Ivonne Maria Reynolds, DO, LLC
OBSTETRICS AND GYNECOLOGY
TopLine MD Alliance

Dr. Ivonne Reynolds
Dr. Fern TaiSenChoy-Bent
Jazmine Felder, APRN, CNM
Tionnei Knight-Bush, APRN

Welcome to our practice!

We want to take this opportunity to thank you for choosing ROSE OBGYN, office of Dr. Ivonne Reynolds, Dr. Fern TaiSenChoy, Jazmine Felder, APRN CNM and Tionnei Knight Bush, APRN for your obstetrical and gynecological needs.

Just a bit about our office….

- We answer our phones on Monday through Thursday 8:30am-12:30; 1:30pm- 4:30pm; and on Friday 8:30am-1:30pm. For any calls outside of office hours, including holidays and weekends, our answering service will contact our on-call provider to address urgent matters.
- Medication refills, laboratory and imaging results, forms and letters will only be addressed during office hours.
- In the event you require hospital services, we have privileges to treat our patients at Northwest Medical Center and Coral Springs Medical Center.
- We have a NO CHILDREN POLICY for the health and safety of our patients. If you bring your child with you, you will be asked to reschedule your appointment.

Please take the time to complete these forms and bring them with you to your first appointment. If you have not provided your insurance information when scheduling your appointment, please call the office prior to your visit so we may verify your benefits before you arrive; this will decrease your wait time. After your visit, you may receive a survey about your experience in our office, we appreciate and value your feedback.

Thank you, in advance, for the completion of the attached forms. We look forward to meeting you and providing you with the quality care you deserve.

Once again, welcome to our practice!

Rose OBGYN

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PATIENT REGISTRATION FORM

Patient Name: _____ **DOB:** _____ **Age:** _____

Address:_____

City: _____ **State:** _____ **ZIP:** _____

Cell Phone: _____**Home Phone:** _____

In order to web enable we require your email - ☐ *Choose not to disclose*

Email: *(please print legibly)* _____

PATIENT DEMOGRAPHICS

Gender Identity: ☐ Female ☐ Male ☐ Transgender MTF ☐ Transgender FTM ☐ Other _____ ☐ Decline

Sexual Orientation: ☐ Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Other _____ ☐ Decline

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Two or More Races ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

GENERAL INFORMATION

Employer: _____ **Employer Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Previous OB/GYN: _____ **Phone:** _____

Referred By: ☐ Physician _____☐ Family/Friend ☐ Insurance ☐ Google/Internet

** **PRIMARY INSURANCE —*If uninsured check here*** ☐ Uninsured – Selfpay

REQUIRED: Insurance Company: _____ **Member ID #:** _____

Group #: _____ **Insurance Phone:** _____

Are you the Policyholder/Subscriber? ☐ Yes ☐ No

If No: **Policyholder Name:** _____ **Relationship:** _____

Policyholder DOB: _____ ☐ Same address as patient

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SECONDARY INSURANCE (check if NA) ☐ None

Insurance Company: _____ **Member ID #:** _____

Group #: _____ **Insurance Phone:** _____

Policyholder Name: _____ **Relationship:** _____ **DOB:** _____

**** PHARMACY — REQUIRED**

☐ CVS ☐ Walgreens ☐ Publix ☐ Walmart ☐ Target ☐ Other: _____

Pharmacy/Store #: _____ **Phone:** _____

Address/Cross Streets: _____

EMERGENCY CONTACT

Name: _____ **Relationship:** _____ **Phone:** _____

INSURANCE, FINANCIAL & ASSIGNMENT ACKNOWLEDGMENT

I certify that the information provided above is accurate and authorize **Ivonne M. Reynolds, DO, LLC / ROSE OBGYN** to submit claims to my insurance carrier and receive payment of benefits directly for services provided. I authorize the release of medical and billing information as reasonably necessary for treatment, payment, insurance claims, and healthcare operations as permitted by law.

I understand that verification of insurance benefits **does not guarantee coverage or payment** and that I am financially responsible for applicable copayments, deductibles, coinsurance, non-covered services, and balances not paid by my insurance carrier. I acknowledge that outside laboratory, pathology, imaging, genetic testing, and other third-party services may be billed separately. I acknowledge receipt of and agree to ROSE OBGYN's Financial Policy.

Patient/Responsible Party Signature: _____ **Date:** _____

Printed Name: _____ **Relationship:** _____

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PHQ-9 PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____Date of Birth: _____

Today's Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	**Several days 1**	**More than half the days 2**	**Nearly every day 3**
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed; or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

TOTAL SCORE: _____ / 27

Functional Impact

If you checked off **any problems**, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

PHQ-9 Total Score: _____

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CONSENT TO RELEASE INFORMATION TO:

In the event you are unable to communicate with our office regarding your medical information, you can elect to have a representative make requests on your behalf, receive medical information and speak to the physician/staff regarding your care. *Without this information ROSE OBGYN, is unable to disclose any medical information to anyone*. The delegated representative information will remain in your record until rescinded by you.

I, _____, authorize the following individual(s) to receive medical information.

Name	Relationship
Name	Relationship
Name	Relationship

Patient's rights of disclosures

In general, the HIPAA privacy rule gives an individual the right to request restriction(s) on usage and disclosure of health information. The individual is also provided the right to request confidential communication of health information be made by alternative means.

I, _____, wish to be contacted in the following manner *(please check preferred method(s).*

_____Home, ok to leave message? ☐Yes ☐No

_____Cell Phone, ok to leave message? ☐Yes ☐No

_____Work , ok to leave message? ☐Yes ☐No

Written Communication

Your patient portal should be your main source of receiving confidential medical information.

In the event you have elected to not use your patient portal, you must select at least one of the written communication methods below:

_____Ok to mail to home

_____Ok to email – limited information _____

_____Ok to fax_____

Patient Signature: Date:

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REQUEST FOR MEDICAL RECORDS

Patient Name:_____ Date of Birth:_____

Cell: _____Home Phone: _____

Address: _____ City/State/Zip: _____

Above listed patient authorizes the following healthcare facility to RELEASE MY MEDICAL RECORDS

FROM: ☐ ROSE OBGYN

2960 North State Road 7, Suite 200, Margate, FL 33063

Fax (less than 25 pages) 1.800.579.8738

FROM: ☐ Other: _____

PHONE: _____

FAX: _____

Dates and Type of information to disclose:

□ 2 years prior from last date seen

□ Labs/Diagnostic Results Date: _____

□ Most recent office visit with labs

The purpose of disclosure is:

□ Change of Insurance or Physician

□Continuation of Care

□ OB CHART ONLY

RESTRICTIONS: **Only medical records originated through this healthcare facility will be copied** unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.
I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Records to be sent to:

□ Rose ObGyn

2960 North State Road 7, Suite 200, Margate, FL 33063

Fax (less than 25 pages) 1.800.579.8738

□ Other: _____

Fax: _____

Phone: _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. **I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

X_____ _____
Signature of Patient / Parent / Guardian or Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____
Printed name of Authorized Representative Relationship / Capacity to patient **Date**

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Healow - Your Patient Portal!!

We are honored that you have chosen us as your healthcare provider.

As we continue in our efforts to provide our patients with the highest quality of care, we are constantly looking for methods of working together to ensure that you are not only aware of, but also involved in the management and improvement of your health.

We are proud to inform you that our practice offers the opportunity to track the most important aspects of your healthcare through our office using the Healow patient portal. The patient portal enables you, the patient, to communicate with our doctors, nurses and staff members easily, safely and securely.

Once you have provided your email to us, you will receive an email inviting you to join the portal. By utilizing a secure user ID and password, you will gain access to your medical records allowing you to view your personal and private documents including labs, diagnostic test results, prescriptions, and the ability to pay invoices online. Once you have signed up, you can download the Healow app on your android or apple device, or you can access the portal via our website at toplinemd.com/Ivonne-m-reynolds.

I have read and understand the responsibilities and benefits of the patient portal. I also understand the risks associated with unsecured online communications increasing the need to utilize the portal. I consent to the conditions outlined and I agree to keep my password confidential. I will notify the office if my email address changes at any time.

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

***We do not offer the patient portal to minors or those patients which do not make their own medical decisions.*

Patient Name (PRINT) DOB

_____

Email Address (PRINT LEGIBLY)

_____ I **DO NOT** wish to participate in the patient portal at this time

_____ I do not have an email address

_____ I do not wish to share my email address

_____ English is not my preferred language

_____ Other : _____

ROSE OBGYN - Financial Policy

Thank you for choosing **ROSE OBGYN** for your healthcare needs. We are committed to providing quality care while maintaining clear and consistent financial policies. We ask that you review the following information carefully. **Ultimately, the patient is responsible for understanding their insurance benefits and for payment of all charges not covered by their insurance plan.**

Insurance Card & Identification

Patients are required to present a **current insurance card prior to or at the time of each appointment** so that coverage and benefits can be verified.

If you are unable to provide valid insurance information at the time of your appointment, **you may be required to pay our self-pay rate at the time services are rendered**. Submission of insurance information after the visit does not guarantee that the claim can be rebilled or that the self-pay amount will be refunded.

A **valid photo ID must be presented at each appointment** for identification and patient-safety purposes.

Understanding Your Insurance Benefits

Your health insurance plan determines how the cost of your healthcare is divided between you and your insurance carrier. Depending upon your plan, you may be responsible for one or more of the following:

Copayment (Copay): A fixed dollar amount that your insurance plan requires you to pay for a covered healthcare service. Copayments are generally due **at the time services are rendered**.

Deductible: The amount you are required to pay out-of-pocket for covered healthcare services before your insurance plan begins paying its portion of eligible expenses.

Coinsurance: The percentage of the cost of a covered healthcare service that you are responsible for after applicable deductible requirements have been met. For example, if your plan has 20% coinsurance, you may be responsible for 20% of the insurance-approved amount.

All applicable **copayments, deductibles, coinsurance, self-pay charges, and other known patient-responsibility amounts are expected to be paid at the time services are rendered**, unless other arrangements have been approved by our office.

Insurance Verification & Estimates

As a courtesy, ROSE OBGYN verifies eligibility and available benefit information through your insurance carrier and may provide you with an **estimate of your anticipated financial responsibility**.

Insurance verification and benefit information are **not a guarantee of payment or coverage**. The information provided to our office by your insurance carrier is an estimate based on the benefits available at the time of verification.

Your final financial responsibility is determined after your insurance carrier processes the claim and may vary based on:

- The actual services and procedures performed;
- Your deductible and coinsurance status;
- Your insurance carrier's determination of covered or non-covered services;
- Medical necessity or authorization requirements;
- Changes in eligibility or benefits; and
- Your insurance carrier's processing of the claim.

You may receive a balance after your insurance carrier processes your claim, even if you previously paid an estimated amount.

Outside Laboratory & Pathology Services

Laboratory testing, pathology, genetic testing, imaging, or other services performed by an **outside facility or independent provider are billed separately** and are **not included in ROSE OBGYN's charges for your office visit or procedure unless specifically stated otherwise**.

You may receive a separate bill directly from the laboratory, pathology provider, imaging facility, or other outside provider. ROSE OBGYN does not determine the fees, insurance participation, or patient-responsibility amounts charged by independent providers.

Payment Methods

ROSE OBGYN accepts: Major credit and debit cards - Cash

Payment is expected at the time services are rendered for all amounts known to be the patient's responsibility.

Outstanding Balances & Collection Efforts

Patients are responsible for promptly paying balances remaining after insurance processing.

ROSE OBGYN will make reasonable efforts to notify patients of outstanding balances and provide an opportunity to resolve the account.

Accounts with an outstanding balance that remain unresolved for 90 days may be referred to an outside collection agency. The patient remains responsible for the outstanding balance and any lawful costs associated with collection, when permitted by applicable law and contract.

Unresolved balances may also affect the ability to schedule non-emergency or non-urgent services, subject to applicable law and continuity-of-care requirements.

Insurance Is a Contract Between You and Your Carrier

Although ROSE OBGYN will assist with insurance verification and claim submission, your insurance policy is a contract between **you and your insurance carrier**. It is ultimately the patient's responsibility to understand their coverage, including deductibles, copayments, coinsurance, exclusions, authorization requirements, referral requirements, and limitations.

Insurance coverage does not relieve the patient of financial responsibility for services received.

Patient Acknowledgment

By signing below, I acknowledge that I have read and understand the ROSE OBGYN Financial Policy. I understand that insurance verification or an estimate of benefits is not a guarantee of payment by my insurance carrier.

I understand that I am financially responsible for applicable copayments, deductibles, coinsurance, non-covered services, self-pay services, and any remaining balance determined to be my responsibility after my insurance carrier processes my claim.

I further understand that outside laboratory, pathology, imaging, and other independent services may be billed separately.

Patient Name: _____Date of Birth:_____

Patient/Responsible Party Signature: _____

Today's Date: _____

Relationship to Patient (if applicable): _____

NOTICE OF PRIVACY PRACTICES

https://www.toplinemd.com/practice-terms-policies/

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") provides me with certain rights regarding the privacy of my protected health information. I acknowledge that I have been provided access to the Practice's Notice of Privacy Practices through a QR code and/or website link and have been given the opportunity to review it. I understand that the Practice may revise its Notice of Privacy Practices from time to time and that I may access the most current version by using the QR code and/or website link.

Patient Signature: _____

Patient or Legal Guardian Name (print): _____

Date: _____

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: _____