Patient Registration Form

(Reason for visit) _____

Patient _____ _____ _____
(Last Name) (First Name) (Middle)

_____ _____ _____ _____
(Primary Street Address) (City) (State) (Zip)

_____ _____ _____ _____
(Secondary Street Address) (City) (State) (Zip)

_____ _____ _____ _____
(Home Phone) (Cell Phone) (Date Of Birth) (Mar. St.-S/M/D/W)

E-Mail Address: _____

_____ _____ _____ _____
(Referring Physician) (Primary Care Phys. – if applic.) (Primary Language) if other than English (Race-Wh/Bl/His/As/Oth)

First Day of Last Menstrual Period: _____

Patient Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____ Relationship_____

Pharmacy: _____ Pharmacy Phone number: _____

PRIMARY INSURANCE: (1)_____ SECONDARY INSURANCE:(2)_____

Primary Policyholder NAME: _____ Primary Policyholder NAME: _____

Patient RELATIONSHIP to Policyholder: _____ Patient RELATIONSHIP to Policyholder: _____

Certificate / ID # _____ Certificate / ID # _____

GROUP # _____ Plan Type _____(PPO/HMO/Other) GROUP # _____ Plan Type _____(PPO/HMO/Other)

D.O.B of Policyholder _____ D.O. B of Policyholder _____

INSURANCE PHONE # on Card_____ INSURANCE PHONE # on Card _____

GUARANTOR (Responsible for Bill) (__) Self (__) Spouse (__) Parent Guarantor Name_____

Guarantor Address_____ Guarantor Phone_____

Guarantor Employer_____ Employer Address_____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION: I hereby assign all medical and/or surgical benefits including Medicare, Medicaid, Private Insurance and other health plans to Partners in Women's Health.

I hereby also authorize assignee to release all information, including HIV test results to secure payment. I understand I am financially responsible for all charges whether or not paid by insurance and will be held responsible for all collection costs and associated legal fees should it become necessary to secure payment for services rendered. I am aware that finance charges will accrue on balances older than 30 days once they have been transferred to the patient's responsibility.

A photocopy of this assignment is considered as valid as an original and this assignment and release will remain in effect until revoked by me in writing and delivered to Partners in Women's Health.

_____ _____ _____ _____
Signature of Patient Date Signature of Guarantor/Insured Date

Patient History & Physical Form

Patient _____ Age _____ Birthdate _____
(Last) (First) (Middle)

Current Medications _____

Drug Allergies _____

Check if you (describe usage): ☐ Smoke ☐ Drink ☐ Use Marijuana / Other Drugs _____

Surgeries, Illness, And /Or Injuries _____
_____

Menstrual Periods: Last Period Date Was _____. Period comes every _____days and flow lasts____ days.

Period began at age____. Periods are ☐ Regular or ☐ Irregular Problems: _____ ☐ Gardasil

BIRTH CONTROL: _____ DATE OF LAST PAP SMEAR _____ LAST MAMMOGRAM_____

LIST ALL PREVIOUS PREGNANCIES AND BIRTHS (PLEASE INCLUDE ANY MISCARRIAGES AND/OR ABORTIONS)

Infant Birthdate	Sex:	Infant Birth Weight:	Length of Pregnancy	Length of Labor	Complications

CHECK IF YOU HAVE A PERSONAL HISTORY OF ANY OF THE FOLLOWING:

- ☐ Abnormal mammogram
- ☐ Abnormal pap smear
- ☐ Abnormal vaginal bleeding
- ☐ Abuse- Sexual / Physical
- ☐ Acne
- ☐ Alcoholism
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Anemia
- ☐ Blood Clots
- ☐ Blood Transfusion
- ☐ Breast Disease
- ☐ Cancer
- ☐ Cholesterol elevation
- ☐ Constipation
- ☐ Depression
- ☐ Diabetes / low blood sugar
- ☐ Diarrhea
- ☐ Diverticulosis
- ☐ Drug Dependency
- ☐ Emotional problems
- ☐ Endometriosis
- ☐ Epilepsy / seizures
- ☐ Eye problems
- ☐ Fainting
- ☐ Gallbladder problems
- ☐ Headaches
- ☐ Heart problems
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ High blood pressure
- ☐ HIV testing
- ☐ Intestinal problems
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Menstrual period pain
- ☐ Neurologic problems
- ☐ Ovarian tubal infections
- ☐ Pain with intercourse
- ☐ Pelvic / abdominal pain
- ☐ Pelvic inflammatory disease
- ☐ Respiratory problems
- ☐ Rheumatic / scarlet fever
- ☐ Sexual problems
- ☐ Stroke
- ☐ Sickle cell anemia
- ☐ Thrombophlebitis
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urinary tract infections.
- ☐ Urinary incontinence
- ☐ Varicose veins
- ☐ Vaginal discharge
- ☐ Vaginal infections
  - ☐ Chlamydia ☐ Trichomonas
  - ☐ Gonorrhea ☐ Warts
  - ☐ Herpes ☐ Yeast
  - ☐ Syphilis ☐ Other
- ☐ Vomiting
- ☐ Other

CHECK IF YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING

- ☐ Alcoholism
- ☐ Cancer _____
- ☐ Congenital problems _____
- ☐ Adopted
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Lung disease
- ☐ Mental illness
- ☐ Other _____

PROVIDER NOTES:

RELEASE OF INFORMATION

In accordance with the Health Insurance Portability and Accountability Act: of 1996 (HIPAA), we are required to obtain authorization before releasing written or verbal information regarding any patient. Please fill out the below form accordingly. We thank you for your help and understanding.

I, _____ authorize Partners in Women's Health of Jupiter, LLC and its staff to release information regarding my condition to the following people.

1) _____

2) _____

3) _____

3) _____

(Note; Include everyone's name that you are allowing for us to release information to including, but not limited to: yourself, spouse, child, referring/other physicians, relatives or friends. If the name is not listed above, we are unable to speak or release information to them.)

Also, in the event that l am not home, with regards to test results such as. Bloodwork, Biopsies, etc.

Please DO leave messages on my cell phone Y N (circle one)

Please DO leave messages on my work phone Y N (circle one)

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have reviewed and/or received the Privacy Notice.

_____ _____

PATIENT (or Personal Representative) SIGNATURE DATE

If the personal Representative's signature, please describe the relationship, to the patient:

_____

Jeffrey M. Litt, M.D., FACOG
Marc A. Kaufman, M.D., FACOG
Anthony Shaya, M.D., FACOG
Laura Alsina-Sanchez, M.D., FACOG
Elise Gershman, M.D., FACOG
Sandra Diaz M.D., FACOG
Ann Patrice (Pat) Casale, A.R.N.P.
Kylie Steele, DNP, APRN, FNP-C

550 Heritage Drive, Suite 203
Jupiter, FL.33458
(561) 354-1515

INSURANCE WAIVER

All services that we provide for you in our office will be billed to your insurance company. Any services not paid by your insurance company will be your patent responsibility.

Due to the magnitude of changes within the insurance companies we are unable to pre-verify benefits for all gynecological and/or diagnostic services. Patients need to be aware of their own insurance benefits and what will be covered by their plans.

In addition, it is the patient's responsibility to be sure that we are participating with their insurance plan.

I hereby accept and understand the above waiver.

Patient Name

Date

Signature Of Patient

IMPORTANT NOTICE UNDER FLORIDA STATUTE LAW 458.320 PLEASE READ THIS IMPORTANT DOCUMENT AS THESE ARE YOUR RIGHTS UNDER FLORIDA STATUTE LAW 458.320

Dear Patient:
Under Florida Law statute (458.320 F. S), physicians are generally required to carry medical malpractice insurance or demonstrate financial responsibility to cover potential claims for medical malpractice. OUR PROVIDERS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida Law under certain conditions. Florida Law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising (458.320 F. S).

This document MUST BE SIGNED AND WITNESSED before you initiate or continue under the care of your physician.

Note: No treatment can be provided by your physician before this form has been read and signed. This form is provided to protect your rights under Florida Statute 458.320.

I, _____ have read this document and acknowledge and understand its content.

Signature _____ Date _____

Witness _____ Date _____

Copy available upon patient request.

COPY OF STATUTE PROVIDED ON REQUEST OR SIGNS CONCERNING THE FLORIDA STATUTE LAW 458.320 ARE POSTED IN OUR OFFICE.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for electronic copies of their PH| contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format.

Covered entices may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHl.

Right to Inspect and Copy. You have a night to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing. We are not required to agree to your request, If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Dan Williams. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Dan Williams, Director. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying “Acknowledgement” form

550 Heritage Drive, Suite 203
Jupiter, FL 33458
Office: (561) 354-1515
Fax: (561) 354-1516

Notice of Privacy Acknowledgement

l understand that under the Health Insurance Portability and Accountability Act (HIPAA), 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

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:_____

PELVIC EXAMINATION INFORMED CONSENT

I understand by law my health care practitioner requires written informed consent to perform a Pelvic Examination on me. I have been informed that I may be receiving a Pelvic Examination.

Description of the Examination

A "Pelvic Examination" means an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combinations of modalities which may include, but may not be limited to, the health care provider's gloved hand or instrumentation.

I have been informed as to the nature and process of the Pelvic Examination. I have been informed that multiple pelvic examinations may be conducted during the course of my care and treatment. Any and all questions have been answered to my satisfaction.

I hereby GIVE MY INFORMED AND VOLUNTARY CONSENT to receive a pelvic examination.

Patient Name or Legal Guardian (print) Date

Signature

To the Patient: Welcome to our practice. At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedure as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended surgical, medical or diagnostic procedure to be used. You may then decide whether or to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. A medically indicated examination including but not limited to a pelvic exam. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, or the designee as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice or one that has been identified. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure (s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient

Date