

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 Estado Código Postal

Email Address _____

Home Phone (_____) _____
Telefono del Hogar

Work Phone (_____) _____
Telefono del Trabajo

Cell Phone (_____) _____
Telefono Cellular

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 # _____ Sex _____ Date of Birth _____ / _____ / _____
Numero de Seguro Social Sexo Fecha de Nacimiento

Relationship _____ DAYTIME PHONE (_____) _____
Relación Teléfono durante el día

First Name _____ Middle _____ EMPLOYER _____
Primer Nombre Segundo Nombre Empleo

Last Name _____ ADDRESS _____
Apellido Direccion

Address _____ CITY _____ STATE _____ ZIP _____
Direccion Ciudad Estado Código Postal

City _____ State _____ Zip _____
Ciudad Estado Código 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
603 N Flamingo Road, Suite 351 Pembroke Pines, FL 33028
2300 N Commerce Parkway, Suite 205 Weston, FL 33326
Phone 954-389-3855

Dear Patient:

Congratulations on your pregnancy! Thank you for choosing Todd Goldberg, OB/GYN to care for you during this most important time in your life. We are honored and grateful for your trust in us. Dr. Goldberg and his caring staff look forward to treating you for your pregnancy. A few things to think about as you go through your pregnancy:

- If you have a boy, we offer in office circumcisions for most insurance plans. We feel it is a more personalized service. Please speak with our staff regarding your particular insurance plan.
- We encourage our patients to consider cord blood collection. We have information on several different companies in our office. There is a charge of \$150 for the physician to do the collection. This is not covered by insurance.
- We encourage you to visit our website at www.toddgoldbergobgyn.com for many informative and educational links. You will find valuable and important information on our website.

Again, thank you for choosing TODD GOLDBERG OB/GYN for your obstetrical care. We strive to provide you and your baby with outstanding compassionate care during this important time. You can contact our office at any time with questions or concerns at 954-389-3855.

Patient Name and Date

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

Welcome to Todd Goldberg, OB/GYN. For those of you who have been to our practice before, we appreciate your support and the confidence you have in our practice. To our new patients, we will strive to meet your expectations.

Please be advised that we only deliver and work out of **Memorial Hospital West**. If you seek care at any other hospital than **Memorial Hospital West**, we will be unable to care for you while you are in the hospital.

We cross cover with other physicians.

Although we encourage a strong physician/patient relationship, as a practice we cannot guarantee your provider will be on call at the time of your delivery. Once again, we welcome you to our practice. Please do not hesitate to ask any questions or voice any concerns.

Patient Signature _____ Date _____

Physician/Nurse Signature _____

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

I have been furnished information by Dr. Todd Goldberg, OB/GYN, prepared by Florida Birth-Related Neurological Compensation Association, and have been advised that Todd Goldberg, DO is a participating physician in the program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor, delivery or resuscitation. For specifics on the program, I understand I can contact Florida Birth-Related neurological Compensation (NICA), 1435 Piedmont Drive East, Suite 101, Tallahassee, Florida 32312, 1-800-398-2129. I further acknowledge that I have received a copy of the brochure prepared by NICA.

Dated this _____ day of _____, 20__.

Signature

Name of Patient

Social Security

Attest:

Nurse or Physician

Date

See Section 766.316, Florida Statutes

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

Attention All Obstetrical Patients:

During your pregnancy you may be referred to several different specialists that will consult with us on your care. You will see the perinatologist for genetic testing and ultrasounds. You may see other doctors as your medical history and conditions dictate. However, you will continue to see us as your primary physician during your pregnancy on a regular basis. You will be seen on a monthly basis and then as your pregnancy progresses you will be seen more frequently as your doctor deems necessary. Please make sure to schedule a follow up appointment before you leave our office after each visit. Thank you for allowing us to participate in your care.

Patient Sign and Date

Physician or Nurse Sign and Date

TODD GOLDBERG OB/GYN
TODD GOLDBERG, D.O., FACOG
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 OBSTETRICAL PATIENTS:

For our OB patients, it is our policy to pre-collect any copays, deductible and coinsurance prior to your 32th week of pregnancy. The amount we pre-collect goes into a "bank account" on your account to go towards global maternity. Global maternity is billed AFTER you deliver. We will verify your benefits, and any financial responsibility to be collected will be explained to you as soon as possible.

The \$20.00 lab fee covers all of your blood drawing fees here in the office during your pregnancy. It is a convenience fee and non-billable to your insurance company and non-refundable. If you choose to take a requisition to have your blood drawn at an outside lab, then that will be in force for your entire pregnancy. Should you change your mind, you will be charged the \$20.00 fee.

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:

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, then you **MUST CONTACT** the office manager to set up a payment plan. We would typically require at least half the balance to be paid and then a minimum monthly payment arrangement. This is discussed on an individual basis per patient due to the typically larger balance of obstetrical patients.

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

CONSENT TO HIV-1 ANTIBODY TESTING IN PREGNANCY

The purpose of the test, its potential uses, and the limitations and the meaning of the results have been explained to me. I understand that if the results indicate that my blood contains antibody to HIV, it means that I may have been infected with the HIV virus, which is believed to cause AIDS (acquired Immune Deficiency Syndrome)

AT FIRST PRENATAL VISIT

- I authorize my healthcare providers to collect one or more blood specimens from me at the time of my first prenatal visit in order to detect whether or not I have antibodies in my blood to HIV-1 (human immunodeficiency virus). This is the virus which has been associated with AIDS (Acquired Immune Deficiency Syndrome). I understand that my physician will report the test results to me in person and not by telephone or mail. At that time, I will have the opportunity to receive counseling about the meaning of the test results, the possible need for retesting, and other matters. Information regarding measures for the prevention of exposure to, and transmission of HIV has been made available to me.

Consent to Release

I understand that the test results will be confidential and will not be disclosed to any person without my consent unless permitted or required by law. I hereby consent to the release of the test results to All Women's Healthcare of Southern Florida. I understand All Women's Healthcare of Southern Florida will comply strictly with the law regarding access by All Women's Healthcare of Southern Florida employees to the test results. I also consent to the release of the test results to _____

REFUSAL OF HIV-1 ANTIBODY TESTING

With the information presented above having been explained to me completely and clearly in the language I understand, all of my questions having been answered with full knowledge of the consequences, I refuse to give my consent for HIV testing.

Patient Signature

Date/Time

Witness

Name of Patient (please print)

IN THIRD TRIMESTER

- Authorization for Repeat HIV Testing in Third Trimester of Pregnancy**
I authorize my health care provider to repeat the testing for sexually transmitted diseases and HIV later in this pregnancy. This consent for repeat testing is limited to the course of my current pregnancy. I understand that my health care provider will discuss testing with me before the retest is performed and will provide me with the test results.
- I Decline Repeat HIV Testing in Third Trimester of Pregnancy**
With the information presented above having been explained to me completely and clearly in the language I understand, all of my questions having been answered with full knowledge of the consequences, I decline repeat testing for sexually transmitted diseases and HIV later in this pregnancy.

Patient Signature

Date/Time

Witness

Name of Patient (please print)

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