

Date _____
Fecha _____

Patient Registration Registración del Paciente

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

Patient Information - Información del Paciente

Social Security # _____
Numero de Seguro Social

First Name _____ Middle _____
Primer Nombre Segundo Nombre

Last Name _____
Apellido

Sex _____ Date of Birth _____ / _____ / _____
Sexo Fecha de Nacimiento

Marital Status Married Single Divorced Widowed
Estado Civil Casada Soltera Divorciada Viuda

(Check One) Employed Retired Full-Time Student
Marque Uno Empleada Retirada Estudiante Tiempo Completo

Other _____
Otro

Employer _____
Empleador

Home Address _____
Direccion del Hogar

City _____ State _____ Zip _____
Ciudad EstadoCodigo Postal

Email Address _____

Home Phone (_____) _____
Telefono del Hogar

Work Phone (_____) _____
Telefono del Trabajo

Cell Phone (_____) _____
Telefono Celular

Referring Physician _____
Referida Por el Dr:

How did you hear of us? _____
Como usted supo de nosotros?

Insurance Information - Información del Seguro

Please provide your insurance card to the receptionist - Por favor entregue su tarjeta de seguro a la recepcionista

Commercial Medicaid Medicare Other _____

Insurance company _____
Compañía de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado Relación

Policy # _____ Group # _____ Phone () _____
Numero de Poliza Numero de Grupo Telefono

Secondary Insurance Information - Información del Seguro Secundario

Commercial Medicaid Medicare Other _____

Insurance company _____
Compañía de Seguro

Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado Relación

Policy # _____ Group # _____ Phone () _____
Numero de Poliza Numero de Grupo Telefono

Emergency Contact - En Emergencias, contactar a:

First Name _____ Middle _____ Home Phone (_____) _____
Primer Nombre Segundo Nombre Telefono del Hogar

Last Name _____ Work Phone (_____) _____
Apellido Telefono del Trabajo

Spouse / Guarantor / Responsible Party - Esposo / Persona Responsable

Social Security # _____
Numero de Seguro Social

Relationship _____
Relación

First Name _____ Middle _____
Primer Nombre Segundo Nombre

Last Name _____
Apellido

Address _____
Direccion

City _____ State _____ Zip _____
Ciudad EstadoCodigo Postal

Sex _____ Date of Birth _____ / _____ / _____
Sexo Fecha de Nacimiento

DAYTIME PHONE (_____) _____
Telefono durante el dia

EMPLOYER _____
Empleo

ADDRESS _____
Direccion

CITY _____ STATE _____ ZIP _____
Ciudad EstadoCodigo Postal

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos ciertas tarjetas de credito. Su seguro medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsable de los gastos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to S.458.320 (5)(g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida law.

Hemos elegido no llevar seguro de negligencia medica o no demostrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (la ley 5) (g). Florida impone penas contra los medicos de los no-asegurado que no pueden satisfacer los juicios adversos que se presentan de demandas de la negligencia medica. Este aviso esta conforme a la ley de la Florida.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by the physician. I understand that I am financially responsible to the physician for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a el medico todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico.

PATIENT'S / GUARANTOR'S SIGNATURE

DATE

**TODD GOLDBERG OB/GYN
TODD GOLDBERG, D.O., FACOOG
2300 N COMMERCE PARKWAY, SUITE 205
WESTON, FL 33326
954-389-3855**

I, _____ hereby consent to a medically indicated physical examination. This may include but is not limited to a pelvic examination. This will be performed by **Dr. Todd Goldberg**. This consent will remain active until I withdraw my consent in writing.

Print Name: _____

Signature: _____

Date: _____

TODD GOLDBERG, D.O., FACOOG

OB/GYN

2300 N COMMERCE PARKWAY, SUITE 205

WESTON, FL 33326

954-389-3855

Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Todd Goldberg OB/GYN to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Todd Goldberg OB/GYN.

I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am financially responsible for all charges including costs of collection and litigation if necessary.

Date: _____

Signature: _____

Physician Financial Responsibility

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for malpractice. YOUR DOCTOR HAD DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgement arising from claims of medical malpractice. This notice is pursuant to Florida law.

Date: _____

Signature: _____

Medical Malpractice Agreement

Further, I understand that I am entering into a contractual relationship with Todd Goldberg OB/GYN for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Todd Goldberg OB/GYN, I (the patient) and /or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Todd Goldberg OB/GYN.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/ or my representative agree to use ABMS board-certified expert medical witness(es) in the same or similar specialty as Todd Goldberg OB/GYN. Furthermore, I agree that these expert witness(es) will adhere to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case. In further consideration for this, Todd Goldberg OB/GYN, agree to the same stipulations.

Date: _____

Signature: _____

INITIALS _____

TODD GOLDBERG, D.O., FACOOG
OB/GYN
2300 N COMMERCE PARKWAY, SUITE 205
WESTON, FL 33326
954-389-3855

PAYMENT POLICY GYN PATIENTS:

Our office policy regarding copays, deductibles and coinsurance amounts is as follows.

For GYN patients, any copays for that day's services, as well as the lab draw fee are due upon arrival. If benefits have been verified to show that you have any remaining deductible that has not been met and/or coinsurance, then we will pre-collect on that amount that will be due. The minimum amount that we will collect upfront will be \$140.00. If the charges are covered in full by your insurance company once the claim is completely processed, then we will refund you the difference.

The \$10.00 lab draw fee is not billable to insurance and is non-refundable. This is a convenience fee. This is a per visit fee as necessary. If you would rather be given a requisition and go to a lab elsewhere to have your blood drawn, then you must inform the medical assistant prior to having your blood drawn.

If for any reason, we have not pre-collected or if the information that was provided to us by you or your insurance was incorrect, which results in a balance due by you, then the following is the office policy for the balance due:

We would prefer the balance to be paid in full after you receive the first statement from us.

If you should need to make monthly payments, we can accept \$50 monthly for balances that are \$150 or less and \$100 monthly for anything over \$150.00. You can send in a check monthly with your statement or you can set up a recurring payment plan by credit card that is automatically charged by the billing manager at a designated time each month.

If two consecutive statements are sent to you, without a payment on account we will start the collection process.

If you need to make any other payment arrangements, you would need to call the office and contact the office manager to set up a payment plan.

Thank you in advance for your cooperation. We strive to maintain a positive experience with all of our patients.

INITIALS: _____

TODD GOLDBERG, D.O., FACOOG

OB/GYN

2300 N COMMERCE PARKWAY, SUITE 205

WESTON, FL 33326

954-389-3855

ADVANCE DIRECTIVE "LIVING WILL"

Declaration made this _____ day of _____, 20_____.

I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

If, at any time I should have a terminal condition and if my attending physician has determined that there can be no recovery from such a condition and that my death is imminent, I direct that life prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially to process of dying and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort or to alleviate pain.

In the absence of my ability to give directions regarding the use of such life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this declaration shall have no force or effect during the course of my pregnancy.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signature of Declaring

The declaring is known to me and I believe her to be of sound mind.

Witness

Witness