NORTH FLORIDA Gynecology SPECIALISTS, LLC

TopLine MD Alliance

Mary Ellen Wechter, MD, MPH, FACOG

Paulami Guha, MD FACOG

Baptist Medical Pavilion
836 Prudential Drive, Suite 1600
Jacksonville, FL 32207
Phone (904) 399-4862 ▪ Fax (904) 402-8948

Patient Registration and Insurance Information

Patient_____ Date of Birth _____
(Last) (First) (Middle Initial)

Address_____
(Street #) (Apt#) (City) (State) (Zip)

Primary Phone: _____ Secondary Phone: _____

Employer_____ Marital Status _____

Referring Physician _____Primary Care Physician _____

Emergency Contact _____ Relationship_____ Phone # _____

Race: _____ ETHNICITY: Non-Hispanic or Hispanic (Circle one)

How did You Hear About Our Office: _____

Email Address: _____

(If providing, you ARE CONSENTING TO EMAIL CORRESPONDENCE)

PLEASE COMPLETE ALL INSURANCE INFORAMTION

Primary Insurance: _____

Subscriber (Insured) Name_____ Subscriber: Date of Birth_____

ID#_____ Patient Relationship to Insured_____
(Self, Spouse, Child)

Secondary Insurance: _____

Subscriber (Insured) Name_____ Subscriber: Date of Birth_____

ID#_____ Patient Relationship to Insured_____
(Self, Spouse, Child)

Signature _____**Date**_____

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Consent for Medical Information Release

There are times we are asked to give family members or others information on test results, especially if you will not be available to receive them. If you would like for us to give out information regarding your treatment and/or test results to your family or friends, please fill in their name and their relationship to you. **Please designate which type of information each person may receive** by checking the items we may release and any item we should not disclose. Make your own notes, if necessary, for clarification.

Definitions:

All Information: Any and All information we have in our file related to you which may include billing information, appointments, treatment, test results, etc. and information on sexually transmitted disease; HIV/AIDS, birth control, pregnancy and mental health information

Appointment Only: Only information related to appointment dates and times.

STD's/HIV: Information related to sexually transmitted disease including HIV, AIDS, HPV, dysplasia, abnormal paps, herpes, GC, Chlamydia, syphilis, vaginitis, Trichomonas, etc.

Preg/Ab: Information related to pregnancy and abortion.

BC: Information related to preventing pregnancy including birth control pills, diaphragms, condoms, IUD's, etc.

Relationship Name of person allowed	**Type of info which may be released to receive info.**
Mother _____	☐ All info ☐ Appts only ☐ STD's/HIV ☐ Preg/Ab ☐ BC
Father _____	☐ All info ☐ Appts only ☐ STD's/HIV ☐ Preg/Ab ☐ BC
Spouse _____	☐ All info ☐ Appts only ☐ STD's/HIV ☐ Preg/Ab ☐ BC
_____ _____	☐ All info ☐ Appts only ☐ STD's/HIV ☐ Preg/Ab ☐ BC
_____ _____	☐ All info ☐ Appts only ☐ STD's/HIV ☐ Preg/Ab ☐ BC

□ NO INFORMATION TO BE RELEASED

This consent to release information will remain in effect until revoked in writing.

_____ _____ _____

Print Patient's Name | Signature | Date

_____ _____

Staff Witness | Date

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Annual Well -Woman Examination: Financial Consent

Annual Examinations are considered Preventive Care and include:

- Routine health history screening
- Breast and pelvic examinations
- Pap smear and hemoccult screening, if indicated
- Ordering of screening mammogram, bone destiny study, colonoscopy, if indicated
- Contraceptive Counseling
- Refills of annual prescriptions

Any examination, testing or consultation for a specific medical condition or concerns, is considered Outside of the scope of Preventive Care by most insurance companies, and should be addressed at a separate office visit. For your convenience, and if the time permits, our providers will attempt to address all of you concerns or problems while you are already in the office to prevent a return visit, but this will still result in an additional, separate office visit charge to your insurance.

In accordance to your insurance policy, you may be responsible for a copayment, co-insurance, or deductible for the additional office visit.

Non-Preventive care includes: new prescriptions for acute problem, abnormal menstrual cycles, changes in hormone therapy, infertility, and other condition. As a general rule, additional office visits charges are assessed when significant time is spent addressing the problem; and the provider is always willing to discuss whether the problem falls outside normal preventive measures.

I understand this policy and my potential financial responsibility. I understand I am under no obligation to address my non- preventive concerns or conditions today and have the option to schedule a return office visit for further evaluation and a management.

_____	_____	_____
Print Patient's Name	Signature	Date

_____	_____
Staff Witness	Date

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CONSENT FOR PELVIC EXAMINATION

A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum or external pelvis tissue or organs. The procedure is used diagnose and/or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider's gloved hand or instrumentation.

The risk and complications associated with a pelvic examination include, but are not limited to:

- Discomfort
- Bleeding
- Infection

The risk associated with failing or refusing to undergo a pelvic examination include:

- *The inability to obtain a diagnosis and/or delay in diagnosis of a medical condition;*
- *The inability of your health care provider to have information needed to appropriately treat you.*

By Signing this consent, I _____authorize and direct

(***Print Patient's Name)***

North Florida Gynecology Specialists, LLC and my treating GYN physician to perform a pelvic examination as described above. I have read or have had read to me the contents of this form. My provider and I discussed in detail the risks, benefits, alternative and indication for this examination. I understand the risks, benefits, alternatives, and indications of a pelvic examination and all my questions have been answered to my satisfaction. I understand that I may revoke this consent at any time by providing written notice to the office or notice directly to my provider prior to administration of the pelvic exam.

_____

Patient Name/Legal Representative Signature Printed Name and Date

_____

Witness Signature Printed Name and Date

_____

Provider Signature Printed Name and Date

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FINANCIAL AGREEMENT

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have had the opportunity to review a copy of **North Florida Gynecology Specialists, LLC Privacy Notice** dated **September 01, 2013** ("Notice"). I understand that I am responsible to read this Notice and notify **North Florida Gynecology Specialists, LLC**, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand the notice included electronic access to my medication history. **North Florida Gynecology Specialists, LLC** has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times. **North Florida Gynecology Specialists, LLC** will provide me with a copy of its most recent Notice upon my request.

Patient Signature: _____ **Date of Birth:** _____

Parent, Guardian, or Legal Representative Signature: _____

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is **my responsibility** to provide **North Florida Gynecology Specialists, LLC** with a copy of my **current insurance** card and, if required by my insurance, **to obtain a referral** from my Primary Care Physician. **North Florida Gynecology Specialists, LLC** is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. **I will notify North Florida Gynecology Specialists, LLC immediately upon any change to my insurance.**

INSURANCE WAIVER, NON-COVERED SERVICES WAIVER and OUTSIDE LAB SERVICES

I understand that if I do not have a copy of a current insurance card and/or valid referral, **North Florida Gynecology Specialists, LLC** is not obligated to see me. But if I still wish to be seen, I can be seen as a "Private Pay" patient. I agree that neither the LL, nor I, will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan "Non-Covered Services"; I understand I must pay for Non-Covered Services. If feasible, a waiver will be completed for each Private Pay visit or Non-Covered Service. I understand services sent to an outside lab are billed to my insurance or me by the lab and I will receive a separate invoice from the lab.

CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. **North Florida Gynecology Specialists, LLC.**

FINANCIAL AGREEMENT

ANNUAL EXAMS (Including Medicare Annual Visits)

Annual "well-women" exams are preventive visits and are not paid for by all insurance carriers
I understand I am responsible for payment, if the exam or portion of the exam is not covered by my insurance. Annual exams do not typically include problems I may be having – as problem visits may require longer time. If I am experiencing problems, the office may be required to reschedule another visit to address these concerns.

ADDITIONAL INFORMATION

Payment may be made to the LLC in the form of: Cash, Check, Debit and Credit Cards. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to me by **North Florida Gynecology Specialists, LLC.** Patient credits are applied to other outstanding patient balances prior to any refunds that may be issued. I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged if I do not cancel my scheduled appointment, for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of service, for telephone management services, for educational materials, for payment agreements which extend beyond 12 months, and for other administrative expenses not covered by my insurance plan.

ASSIGNMENT OF BENEFITS

For the services rendered by **North Florida Gynecology Specialists, LLC** I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits either to myself or to the party who accepts assignment (**North Florida Gynecology Specialists, LLC**.). I agree to hold **North Florida Gynecology Specialists, LLC** harmless from any and all costs, liability, and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient's Printed name _____

Patient's Date of Birth: _____

Patient's Signature: _____ **Date signed:** _____

Parent, Guardian, or Legal Representative Signature: _____

Employee's signature who reviewed intake of form: _____

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Date: _____

Name: _____ **D.O.B.**_____

Referred by: _____ **Your Occupation:** _____

Reason for visit: Well-Woman screening ***or*** Problem: _____

Pharmacy name, address, phone: _____

Do you have any medication allergies? If yes- list below

Drug	Reaction	Drug	Reaction

List all medicines you take- Include over-the-counter, and herbal/ dietary supplements

Drug	Dose	How often?	Drug	Dose	How often

Menstrual History:

Age of First Period: _____ 1st day of last Period: _____ Regular? Yes/ No
Flow: light / mod / heavy Cycle length start to start: _____# days of bleeding: _____
Postmenopausal? Yes/ No Year of Last period_____

Do you currently have? Circle below

Pelvic pain	Vaginal discharge	Night Sweats/ Hot Flashes
Bleeding between periods	Vaginal irritation	Pain with intercourse
Bleeding after intercourse	Leaking of Urine	Pain with periods
Bleeding after menopause	Night sweats	Other:

Medical History: Do YOU have any of the following?

__Heart disease
__Heart Murmur/ MVP
__High Blood Pressure
__High Cholesterol
__Stroke
__Migraine headaches
__Depression
__Anxiety
__Bleeding disorder
__Deep venous clot
__Pulmonary embolus
__Anemia
__Thyroid disease
__Osteoporosis
__Diabetes
__Kidney problems
__Reflux/ IBS/ Ulcer
__Hemorrhoids
__Colitis/ Crohns
__Hepatitis
__Seizures
__Breast problems
__Abnormal Pap
__Fibroids
__Endometriosis
__Infertility
__Polycystic Ovarian Synd
__STD
__HIV+/ AIDS
__Cancer:
__Hx abnormal Pap-smear
__Other: _____

Name: _____ D.O.B._____

List any surgeries: (*Include any C-Sections*)

Date	Surgery

Pregnancy History

Number of pregnancies: ____ births: ____ miscarriages: _____ abortions_____ children_____

Family history: (Include mother/father/ grandparents/ aunts/ uncles/ siblings/ children)

	Whom?		Whom?	Cancer	Whom and Age dx?
High blood pressure		Birth Defect		Breast	
High cholesterol		Thyroid disorder		Ovarian	
Heart disease		Osteoporosis		Uterine	
Stroke		Alzheimer's		Colon	
Diabetes				Melanoma	
Blood Clots				Other Cancer	

Do you drink alcohol? Never / Occasionally / Daily

Any past or current tobacco use? Never/ Past/ Current **How much?** _____

Any past or current drug use? Never/ Past/ Current **What kind?** _____

Currently sexually active? Yes/ No **With opposite sex** or **With Same sex**

Gender Identity: _____

Current birth control method: None/ Pill / Patch/ Ring/ injection/ IUD/ tubal ligation/condoms/hysterectomy partner has vasectomy/ abstinence/ Natural Family planning

Any current or past abuse, domestic violence, or sexual abuse? No/ Yes

Health Screening: (give date)

Last Pap Smear: _____ Normal or Abnormal

Last Mammogram: _____Normal o Abnormal

Last Bone Density: _____ Normal or Abnormal

Last Colonoscopy: _____ Normal or Abnormal

Last STD/STI Screening: _____ Normal or Abnormal