STROGOLO
OBSTETRICS & GYNECOLOGY

14540 Old St. Augustine Rd., Suite 2391
Jacksonville, FL 32258
904.647.6946

Patient's Name: _____ DOB: ____/____/____ Age: _____ Race: _____

Referred by: _____ Primary Care Physician: _____

Reason for Appt: _____ Pharmacy: _____

_____ Gender: _____

Allergy/Reaction: _____

(Please list anything you are allergic to and the reaction it causes. MEDICATION AND CONTACT ALLERGIES INCLUDED)

Medication & Dosage: _____

_____

_____

Vaccinations: FLU VACCINE _____ TETANUS _____ HEPATITIS SERIES _____ HPV VACCINE _____ PNEUMOVAX _____

Past Medical History: Have you ever had any of the following illnesses? Circle Yes or No

Y N Have you ever had a blood transfusion?

Y N Are you willing to have a blood transfusion to save your life?

Y N Have you ever had an abnormal Pap Smear? If yes, treatment _____ Year: _____

Y N	Heart Trouble	Y N	Osteoporosis	Y N	Diabetes	Y N	Gonorrhea
Y N	Kidney/Bladder Problem	Y N	Fibroids	Y N	Blood Disorders/Clots	Y N	Hepatitis
Y N	High Blood Pressure	Y N	Pelvic Prolapse	Y N	Breast Discharge/Problem	Y N	HIV
Y N	Low Blood Pressure	Y N	Depression	Y N	Hemorrhoids	Y N	Genital Herpes
Y N	Thyroid Problem	Y N	Endometriosis	Y N	Anesthesia Problems	Y N	Genital Warts
Y N	Rectal Bleeding	Y N	Seizures	Y N	Heart Murmur/MVP	Y N	Syphilis
Y N	Stomach Trouble	Y N	Anemia	Y N	Antibiotic for dental work	Y N	HPV
Y N	IBS	Y N	High Cholesterol	Y N	Polycystic Ovarian Syndrome	Y N	Cancer:_____
Y N	Ulcer	Y N	Anxiety	Y N	Chlamydia	Y N	Other:_____

Surgical History: Please list all surgeries including hospitalizations (not related to pregnancy)

Date	Procedure

Pregnancy History: ___ # of pregnancies ___# live births ___#miscarriages ___#abortions ___#living children

Date	Delivery Type (vaginal/cesarean)	Weeks	Sex	Lbs/Oz	Complications

Social History

Marital History: (Circle One)	Single Married Separated Divorced Widowed		
Alcohol Use: Never/ Daily / Social/ Rare / _____ # drinks _____ daily/wk/month	Use of Tobacco: Never/ Current / Past _____cigs/day	Use of drugs in past 12 months: Y / N Type of drug? _____	Hx of domestic violence: Y N Past / Current? Do you have a safety plan? Y N
Hx of sexual abuse: Y N	Birth Control Method:	Exercise: Y N #/wk	

Gyn History

1st Day of LMP:	Cycle Length:	Cycle: Regular / Irregular	Flow: Light / Mod / Heavy
Last Pap: _____ Normal / Abnormal	Last Mammogram: _____ Normal / Abnormal	Last Bone Density: _____ Normal / Abnormal	Last Colonoscopy: _____ Normal / Abnormal
Age Menses Began:	Sexually Active: Y N	# of partners:	Sexual Orientation: Men / Women / Both

Family History: Please list illnesses of these family members: Mother/Father/Children/Siblings/Grandparents

		Cancer Type	Family Member/Age			
Y	N	Breast Cancer		Y	N	Heart Disease. Who? _____
Y	N	Uterine Cancer		Y	N	High Blood Pressure. Who? _____
Y	N	Skin Cancer		Y	N	High Cholesterol. Who? _____
Y	N	Ovarian Cancer		Y	N	Blood Disorder. Who? _____
Y	N	Colon Cancer		Y	N	Diabetes. Who? _____
				Y	N	Thyroid Disease. Who? _____

Other Significant Family History: _____

Patient Information (PLEASE PRINT)

Name_____ Date of Birth_____ SSN _____

Home Phone_____ Cell Phone_____ Work Phone_____

Address_____ Apt/Unit #_____

City_____ State_____ Zip_____

Email Address_____

Employer_____Occupation_____Marital Status _____ Race_____

MINORS ONLY Mother's Name_____ Phone_____
Father's Name_____ Phone_____
Guarantor's Name (who is financially responsible) _____ Relationship_____

Emergency Contact
Name_____ Phone_____Relationship_____

Insurance Information
Primary Insurance_____ Policy ID_____ Group_____
Subscriber's Name_____ Date of Birth_____ SSN _____
Employer_____ Relationship to Patient _____

Secondary Insurance_____ Policy ID_____ Group_____
Subscriber's Name_____ Date of Birth_____ SSN _____
Employer_____ Relationship to Patient _____

Primary Physician
Name_____ Phone_____
Address_____ City, State, Zip_____

Pharmacy
Name_____ Phone_____
Address_____ City, State, Zip_____

CONSENT FOR TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure(s) to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment which may include but is not limited to a pelvic examination. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue 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 recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, which may include but is not limited to a pelvic examination. This consent will remain active until I withdraw my consent in writing. 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_____ Date_____

Printed Name_____ Relationship (if other than the patient) _____

Authorizations and Acknowledgments

We are committed to providing the best possible care and we are committed to discussing our professional fees at any time. We gather all information and demographics for the purpose of treatment, to keep accurate medical records and/or for the timely payment from your insurance company. All new patients are asked to provide patient information prior to being seen by the physician and/or midlevel practitioner.

_____ **(please initial)** Trogolo Obstetrics and Gynecology, LLC charges to complete forms, such as but not limited to: FMLA, disability and other forms relating to outside the office of Trogolo Obstetrics and Gynecology, LLC. The charge is $25 per form. Please allow 7-10 business days to complete forms and payment must be made prior to forms being completed.

_____ **(please initial)** We will verify your insurance to determine any copays, deductible and/or coinsurance due at the time of service. Payment will be collected at the check-in window and is only an estimate of what is due. Your insurance will determine your final responsibility at the time your claim is processed. All payments are due at the time of service.

_____ **(please initial)** Trogolo Obstetrics and Gynecology, LLC charges a "no show" fee of $35. Please kindly give our office a 24-hour notice of an appointment cancellation to avoid a charge.

_____ **(please initial)** Trogolo Obstetrics and Gynecology, LLC charges a $40 return check fee. If your check is returned for any reason, this fee will be assessed. This fee, in addition to the original amount must be paid with cash or credit/debit card within 15 days after notification from our office. If this is not paid, you understand that your retuned check will be sent to the State Attorney's office for collection.

I understand that I am directly and primarily responsible to Trogolo Obstetrics and Gynecology, LLC for is customary fees for the services rendered to me. I realize that if my insurance company fails to pay or there is any delay in payment to Trogolo Obstetrics and Gynecology, LLC, it is my responsibility to pay the office directly. I further understand and agree that if I fail to make timely payments to Trogolo Obstetrics and Gynecology, LLC, that I will be responsible for any reasonable cost of collections, including filing fees as well as any reasonable attorney fees.

For the services rendered by Trogolo Obstetrics and Gynecology, LLC, I authorize the release of any information, medical or otherwise, necessary to process claims to my insurance carrier. This may include the diagnosis and records pertaining to the course of examination or treatment. I also request payment of government benefits either to myself or the party who accepts assignment such as, to Trogolo Obstetrics and Gynecology, LLC. I authorize payment of medical benefits to the physician that submits the claim. I agree to hold Trogolo Obstetrics and Gynecology, LLC harmless from any and all cost, liability and damages whatsoever- including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this content.

I understand the office may employ a mid-level provider (Advanced Practice Registered Nurse, Midwife or Physician Assistant, and if I am scheduled with them, I am willing to see them instead of seeing the physician.

I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications in which the judgement of my provider of care may consider necessary or advisable for my diagnosis/treatment.

I consent to electronic access to my medication history.

I acknowledge that I have read this authorization and fully understand its contents.

Signature_____ Date_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORD

PATIENT INFORMATION

This authorization is for the release of medical information.

PATIENT'S NAME _____
Last First M.I.

ADDRESS _____

BIRTH DATE _____ / _____ / _____ **DAYTIME TELEPHONE NUMBER** _____
Month Day Year

SOCIAL SECURITY NO. _____

ORGANIZATION PROVIDING INFORMATION:

_____
Name of person or organization releasing information

_____
Street Address

_____
City, State, Zip

ORGANIZATION REQUESTING INFORMATION:

_____
Name of person or organization releasing information

_____
Street Address

_____
City, State, Zip

INFORMATION TO BE DISCLOSED:

☐ Medical Notes/Summary ☐ Operative/Procedure Reports_____ ☐ Pathology_____

☐ PAP/HPV type ☐ Mammograms/Sonograms (report only, no films) ☐ Pelvic Sono ☐ Bone Density ☐ CXR / EKG

☐ Recent Labs ☐ All Medical Records ☐ Other: _____

SPECIAL AUTHORIZATION TO DISCLOSE SUPER-CONFIDENTIAL INFORMATION:

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulation 42 CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent as initialed below. **I UNDERSTAND** that these records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection.

AS PART OF THE MEDICAL RECORDS CHECKED ABOVE, THE FOLLOWING INFORMATION WILL BE RELEASED UNLESS STRICKEN:

HIV/AIDS related information and/or records

Mental Health information and/or records

Sexually transmitted diseases

Drug/alcohol diagnosis, treatment or referral information

SIGNATURE: _____ **DATE:** _____
Patient or legal representative

PURPOSE OF DISCLOSURE:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORD

☐ Continuing medical treatment ☐ Residence Relocation ☐ Second Opinion ☐ Patient Request

For purposes other than Treatment, Payment and Operations:
(Patient is to receive a copy of the Authorization)

☐ Research ☐ Disability Insurance ☐ FMLA ☐ Life Insurance

☐ Marketing Promotion: I have been informed **TROGOLO OBSTETRICS AND GYNECOLOGY, LLC** is not receiving any direct or indirect compensation from a third party as a result of disclosing information for this purpose.

☐ Other (please specify): _____

I understand that this authorization will expire **one year** from the date of signature below.

RIGHT TO REVOKE AUTHORIZATION:

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, IN WRITING, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST. I HEREBY RELEASE **TROGOLO OBSTETRICS AND GYNECOLOGY, LLC** FROM ANY AND ALL LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THIS INFORMATION TO THE PARTY NAMED ABOVE.

AUTHORIZATION & SIGNATURE:

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be redisclosed and may no longer be protected by federal privacy regulations. Therefore, I release **TROGOLO OBSETRICS AND GYNECOLOGY, LLC** from all liability arising from this disclosure of my health information.
I understand and agree that I am financially responsible for the following fees associated with my request: copying charges and postage related to the production of my information. *For patients and governmental entities*: 1.00 per page for the first 25 pages and 25¢ per page for each page in excess of the first 25 pages. *For other entities*: up to $1.00 per page for each page copied, in accordance with Florida Administrative Code 64B8-10.003.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Printed Name of Patient: _____ Date: _____

Patient Signature: _____ Social Security #: _____

Printed Name of Parent, Guardian or Legal Representative: _____

Parent, Guardian or Legal Representative Signature: _____ - _____

Relationship to Patient: _____ **Records are needed by**: _____(date)

Send by: ☐ **Fax**_____ (Patient must initial approval) ☐ **Mail** ☐ **Patient will pick up** ☐ **Electronic format if EMR**

E-mail Consent & Acknowledgment Form

Trogolo Obstetrics and Gynecology, LLC

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
h. E-mail can be used to introduce viruses into the computer system.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
e. It is the patient's responsibility to follow-up and/or schedule an appointment.

E-mail Consent & Acknowledgment Form

3. PATIENT RESPONSIBILITIES AND INSTRUCTIONS:

To communicate by e-mail, the patient shall:

a. Limit or avoid using his/her employer's computer.

b. Inform Provider of changes in his/her e-mail address.

c. Confirm that he/she has received and read the e-mail from the Provider.

d. Put the patient's name in the body of the e-mail.

e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).

f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.

g. Withdraw consent only by e-mail or written communication to Provider.

4. TERMINATION OF THE E-MAIL RELATIONSHIP

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (Print) : _____

Patient Signature : _____ Date : _____

Patient Email: _____

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. I acknowledge that I have received or 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 the “Notice of Pricacy Practices”:

Date_____ Attempt_____

Staff Name_____

TROGOLO
OBSTETRICS & GYNECOLOGY

Consent to Release Medical Information

There are times we are asked to give family members or others information on test results, especially if you will not be available to receive them. If you would like for us to give out information regarding your treatment and/or test results to your family or friends, please fill in their name and their relationship to you. Please designate which type of information each person may receive by checking the items we may release and any item we should not disclose. Make your own notes, if necessary, for clarification.

Definitions:

All Information: Any and All information we have in our file related to you which may include billing information, appointments, treatment, test results, etc. and information on sexually transmitted disease; HIV/AIDS, birth control, pregnancy and mental health information

Appointment Only: Only information related to appointment dates and times.

STD's/HIV: Information related to sexually transmitted disease including HIV, AIDS, HPV, dysplasia, abnormal paps, herpes, GC, Chlamydia, syphilis, vaginitis, trichomonas, etc.

Preg/Ab: Information related to pregnancy and abortion.

BC: Information related to preventing pregnancy including birth control pills, diaphragms, condoms, IUD's, etc.

Relationship	Name of person allowed	Type of information which may be released to receive information				
Mother	_____	❑ All info	❑ Appts only	❑ STD's/HIV	❑ Preg/Ab	❑ BC
Father	_____	❑ All info	❑ Appts only	❑ STD's/HIV	❑ Preg/Ab	❑ BC
Spouse	_____	❑ All info	❑ Appts only	❑ STD's/HIV	❑ Preg/Ab	❑ BC
_____	_____	❑ All info	❑ Appts only	❑ STD's/HIV	❑ Preg/Ab	❑ BC
_____	_____	❑ All info	❑ Appts only	❑ STD's/HIV	❑ Preg/Ab	❑ BC

❑ NO INFORMATION TO BE RELEASED

This consent to release information will remain in effect until revoked in writing.

_____	_____	_____
Print Name	Patient Signature	Date
_____	_____	_____
Staff Witness	Witness Signature	Date

LAB CONSENT

January 1, 2020

Dear Patient:

Please identify the lab you wish to process your lab work and notify our staff. Your insurance company may have selected a preferred lab for your specific policy that may affect your coverage. Our office uses Quest, LabCorp, and Bernhardt Labs to process most lab work collected in our office including blood, pap smear, biopsies, and urine samples.

Please indicate the lab you wish for us to use to process your labs. Depending on your lab coverage, you may receive a bill from your lab work (including preventative testing). We encourage you to determine your preferred lab before any lab work is sent to minimize costs to you.

**** Please note:** Specialized lab work (genetic testing, BioTe hormone replacement therapy, and infertility) may not be covered by your insurance.

Please complete the area below:

Selected Lab:	❑	Quest	❑	LabCorp	❑	Bernhardt Labs
Type of Lab:	❑	Pap Smear	❑	Blood	❑	Other_____

Patient Name: (print)_____

Patient Signature_____ Date_____