WELCOME TO OUR OFFICE

We would like to take this opportunity to thank you for choosing Dr. Jessica White-Videa as your OB/GYN. We look forward to providing you with quality care and demonstrating why this is the IDEAL place for all of your obstetrical and gynecological needs. Please complete the attached forms prior to your visit. In addition to these forms, we will need your insurance card and photo ID. If you did not provide your insurance information in detail when making your appointment, please call our office prior to your visit. Providing this information in advance will allow us to verify your benefits before you arrive and decrease your wait time. Lastly, after your visit, you may receive a survey about your experience in our office. We appreciate and value your input.
Registration Form

Name: ____________________________________________________ Today’s Date ________________

Last    First    Middle initial

Date of Birth: ___________________     Age: ________     Social Security #______-_______-_______

Mailing Address:

______________________________  Street  _______________  City  ___________________________  State  ___________  Zip Code

Cell Phone: _______-_________-_________.       Home Phone: ________-_______-___________

Employer: ____________________________________ Employer Phone: _______-_________-_______

Primary Care Physician: _________________________ Physician Phone: _______-_______-________

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

Referred by: (_) Physician (_) Family/Friend (_) Insurance (_) Google search (_) social media

PRIMARY INSURANCE

Ins. Co Name: ____________________________________ Phone: _______-_______-________

Address_____________________________________________________________________________________

ID No_______________________________Group#________________________________________

ARE YOU A DEPENDENT ON THIS PLAN?
(   ) YES- If yes, who is the PRIMARY INSURED?

The Office of Dr. Jessica White-Videa
2855 N. University Drive, Suite 300
Coral Springs, FL 33065
Telephone (954)317-0772*Fax (954)317-0787
( _) NO

NAME OF PRIMARY POLICY HOLDER/SUBSCRIBER ________________________________________

Relationship to Patient _________________________ Policy Holder Date of Birth ___-___-____

( _) Check here if the subscriber has the same billing address as you

Address ________________________________________________________________

SECONDARY INSURANCE  ( _) NOT APPLICABLE

Ins. Co Name: ____________________________________ Phone: _______-________-________

Address: _____________________________________________________________________

ID No: _______________________________ Group No_______________________________

ARE YOU A DEPENDENT ON THIS PLAN?
•  ( _) YES- If yes, who is the PRIMARY INSURED?
•  ( _) No

PRIMARY POLICY HOLDER/SUBSCRIBER ________________________________________

Relationship to Patient _________________________ Policy Holder Date of Birth ___-___-____

( _) Check here if the subscriber has the same billing address as you

Address: _______________________________________________________________________

PHARMACY: INFORMATION

( _) CVS    ( _) TARGET    ( _) WALGREENS    ( _) WALMART    ( _) PUBLIX    ( _) OTHER

Streets/Address: _____________________________________________________________

Phone Number _______-________-_________
EMERGENCY CONTACT

Who Should We Contact? ____________________________________________

Relationship: ______________________

Phone: _______ - _______ - _______

Signature_________________________________________ Date___________________

Patient’s rights of disclosures

How would you like to be contacted by us?

In general, the HIPAA privacy rule gives the individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communications of health information be made by alternative means.

I_______________________________________, wish to be contacted in the following manner:

HOME
____ Ok to leave a detailed message
____ Leave message with callback number only

CELL PHONE
____ Ok to leave a detailed message
____ Leave message with callback number only
____ Ok to send text messages

WORK
____ OK to leave detailed message
____ Leave message with callback number only

WRITTEN COMMUNICATION
____OK to mail to home

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List all persons in your household with whom we may speak to regarding your medical information.

NAME_____________________________________________Relationship________________________

Patient Signature: ________________________________________ Date: ____________________

Notice of Privacy Acknowledgement
I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). 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 IDEAL WOMEN’S HEALTH CARE, LLC has the right to change its Notice of Privacy practices and that I may contact the practice at any time to obtain and current copy of the NPP.

__________________________________________
PATIENT LEGAL NAME(PRINT) SIGNATURE DATE

OFFICE USE:
WE HAVE MADE THE FOLLOWING ATTEMPT TO OBTAIN THE PATIENT’S SIGNATURE ACKNOWLEDGING RECEIPT OR NOTICE OF PRIVACY PRACTICES

__________________________________________
ATTEMPT MADE BY DATE

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FMLA/DISABILITY Form Notification

I acknowledge that there is a $25.00 fee for any disability, FMLA or any other paperwork that needs to be completed by the physician. As a patient, I am required to provide the paperwork from my employer (and/or disability company) and complete the patient portion(s). This fee is not paid by the insurance company nor is it included in the visit. Please allow 3-5 business days for your paperwork to be completed.

_______________________________________________________________
PATIENT NAME (PRINT) SIGNATURE DATE
FINANCIAL POLICY

We have developed a set of guidelines regarding financial responsibility. If you have any questions, please speak with the office manager.

You must present your insurance card (and your ID card) at the time of your visit. If we do not receive your insurance card before you see the doctor, that visit becomes a SELF PAY, and payment is expected.

For your convenience, we accept cash, check, MC, Visa, Discover and American Express. Any bounced checks will result in a $35 returned check fee.

We will make every effort to collect payments from the patient’s or guarantor’s insurance company through courtesy filing of insurance claims and other required documentation.

Since most carriers have time limits for filing correct information it is imperative that we receive complete and correct insurance information. Although assistance will be provided, it is the patient’s responsibility to make sure his/her insurance carrier pays his/her claim.

Patients, or their guarantors, are responsible for payment in full of financial obligations whether or not their insurer makes a payment.
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 of all charges is the patient's responsibility and should it be necessary for this account to be turned over to a collection agency, I understand that I will be liable for any charges incurred, including collection agency's fee, attorney's fee and court costs.

Co-pay, Deductible, and Co-insurance. A copay is a set dollar amount you owe for each office visit. Some insurance plans are subject to a deductible and coinsurance. Our office staff will attempt to contact you prior to your visit, to advise you of your responsibility. You will be expected to make payment before services are rendered.

Estimation of Services, whenever possible, our office staff verifies your benefits with the insurance company and will provide you with the approximate cost of the service. The final cost may change based on what is actually done on the day of your visit. Additionally, the estimate of our charges will not include any outside lab or pathology service.

Lab/Pathology Fees, if any laboratory testing is collected (blood work, cultures, biopsy, PAP smear, etc.) in our office to confirm a diagnosis or to determine a course of treatment, the laboratory will perform the actual testing of the sample. THIS MEANS YOU MAY RECEIVE A SEPARATE BILL FROM THE LAB/PATHOLOGIST- we do not verify your lab benefits.

☐ Physician’s Release and Assignment: I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carries /HMO/TPP for services rendered by the physician. I understand that I am financially responsible to the physician for any and all co-insurance, deductibles, copays and/or non-covered service charges that the carrier declines to pay. I hereby authorize the release of my medical records to my insurance provider as deemed necessary for payment of insurance benefits.

_________________________________________________________________________________
PRINT NAME SIGNATURE DATE

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CONSENT FOR PELVIC EXAMINATION

Written consent of the patient or the patient’s legal representative or guardian is required prior to a gynecological examination. The examination may include but is not limited to a breast examination as well as a pelvic examination including rectal examination,

A pelvic examination is defined by and includes an examination of the vulva, vagina cervix, uterus, fallopian tubes, ovaries, uterus, rectum, or external genitalia, or pelvic organs using a combination of modalities, which may include, but not be limited to, the healthcare provider's gloved hand or instrumentation.

I understand and consent to a “MEDICALLY INDICATED GYN EXAMINATION INCLUDING BUT NOT LIMITED TO A PELVIC EXAMINATION AND/OR RECTAL EXAMINATION”.

Patient Name: ___________________________ Date: ___________________

Patient Signature: _______________________________________________________

Signature of Legal Representative or Guardian: ________________________________
(If patient under the age of 18)

Witness Signature: ________________________________________________________
PATIENT PORTAL

The Patient Portal enables our patients to communicate with the doctor or staff members securely via the Internet.

Participating patients are given secure User IDs and passwords, enabling them to access the portal to view their personal and private documents, including lab and diagnostic test results, educational information, billing statements, and other health information.

Through the Patient Portal, you are able to:

- Ask questions/send messages directly to the doctor or staff members
- Request prescription refills and referrals
- Request appointments
- View your personal health record

All from the comfort of your home, whenever it is convenient for you!

Online communications do not decrease or diminish any other ways in which you can communicate with your provider. It is an additional option and not a replacement.

The practice may stop providing online communication or change the services provided online at any time without prior notification to you.
I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communication. I consent to the conditions outlined and I agree to keep my password confidential and notify the office if my email address changes at any time.

I am over the age of 18 and have sole responsibility for my medical care.

PRINT PATIENT NAME: ________________________________________________

DATE OF BIRTH: _____________________________________________________

EMAIL ADDRESS _____________________________________________________ please print legibly

**Please download the Healow App and use the information below to gain access to your account.
Provider ID #

[ ] I DO not want to participate in the Patient Portal at this time.

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

To make sure that you understand how we will use and disclose your health information, we have included definitions of the terms used in this notice. Below is a list of ways we may use and disclose your health information.

Treatment: We use and disclose health information about you for your treatment. Treatment includes services, supplies, facilities, and billing for our services or supplies. We may use and disclose health information for treatment purposes in any facility or care setting in which we provide medical care. We may use and disclose health information to another health care provider performing treatment services on our behalf. For example, if you are referred to a specialist, we may forward a report of your health information to the specialist to help that provider to care for you.

Payment: We may use and disclose health information to obtain payment for your services. We may bill insurance companies for treatment services you receive. We may use or disclose health information to any entity to which we make payment for your care. We may also use and disclose health information to prepare a claim for payment or payment eligibility or for your billing purposes.

Healthcare Operations: We use and disclose health information for healthcare operations purposes. These uses and disclosures are necessary to establish and operate our business. For example, we may use and disclose health information about you for purposes such as case management, data analysis, quality improvement, and planning. We may also use and disclose health information to tell you about alternative treatments, providers, or services available to you.

Appointment Reminders, Treatment Alternatives and Health Related Services and Benefits: We use and disclose health information to contact you and remind you of your appointment status. We may use health information that we do not have about you to tell you about alternative treatments, providers, or services available to you. We may use health information that we do not have about you to tell you about alternative treatments, providers, or services available to you.

Individuals Involved in Your Care or Payment for Your Care: We may use and disclose health information to let you know about individuals involved in your care or payment. For example, we may tell you that a family member is waiting to see you. We may also communicate with someone you authorize, such as a friend or family member.

Workers’ Compensation: We may release health information to a workers’ compensation insurance, if you are a member of the armed forces.

Healthcare Services and Benefits: We may use and disclose health information for healthcare services and benefits. We may use health information to provide benefits under your group health plan.

Research: Under certain circumstances, we may use and disclose health information for research purposes.

Funding Activities: We may use and disclose your health information to fundraise for our business or for our charitable organization.

Special Situations: As Required by Law will disclose Health Information when required to do so by international, federal, state or local law.

YOUR RIGHTS:

You have the right to 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 patients to ask for electronic copies of their PHI contained in electronic health records. Patients may ask to receive an electronic copy of their health information. The final rule on health information technology requires health information to be accessible to patients in an electronic format.

Payment of fees for services: In some cases, we may charge a fee for services. If you have a complaint, you may file a complaint with the department of health and human services. All complaints must be made in writing. You will not be penalized for filing a complaint.

Please sign the accompanying "Acknowledgement" form.

Coral Springs, FL 33065
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