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 | Sarah Bruce, APRN

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

For after-hours calls, contact our office at **(386) 258-0123**. Our answering service will notify the physician on call.

In an emergency, call 911 or go to the nearest emergency room.

Our physicians provide hospital care exclusively at **Halifax Health Medical Center**. If you are admitted to another hospital, your care will be provided by the attending physician at that facility.

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	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

Carefully read each Office Policy below, and *Initial each as your *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. **Credit Card Payments**: A 3% convenience fee will apply to **all** credit card payments. This does not apply to debit cards, HSA cards or FSA cards. Refunds for credit card payments will be issued to the original card used for payment whenever possible; otherwise, a refund check will be issued. _____ **Initial**

4. **Delinquent Accounts:** Our office makes reasonable financial arrangements with our patients. This must be arranged 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 35% fee will be added to your delinquent outstanding balance**. _____ **Initial**

5. **No-Show Policy:** Our office enforces a "No-Show" policy. If you must cancel your appointment, we ask that you kindly give us 24-hours' notice. **New Patient appointment** "No-Show" fee is **$50.00**. **Established Patient appointment** "No-Show" fee is **$25.00**. The "No-Show" fee is required to be paid prior to another appointment being scheduled. _____ **Initial**

6. **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**

7. **Insurance Processing:** Our office will file primary insurance plans ONLY. If you submit your own 2ndary claim, you will be given the information needed when you check out, to forward to your insurance company. _____ **Initial**

8. **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**

9. **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**

10. **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**

11. **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, insurance information and medical treatment. _____ **Initial**

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

_____ _____ _____

Patient/Guardian Printed Name **DOB** Date

_____

Patient/Guardian Signature

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: _____

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 Sarah Bruce, 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 6-2026