LIEVANO - PEREZ
OBSTETRICS & GYNECOLOGY OF MIAMI

8525 SW 92 ST, UNIT D13
Miami, Florida 33156
PH (305) 270-3562 Fax (786)384-5766

Acknowledgment of HIPAA Patient Privacy

I designate the following persons listed below as persons presently involved with my healthcare. I agree that the practice may disclose certain or all aspects of my health information and or billing to listed persons. I understand that I am not required to list anyone and that I may update this at any time in person.

1._________________________ __________________________ ______________
Name Relation to Patient Telephone

2._________________________ __________________________ ______________
Name Relation to Patient Telephone

3._________________________ __________________________ ______________
Name Relation to Patient Telephone

I have been presented with and reviewed the terms of this notice. I understand that I may request a copy of this notice at any time.

__________________________ __________ ____________________________ ___________
Patient Name DOB Signature Patient Date

Dr. G. Lievano, Dr. I. Perez & Associates
OB/GYN
8525 SW 92nd St., Unit D-13
Miami, FL 33156
P# 305-270-3562 F# 786-384-5766

Our goal is to provide each patient with friendly and convenient service during your visit. For your convenience during this visit, our office will collect your blood here in the office and send it to the laboratory for processing.

For this service the office will charge an administrative fee of $20.00 for **annual** gynecologic patients and a one-time fee of $40.00 for obstetric patients that will cover any blood handling and processing throughout your current pregnancy and, if needed, post-partum visits. This service is provided as a courtesy to those patients who do not wish to go to their primary care physician or the lab.

If you choose to take advantage of this service, the administrative fee is due at the time the blood is drawn and is non-refundable. The **lab will bill your insurance company** for the tests that are ordered.

Our office **DOES NOT** verify lab benefits. It is Patient responsibility to be aware of their lab coverage as some of these tests may not be covered or applied to your deductible/coinsurance.

There is also an administrative fee of $20 for administering any type of injection (Rhogam, progesterone, etc.)

There is a charge of $30 for any maternity forms or letters and $10 for any type of GYN letter (per letter)

Please indicate if you would like your blood work done today in our office.

YES __________ NO ____________

Patient Signature ____________________________

Print Name _________________________________ Date _____________

*Occasionally a test will be ordered that needs special handling or sample tubes that we do not have available. If so, you will be given a requisition to take to the appropriate facility. No fee will be charged.

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Patient History Record

Diseases: ___anemia ___asthma ___cancer ___diabetes ___depression ___Cardiac Disease ___hypertension ___problems of kidney /bladder ___pulmonary disease ___thyroid issues ___ gastrointestinal Issues

You smoke: ___Y ___N **Packs per day:**_______
You Drink: ___Y ___N **How many alcoholic beverages do you consume daily**:_____________

Allergies:____
____
____
____
____

Current Medications:____
____
____

History of Menstrual:
Your menstrual cycle is normal:__Y __N __ If No
Explain:____
age at which menstruation began:____________ number of days it lasts:____________

History of pregnancy: how many times.....
pregnant:_____ preterm births:_____ deliveries:_____
miscarriages:_____ abortions:_____ living children:_____

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Review of Systems

Patient:____________________________ Date:______________

Do you now or have you had any problems related to the following systems? Circle Yes or No

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N

Other _____________________________

Eyes

Blurred Vision	Y	N
Double Vision	Y	N

Allergy

Hay Fever	Y	N
Drug Allergies	Y	N
Seasonal Allergies	Y	N

Neurological

Tremors	Y	N
Vertigo/Dizziness	Y	N

Endocrine

Excessive thirst	Y	N
Tired	Y	N
Too hot/cold	Y	N

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N

Cardiovascular

Chest pain	Y	N
Hypertension	Y	N

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N

Other_________________________

Musculoskeletal

Joint Pain	Y	N
Extremity Pain	Y	N

Ears/Nose/Throat/Mouth

Ear infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of Breath	Y	N

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting	Y	N

Psychiatric

Depression	Y	N
Anxiety	Y	N

Physician Reviewed:_________________________________

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PLEASE READ CAREFULLY

Dr. Lievano, Dr. Perez, and/or Dr. Collado have ordered blood work that is medically necessary to evaluate your condition. Our office offers lab services to provide the best care possible for our patients. Your blood work is sent to a lab that participates with your current insurance plan. If you have insurance coverage the laboratory will submit a bill directly to your insurance carrier. This is not billed by our office. Deductible, co-insurance and or copay may apply depending on your type of coverage and plan.

You will be responsible for any bills or claims that you receive from the lab. Any billing questions with regards to lab charges must be addressed directly with the lab. Our office staff does not have access or control of your lab account.

This form acknowledges that you are aware that all blood and pathology tests performed may not be covered by your insurance company and you may be responsible for the bill.

Signature of Patient ____

Print Name ____

Date ____