OB-GYN Health Center of Volusia, LLC

769 N. Clyde Morris Blvd | Daytona Beach, FL 32114
533 N. Clyde Morris Blvd | Daytona Beach, FL 32114
Phone: 386-258-0123 | 386-258-6464
obgynhealthcenter.org

Welcome to OB-GYN Health Center of Volusia, LLC

We are honored that you have chosen our practice for your obstetric and gynecologic care. Our physicians, nurse practitioners, and dedicated staff take pride in building lasting relationships with our patients while providing compassionate, high-quality care through every stage of a woman's life.

Our medical team includes:

John Meyers, M.D., F.A.C.O.G | Christine DaSilva, M.D., F.A.C.O.G | Cynthia Baldwin, M.D., F.A.C.O.G | Kelcey Day Carson, M.D. | Stacey McKinnon, APRN | Kayla Norwood, APRN

Office Hours
Monday – Thursday: 8:00am–12:00pm and 1:30pm–4:30pm
Friday: 8:30am–12:00pm and 1:30pm–4:00pm

If you need to reach the doctor on call after hours, please call **386-258-0123**, and our answering service will notify the provider on call.
In case of an emergency, please go to the **nearest Emergency Room**. Please note that our physicians provide hospital care exclusively at **Halifax Medical Center**. If you are treated at another hospital, the attending physicians at that facility will provide your care.

New Patient Guidelines

Please plan to arrive **30 minutes prior** to your scheduled appointment to complete the registration process. A **valid photo ID** is required. If we participate with your insurance plan and we will be filing your claim, please bring your **insurance card (front and back)** to ensure accurate processing.

Patient Portal

We encourage all patients to enroll in our **secure Patient Portal using Healow App.** Through the portal, you can:
Access lab results, test results and visit summaries

Portal Access Information: You will be sent a link after your initial appointment providing instructions for first-time login and an access code.

Unexpected change in scheduled appointments

Given the nature of obstetrical care, there are times when urgent situations may arise. Should this happen, we appreciate your understanding if we need to reschedule your appointment or arrange for you to be seen by another provider. Please know that your care remains our priority.

We are honored that you have entrusted us with your care and look forward to serving your healthcare needs.

Sincerely,
The Providers and Staff at OB-GYN Health Center of Volusia, LLC

OBGYN HEALTH CENTER OF VOLUSIA, LLC

REGISTRATION FORM

(Please Print)

Today's date:_____

PATIENT INFORMATION

Patients Name: (last --- first --- middle initial)		Birth Date: _____/_____/_____		Social Security: _____-_____-_____
Preferred Name:	☐ Female ☐ Male (Pronouns): _____	Email:		
Street address:		City:	State	Zip Code:
Cell Phone:	Home Phone:	**Are you okay with receiving Text Messages:** _____**YES** _____ **NO**		
Employer:	Employer Phone Number:	Occupation:		
Pharmacy:		**Pharmacy Phone Number / Address:**		
Previous GYN: (In the Last 3 Years) _____ First Name _____ Last Name Phone #:		Primary Care/ Family Doctor: _____ First Name _____ Last Name Phone #:		

INSURANCE INFORMATION

Relationship to patient: ☐self ☐spouse ☐parent ☐guardian	
Insurance Company Name:	Member ID #:
Group Number:	Phone Number:
Name of Policy Holder:	Date of Birth of Policy Holder:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Phone Number:

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all my collection and attorney fees.

Patient/Guardian signature:	Date:

OBGYN HEALTH CENTER of VOLUSIA, LLC

Office Policies & Consent

****Initial after each Policy & Consent****

1. **Insurance Benefits:** Payment is expected at the time of service. This includes copays, co-insurance, and any remaining deductibles. **Please note**, all benefit information is provided to us by your insurance company. If there are any discrepancies with your benefits, we ask that **you** contact your insurance company. _____ **Initial**

2. **Financial Responsibility**: Upon checking in, our staff will inform you of your financial obligation for your appointment as well as any past due balances. Payment at that time will be requested. _____ **Initial**

3. **Delinquent Accounts:** Our office makes reasonable financial arrangements with our patients. These arrangements must be made with our billing/insurance department. If you have not made a financial arrangement and/or have not made an attempt to pay your obligation, your account will be placed in a collection status. Your account will be turned over by the practice to a debt collector. A fee in the amount of **35% of the total amount due**, will be added to your outstanding balance. _____ **Initial**

4. **No-Show Policy:** Our office enforces a "No-Show" policy. We ask that if you must cancel your appointment that you kindly give us a 24-hour notice. **New Patient appointment** "No-Show" fee is **$50.00**. **Established Patient appointments** "No-Show" fee is **$25.00**. The "No-Show" fee is required to be paid before another appointment can be scheduled. _____ **Initial**

5. **Surgical Fees:** At the time your procedure/surgery is scheduled, our office will notify you of your estimated financial obligation. Your obligation is expected to be paid in full no later than your pre-op visit. Failure to pay your portion may result in your procedure/surgery being rescheduled. _____ **Initial**

6. **Insurance Processing:** Our office will file primary insurance plans ONLY. If you are submitting your own claim, you will be given the information needed when you check out to forward to your insurance company. _____ **Initial**

7. **Medical Records:** There is a $1.00 per page fee for the first 25 pages, and $0.25 for each additional page. Allow 72 hours for your request to be fulfilled. Medical Record Request forms (From us & To us) can be printed from our website; ***obgynhealthcenter.org*** _____ **Initial**

8. **Completion of Other Entity Forms**: There is $10.00 Administration fee for each form. The fee is to be paid prior to completion of forms. ***Example: FMLA, Disability, etc.*** _____ **Initial**

9. **Consent:** I hereby consent to a medically indicated physical examination. This may include but is not limited to a pelvic examination. This consent will remain active until I withdraw my consent in writing. _____ **Initial**

10. **Consent to receive Healthcare communication by Telephone, Email and Text message:**
    I give consent to receive electronic communication about my Healthcare. It may include, but is not limited to, appointment reminders, test results, prescriptions, account information and medical treatment. _____ **Initial**

I certify that I have read and understand the above Office Policies & Consent to each.

_____ _____ _____

Patient/Guardian Printed Name **DOB** Date

_____

Patient/Guardian Signature

OBGYN Health Center of Volusia, LLC
Notice of Privacy Practices

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 been provided the opportunity to access your Notice of Privacy Practices by either obtaining it from your office directly, or from your website at https://www.toplinemd.com/obgyn-health-center-of-volusia/ .

_____ _____

PRINT - Patient Name or Legal Guardian DOB

_____ _____

Signature Date

Office Use Only

We have provided information to the patient on how to obtain a copy of our Notice of Privacy Practices. If the attempt to obtain the patient's acknowledgement signature is unsuccessful, staff member is to complete the below.

_____

Reason (if given) for patient not signing acknowledgement

_____ _____

Staff Name Date

Authorization to Discuss Patient's Medical Information

OBGYN HEALTH CENTER of VOLUSIA, LLC

John Meyers, M.D. Christine DaSilva, M.D. Cynthia Baldwin, M.D. Kelcey Day Carson, M.D.
Stacey McKinnon, APRN Kayla Norwood, APRN

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P 386-258-0123

Date: _____

I, _____, _____ give permission to **OBGYN Health Center**
Patient Name Printed DOB

to discuss my medical information with:

_____ _____
Name (Print) Relationship

_____ _____
Name (Print) Relationship

I understand that this Authorization to Discuss my Medical Information expires twelve (12) months from the date of my signature.

_____
Expiration Date: Month/Day/Year

_____ _____ _____
Patient Name Printed DOB Patient Signature Date

_____ _____
Witness Date

Y:authdiscusspt
REV 10/25