ☐No ☐Yes
Diabetes.. ☐No ☐Yes
Insulin or Non-Insulin (circle one)
Excessive thirst or urination............................... ☐No ☐Yes
Heat or cold intolerance..................................... ☐No ☐Yes
Skin becoming dryer.. ☐No ☐Yes
Change in hat or glove size................................ ☐No ☐Yes

GENITOURINARY

Frequent urination………………………………………. ☐No ☐Yes
Burning or painful urination……………………….. ☐No ☐Yes
Blood in urine………………………………………………. ☐No ☐Yes
Incontinence or dribbling……………………………. ☐No ☐Yes
Kidney stones………………………………………………. ☐No ☐Yes
Sexual difficulty……………………………………………. ☐No ☐Yes
Pain with periods…………………………………………. ☐No ☐Yes
Use douche…………………………………………………… ☐No ☐Yes
Irregular periods…………………………………………… ☐No ☐Yes
Vaginal discharge…………………………………………. ☐No ☐Yes
History of vaginal/pelvic infection………………… ☐No ☐Yes

HEMATOLOGIC / LYMPHATIC

Slow to heal after cuts……………………………… ☐No ☐Yes
Bleeding or bruising tendency……………………. ☐No ☐Yes
Anemia…………………………………………………………. ☐No ☐Yes
Phlebitis……………………………………………………….. ☐No ☐Yes
Past transfusion……………………………………………. ☐No ☐Yes
Enlarged glands……………………………………………. ☐No ☐Yes

MENSTRUATION HISTORY

Age at the onset of menstruation: ____________________
Date of **LAST** Menstrual Period: ______________________
PLEASE NOTE: WE CANNOT DO A PAP IF YOU ARE ON YOUR PERIOD
Number of days menstruation lasts: _________________
# of Pads/Tampons used:___________________________

OB/GYN HISTORY

Age at first intercourse:______________________________
Date of last PAP smear:______________________________
Date of last Mammogram:____________________________
Type of Birth Control currently using:_________________

ALLERGIES-Please list all known allergies:
____
____

LIST ALL PREGNANCIES INCLUDING; DATES, WEIGHTS, DELIVERY TYPE and any problems.
*****(Please include miscarriages, terminations and pre-term)*****
____
____
____

PAST MEDICAL HISTORY Please list **ALL PREVIOUS** medical history including surgeries, injuries, diseases, hospitalizations AS WELL AS Conditions such as High Blood Pressure and High Cholesterol:_______________ _______________________
____
____

MEDICATIONS (Please list **ALL** medications currently taking **including** Vitamins and Supplements)__________________
____
____

PATIENT SOCIAL HISTORY

Marital status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed
Use of alcohol: ☐Never ☐Number per week:____
Use of tobacco: ☐ Never ☐Previously Quit-Date Quit:______________________ ☐Current-packs per day:________
Use of drugs: ☐Never ☐Type/Frequency:____
History of: ☐Sexual assault:_______________________________ ☐Domestic violence:______________________

FAMILY MEDICAL HISTORY:

Age: Diseases: If deceased, cause of death
Father:____
Mother:____
Siblings:____
Children:____
Other blood relatives:____

I have filled out the form completely and understand any sections left blank will result in a delay of my visit:

Patient Signature:____ Date:______________________________

Healow Portal Website Registration

Once Pts are Web Enabled in the office they will receive a Welcome email titled:
"Portal login information from your doctor's office"

****Important-PLEASE check Junk or Spam folder**

1. Login Credentials will be In the Welcome email. It will show:
   Login URL: https://health.healow.com/ForWomenOnlyFTL (This is the portal website)
   User ID: JaneDoe1970 (Example Only)
   Password: 5CpY3Z7n (Example-this is a temp password you will change later-CASE SENSITIVE)

2. Click the link above and enter the credentials above to log in

3. Validate your identity with Date of Birth or PH # (it has to match what we have in the system)

4. Next reset your Password and set up Security questions

5. Next- Acknowledge EClinical Works Consent by clicking Next

6. Last-Acknowledge our Practice consent by **checking** the box and clicking **Agree**

Healow Portal App

***At the bottom of the Welcome email or any email from the portal there is a section that says "Let's Connect Via our Healow App-this has our unique "Practice Code" listed**

Step 1. Download Healow App from App Store

Step 2. Enter our unique "Practice Code" to find us: **CHAJAD**

Step 3. Login with User ID & Password (Use Temp info **ONLY IF** you haven't registered on the site yet

Step 4. Agree to Terms