OBGYN By the Sea

The doctors would like you to know a couple things:

- We ***will*** be notifying you with all results whether they are good or bad.
- We post all ***normal results*** to our ***patient portal.*** You ***will not*** receive a call with normal results.
- You will receive a phone call with any abnormal results. Please make sure your ***voicemail is set up and not full,*** that way we can leave you a message to call us back or a detailed message with results.
- If you prefer that we do not leave your results on your voicemail, we will call the number below and leave a message for you to call the office back.

Please provide the best number to contact you

Name: _____ Date: _____

Number: _____

☐ Leave detailed message on voicemail if applicable

☐ Do not leave detailed message

If you have not heard anything from the office within two weeks (via phone or patient portal) regarding your results please contact the office via patient portal.

If you need non urgent assistance please use the portal. We check the portal once a day Monday- Friday. We get back to you within 36 hours (unless it's over the weekend then we will get back you on the next business day)

Reasons for portal use:

- Access results
- Request refills
- Medical questions
- Request someone to call you back to schedule an appt

The portal ***should not*** be used for any medical emergencies.
If you have an ***Urgent matter*** or need to schedule an appt, please call the office.

OBGYN By the Sea, LLC

Patient Registration form

Patient information

*First Name*_____ *Last Name*_____ *MI*___

*Maiden Name*_____ *Marital status*_____ *Social Security #*_____

*Date of Birth*_____ *Age*_____

*Address*_____

*City*_____ *State*_____ *Zip Code*_____

E-Mail Address _____

*Home Phone*_____ *Cell phone*_____ *work phone*_____

*Occupation*_____ *Language spoken*_____

*Please circle **YES** or **NO** if you prefer to have a Medical Assistant in the room during your exam.*

REFERRING PROVIDER: _____

REFERRAL SOURCE: _____

Emergency Contacts : we may contact in case of an emergency or if we cannot reach you

*Full Name*_____ *Relationship*_____ *Telephone*_____

*Full Name*_____ *Relationship*_____ *Telephone*_____

Pharmacy information

*Name and Address*_____

*Phone number*_____ *Fax Number*_____

*Name and Address*_____

*Phone number*_____ *Fax Number*_____

OBGYN By the Sea, LLC

Thank you for choosing OBGYN By the Sea, LLC as your health care provider. We are committed to your treatment being successful. Please understand that your payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require for you to read and sign prior to any treatment.

ALL COPAYMENTS AND/OR DEDUCTIBLES ARE DUE PRIOR TO YOU VISIT

We accept: cash, check, major credit cards: Visa, MasterCard, and Discover Card

INSURANCE: *we will bill your insurance company for your visit AS COURTESTY TO YOU. Due to the difficulty obtaining payment from your insurance plans, we may ask for your assistance in getting your claim paid. Please be advised that it is the patient's responsibility to verify that we are a participating provider with your insurance plan.*

HMO/ REFERRALS*: it is your responsibility to obtain a referral from your primary care physician if you insurance carrier requires it for your visits. It is the patient's responsibility to know and understand the requirements of their insurance plan. Our office is not responsible to obtain referrals for patients on HMO plans.* ***If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.***

MINOR PATIENTS: *the parent or guardian accompanying the minor is responsible for payment of the bill.*

RETURNED CHECKS*: checks returned for any reason will be subject to all bank fees charged to us along with 5% of the face value of the check or $25.00 administrative fee (Whichever greater).*

COLLECTIONS*: should your account become a collection problem, the patient/ debtor assumes all costs of the 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.*

NON-COVERED SERVICES: *You will be responsible for your payment of services "NOT COVERED" by your insurance plan. It is your responsibility to understand your insurance plan's benefits and/or limitations.*

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY. I herby agree to render payment in the accordance with the terms and conditions set forth.

Patient/Responsible party signature _____ ***Date:*** _____

Print Patient Name: _____

OBGYN By The SEA, LLC

Insurance company information

Primary Insurance Company_____

Name of Insured Party_____ Relationship_____

Payment of Benefits

I understand the doctor does not carry malpractice insurance as stated in the sign posted in the reception area. I authorize payment of benefits, as determined by the company, directly to the physician. I understand that I may still be responsible for any amount not paid by my insurance company.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize the release of any medical information necessary to process my health insurance claim form.

Patient or authorized (print):

_____

Patient or authorized signature:

_____

OBGYN By The Sea, LLC

Notice of privacy acknowledgement

I understand that under the health insurance portability and accountability act (HIPPA), 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

OB/GYN by the Sea, LLC is authorized to disclose my protected health information to the person(s) listed below:

*Name(print)*_____*Phone#*_____

*Name(print)*_____*Phone#*_____

NO-SHOW Policy

- In order to be respectful of the medical needs of our patients, please notify us if you are unable to attend your appointment.
- This opens up availability to those who need to be seen and helps us decrease your waiting times for scheduled appointments.
- Please give us at least 24 hours advanced notice. _____ **Initial**

How to cancel/reschedule your appointment

To cancel/reschedule your appointment please call the office and leave a detailed message

- *954-772-3960*
- *954-467-2013*

If you do not give **24-Hour** notice to cancel or reschedule your appointment, this is considered a **NO-SHOW** and you **will be billed**.

- 50.00 dollars for a visit
- 75.00 dollars for a procedure _____ **Initial**

You will not be allowed to make another appointment until the no-show fee is paid in full. _____ Initial

Name: _____ **Date:** _____

Signature: _____

We are excited about our New Patient Portal.

Here is why..

1. It is quick and easy
2. You can see your **normal Lab results**
3. You can request **prescription refills**
4. You can ask the staff a **question**

Here are some things you should know

1. This does not replace your office visits or consultations with your Doctor, but it improves communication with the office and thus your overall experience.

2. We do not post all results to the portal. It is up to the Doctor what is posted

3. If there is any abnormality you will receive a phone call.

And most importantly

4. This should **not** be used for any **medical emergency or urgency** as these questions will be answered within **48 hours.**

We hope you are as excited as we are!
Please make sure your **email address** is correct and look out for a welcome email to get started!

If you prefer not to use this portal please let the front desk know.

Patient name: _____ Date: _____
Patient Signature: _____

OBGYN By The Sea, LLC
265 Commercial Blvd, Lauderdale By Sea, FL 33308
954-772-3960/954-772-3893

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I – Authorization

I,_____, give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II - Health Information

I would like to give the above healthcare organization permission to:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information:
- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Disclose Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other: _____

_____

_____

Form of Disclosure:

☐ Electronic copy or access via a web-based portal
☐ Hard copy

Section III – Reason for Disclosure

Please detail the reason(s) why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

_____

_____

This document will be retained by the providing organization for seven years

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s):

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s)listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

☐ From _____ to _____

Or

☐ All past, present, and future periods

Or

☐ The date of the signature in section VI until the following event: _____

_____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

This document will be retained by the providing organization for seven years

OBGYN By The Sea, LLC
265 Commercial Blvd, Lauderdale By Sea, FL 33308
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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section VI – Signature

_____ _____
Print Patient Name Date

_____
Signature

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form: _____

_____

_____

This document will be retained by the providing organization for seven years.

NEW PATIENT

1) REASON FOR VISIT:

2)CURRENT MEDICATION:

3)MEDICAL HX:

- ALLERGIES TO MEDICATION?
- PERIODS:
- COLONOSCOPY:
- BONE DENSITY:
- HPV VACCINE:
- DIAG MAMMO:
- SEXUALLY ACTIVE:

4)LAST PAPSMEAR: ANY HX ABNORMAL PAP?

5) LAST MAMMOGRAM: RESULTS?

6)LAST MENSTRUAL PERIOD:

7) ANY STD IN THE PAST? IF YES WHICH ONE?

8)TAKING ANY BIRTH CONTROL? IF YES WHICH ONE?

9)AGE OF YOUR FIRST PERIOD:

10)MENOPAUSE: IF YES AT WHAT AGE BEGAN?

11)ABNORMAL MENST:

12)HYSTERECTOMY: IF YES TOTAL OR PARTIAL?

13) TOTAL PREGNACY: VAGINAL? C SECTION?

MONTH: YEARS:

14)FAMILY HX: ANY CANCER, DIABETES ETC?

15)ANY SURGERY: IF YES WHEN AND WHAT TYPE OF SURGERY?

16) SOCIAL HX:

- DRINK?
- SMOKE?

SEE THE BACK

MISCELLANEOUS:

- LEVEL EDUCATION
- ANY HX DOMESTIC VIOLENCE?
- EXERCISE?
- MARITAL STATUS?
- ANY HX SEXUAL ABUSE?
- ANY HX VERBAL ABUSE?

SEE THE BACK

MYRIAD myRisk® Hereditary Cancer

Cancer Family History Questionnaire

Personal Information

Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based on your personal and family history of cancer. **The following blood relatives should be considered:** Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family. (For cancer sites with a 'first-degree relative' notation, only parents, siblings, and children should be considered.)

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, ovarian, or **pancreatic cancer** at any age	☐ Y ☐ N		
Colorectal or **uterine cancer** at 64 or younger	☐ Y ☐ N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Two different **breast cancers** in one relative at any age	☐ Y ☐ N		☐ M ☐ P	
Three **breast cancers** in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with **breast cancer** at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age (1st-degree relative)	☐ Y ☐ N		☐ M ☐ P	
Metastatic prostate cancer at any age (1st-degree relative)	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at 49 or younger (1st-degree relative)	☐ Y ☐ N		☐ M ☐ P	
Uterine cancer at 49 or younger (1st-degree relative)	☐ Y ☐ N		☐ M ☐ P	
Three **colon** and/or **uterine cancers** on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	**Who?**	**What gene(s)?**	**What was the result?**

Cancer Risk Assessment Review (to be completed after discussion with your healthcare provider)

Patient Signature _____ Date _____

Healthcare Provider Signature _____ Date _____

Office Use Only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No ☐ Accepted ☐ Declined

If yes, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis*® REFLEX to BRAC*Analysis*® with Myriad myRisk®
☐ COLARIS®PLUS with Myriad myRisk® ☐ COLARIS *AP*®PLUS with Myriad myRisk® ☐ Single Site Testing ☐ Myriad myRisk® Update Test
☐ Other: _____

Follow-up appointment scheduled? ☐Yes ☐No Date of next appointment: _____