WHK OBGYN

CONSENT TO OPERATION OR OTHER PROCEDURE

Patient _____ Date of Birth: _____

1. I hereby request and authorize Women's Healthcare of, LLC. And/or such physician associate(s) as may be selected by him or her, to perform on the patient the following: **this consists of a physical exam of by body including my breasts and genital organs and medically indicated examination including not limited to a pelvic exam and/or surgical operation(s), mentioned below,** the nature to the extent of which has been explained to me by the physician in lay terms completely understandable to me.

_____

_____

_____

DO YOU ACCEPT BLOOD TRANSFUSIONS, in case of an emergency? YES or NO _____
Initials

2. I have been fully informed by the physician in lay terms understandable to me all medical acceptable alternative treatment.
3. I have been fully informed by the physician in lay terms understandable to me the risk and consequences, which are associated with the surgical procedure(s) described below.
4. I was told that I have the option of refusing the operation or procedure.
5. I have been fully informed that physicians at **Women's Healthcare of, LLC** does circumcisions in his office. I agree that if I request a circumcision for my baby, it will be done at Women's MD's office rather than in the hospital.
6. I consent to the administration of such anesthetic agents as shall be selected by those responsible for performing the procedure.
7. If any unforeseen condition arise during the course of the operation, I do hereby authorize and request the physician and/or his physician associates to take whatever procedure(s) they deem advisable, which may be in addition to or different from those now planned.
8. I have also been informed there are other risks including but no limited to, severe loss of blood, infection, cardiac arrest that are attendant to the performance of any surgical procedure.
9. I consent to the appropriate disposal by the office or hospital of any tissues and other body materials, which may be removed during the course of the procedure(s).
10. I have been made aware and acknowledge that the practice of medicine and surgery are not exact sciences and that no guarantees or assurances have been made to me as to any of the results or risks.
11. I further consent to my surgeon (or his designee) making a photographic, videotape or similar records of the operation (which shall remain in my surgeon's custody) fir the purposes my surgeon deems desirable.
12. I understand that my Doctor has decided not to carry medical malpractice insurance. Under Florida Law, physicians generally are required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.
13. I have been notified that if my procedure is in the physician's office, I will be transferred to the closest hospital, where my physician has staff privileges, Baptist Hospital of Miami.

I HAVE READ THE ABOVE PARAGRAPHS AND THEY HAVE BEEN EXPLAINED TO MY SATISFACTION.

_____ _____

Witness (to signature only) **Signature of patient (or parent or legal guardian is unable to sign this consent**

_____ _____

Date of signature obtained **Time signed**

PHYSCIAN'S CERTIFICATION

As a Women's Healthcare of, LLC Provider**,** hereby certify that the patient, or one authorized to act on his/her behalf: (1) has been fully informed by me or by one of my physician associate(s), in lay terms understandable to the patient, of the mature of the surgical procedure, the alternatives as to treatment, and the consequences of and risks to the patient inherent or associated with the procedure; and (2) has authorized the performance of the procedure.

_____

Physician **Date**

Women's Healthcare of Kendall, LLC is a doctor's office regulated pursuant to the rules of the Board of Medicine as set forth in rule division 64B8, F.A.C

10700 North Kendall Drive, Suite 200, Miami, FL 33176 Tel: 305.270.7999 Fax: 305.270.6788

HIV Test Informed Consent

I consent to a human immunodeficiency (HIV) test, which is to determine if an individual is infected with the virus, which causes AIDS. I understand:

1. The blood test for HIV is not 100% accurate and sometimes produces false positive or false negative results.

2. More than one blood test may be necessary to confirm positive results.

3. That information identifying me and test results will be confidential and only those required or permitted by lay will know the results and my identity.

4. That my HIV test results can be released to those whom I give written permission to see or to copy my medical record.

5. I will be provided the test results and the opportunity to receive post-test counseling from my physician.

I acknowledge that I have received information regarding measures for the prevention of, exposure of, and transmission of HIV.

_____ _____

Date **Time** **Signature, Patient/Legal authorized Person**

_____ _____

Date **Time** **Witness**

PHYSICIAN ACKNOWLEDGEMENT

I have provided pre-test counseling, including measures for the prevention of, exposure to, and transmission of HIV, and the right to confidential treatment of the test results and the patient's identity as provided by law. After I explain the rest results, I will give the patient the opportunity to receive post-test counseling.

_____ _____

Date **Time** **Physician Signature**

NOTICE TO PATIENTS (NICA)

I have been furnished information by **Women's Healthcare of Kendall, LLC** prepared by the Florida Birth Related Neurological Compensation Association, and have been advised that Women's Healthcare of Kendall, LLC and Physicians may be a participating physician in that program, wherein certain limited compensation us available in the event certain neurological injury may occur during labor, delivery, or resuscitation.

For specifics on the program, I understand I can contract the **Florida Birth Related Neurological Injury Compensation Association (NICA)**,

PO Box 14567, Tallahassee, Florida 32317-4567, (800)398-2129.

I further acknowledge that I have received a copy of the brochure prepared by NICA. Dated this _____ day of _____, 202__.

Patient Signature:_____

Print Full Name:_____

_____

Date of Birth

Witness:
Date

Women's Healthcare of Kendall, LLC
10700 North Kendall Drive
Suite 200
Miami, FL 33176
P: 305.270.7999 F: 305.270.6788

E-MAIL CONSENT FORM

Patient Name: _____ Date: _____

Patient E-mail address: _____ Phone: _____

1. RISK OF USING EMAIL TO COMMUNICATE WITH OUR PROVIDER.

You provider offers patients the opportunity to communicate by e-mail. Transmitting patient information b 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 confidential of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentions misconduct. Thus, the patient 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 medical record. Because they are part of the medical record, other individual 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 patients 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 patient' responsibility to follow-up and/or scheduled an appointment.

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 to 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

E-MAIL CONSENT FORM

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 condition set forth above or otherwise breached 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 instruction outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may had were answered.

Patient Name (print) _____

Patient Signature _____ Date _____

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designer 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 Providers, and any breach by me of these restrictions and conditions.

Patient Name (print) _____

Patient Signature _____ Date _____

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. **Women's Healthcare of Kendall, LLC** provides you this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- **Women's Healthcare of Kendall, LLC**, has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- **Women's Healthcare of Kendall, LLC** reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but **Women's Healthcare of Kendall, LLC** does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- **Women's Healthcare of Kendall, LLC** may condition treatment upon the execution of this Consent

This Consent was signed by: _____

_____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Date: _____/____/_____

In front of _____
Printed name – Practice Representative

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to

request confidential communications or that a communication of PHI be made by alternative mean, such as sending correspondence to the individual's office instead of the home.

I wish to be contacted in the following manner (check all that apply):

[ ] Home Telephone_____ [ ] Written communication

OK to leave message with details

[ ] OK to mail to my home
[ ] Leave message with call back number
[ ] Leave message with call-back number only

[ ] O.K. to mail to my work address

[ ] Cellular _____
[ ] Work Telephone_____

[ ] Other

[ ] O.K. to leave message with detailed information
[ ] Leave message with call-back number only

MAY WE LEAVE A MESSAGE IN YOUR VOICEMAIL OR ON YOUR ANSWERING MACHINE?
Yes [ ] NO[ ] N/A [ ]

MAY WE CONTACT YOU AT WORK?
Yes [ ] NO [ ] N/A [ ]

MAY WE DISCUSS MEDICAL INFORMATION ABOUT YOU WITH YOUR SPOUSE OR FAMILY MEMBER?
Yes [ ] NO [ ] N/A [ ]

OTHER OR SPECIAL NOTIFICATIONS, PLEASE EXPLAIN:
_____
_____

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to Women's Healthcare of Kendall, LLC. for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fee should assistance become necessary. The undersigned agrees, whether she/he signs as parent, spouse, guarantor, guardian, or patient that in consideration of the services to be rendered to the patient, she/he hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

Print Name: _____ Date of Birth: _____

SIGNATURE: _____

DATE: _____