Women's Care of Davie;LLC

Camil Marrero, MD
1200 N University Drive,
Plantation, Fl 33222
954-474-2220 Office / 954-474-0356 Fax

Dear Patient:

Welcome to the office of Dr. Camil Marrero. Thank you for choosing us as your health care provider. To assist you on planning for your health care cost, we would like to inform you of our financial policies, which we request that you read and sign prior to any treatment.

INSURANCE / FINANCIAL RESPONSIBILITY: Our office is happy to accept you insurance at the time of your visit and we will file with your insurance carrier. Because insurance is a contract between you and your carrier we cannot become involved in disputes regarding claims, deductibles, co payments, non- covered charges, or other denial of payments. **It is part of our contractual agreement with any HMO or PPO policy to collect your co-payment.** We cannot extend any financial courtesy on these polices. If you have any questions regarding your insurance coverage, please contact your insurance representative. **We have the right to send your account to collections if your account balance becomes delinquent for more than 90 days. You will be responsible to pay any late and collection fees.**

REFERRALS: It is responsibility of the patient to obtain all referrals that are needed for any treatment given in this office. **It will be your responsibility to obtain and know that you need a referral to see a specialist** if that referral is not received in the office by the day of your appointment you may have to reschedule to see the Doctor another day. If you still want to be seen by the Doctor without a referral you understand that you will be bill for that day of service if your insurance doesn't pay.

MISSED APPOINTMENTS: Our office understands that there are circumstances that lead patients to miss appointments, at the same time, missed appointments take time away from other patients that need to see the doctor. **Please help us serve you better by keeping scheduled appointments or rescheduling them in a timely manner.**

I HAVE READ, UNDERSTOOD AND AGREE WITH THIS FINANCIAL POLICY.

_____
Patient Name

_____ _____
Signature **Date**

NEW PATIENT WELCOME FORM

Came to see: ( ) Camil Marrero, MD **Are you pregnant?** ( ) Yes ( ) No

Last Name:_____First name:_____Middle initial:_____

Date of Birth **Social Sec #** **Age:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street Address: **E-Mail** :

City: State: Zip

Home Phone: Work phone: Cell Phone:

Name of Employer: Occupation:

Emergency Contact: Phone#: Relation To Patient:

Primary Care Doctor: Phone Number: Fax

Whom May We Thank For Referring You?

Primary Language: English ☐ Spanish ☐ Creole ☐ Other ☐

Primary Insurance Name: **IF YOU ARE NOT THE MAIN INSURED PLEASE FILL OUT!**

Primary Insured Name/ ID#: Date of Birth:

Social Sec# Relationship with Patient

Employer:

Secondary Insurance Name: **IF YOU ARE NOT THE MAIN INSURED PLEASE FILL OUT!**

Primary insured Name: Date of Birth:

Social Sec# Relationship with Patient

Employer:

ASSIGMENT OF BENEFITS: **Pharmacy Number:**

CONSENT FOR TREATMENT: I, the undersigned, on behalf of the patient whose name appears above, hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the attending physician. **INSURANCE BENEFITS:** I authorize payment of medical benefits to Camil Marrero, M.D. I also understand that all payments for medical care are my responsibility if my insurance denied payment unless prescribed by law.
AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any personal and medical information necessary to process my health insurance claim form.
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that I can request a copy of the practice's **NOTICE OF PRIVACY PRACTICES.** I understand that if I have any questions or complaints regarding my privacy rights that I may contact the person listed on brochure. I further understand that the practice will protect my information and will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way.

( ) Patient refused to sign **NOTICE OF PRIVACY PRACTICE ( ) Patient was unable to sign because_____**

_____ _____

SIGNATURE **DATE**

 Please complete for our files ; Mark or describe all that apply :

Name: _____

DOB: _____

EMAIL:_____

Last menstrual period ___/____/_____

Last Pap smear ___/____/_____

Last Mammogram ___/____/_____

Last Colonoscopy ___/____/_____

Drug allergies? O NO **O** Yes _____

# of pregnancies _____# of deliveries _____ # of miscarriages _____# of abortions _____

Contraception:

O Tubal sterilization **O** IUD
O Pills **O** Menopausal
O DEPO **O** No sexually active Other: _____

Medical History :

O Cancer; Describe _____
O Diabetes **O** High blood pressure
O Heart disease/ Stroke **O** Alcoholism
O Epilepsy **O** Drug abuse **O** Depression **O** Ulcer **O** Glaucoma
O fibroids
O Asthma **O** NONE
O Other Describe _____

O Breast reduction
O Other Describe _____

Surgical History: **O** NONE

O Cesarean Section **O** Tubal sterilization **Are you**
O Hysterectomy **O** Appendectomy
O Tonsillectomy **O** Breast augmentation
experience:
☐ Depressive disorder ☐ Domestic violence

Is there anything else you would like to discuss with the doctor? _____

_____

Family History: **Date: _____**

O Cancer; Describe _____
O Diabetes **O** High blood pressure
O Heart disease/ Stroke **O** Alcoholism
O Epilepsy **O** Drug abuse **O** Depression **O** Ulcer
O Glaucoma **O** Suicide attempt
O NONE **Other Describe _____**

Social History:

O Married O Single
O Separated O Divorce
Sexually active: **O Yes O NO** Alcohol use: **O Yes O NO**
O Smoking/ Per day _____ **O** Non smoker
Drug use: **O No_____ O Yes_____**
O Follows diet
O Exercise: / Never / 2-3 times week / daily
O Religious objections to blood transfusion Other:
_____

Review of Systems:

General: **O** weight gain **O** weight loss

O tiredness ***O*** insomnia **O** Hot flushes

Respiratory: **O** Short of breath **O** Coughing

Other:_____

Neuro-Muscular: O Back pain **O** Joint pain

O Headaches Other: _____

Gastrointestinal: O Nauseas **O** Vomiting

O Diarrhea **O** Heartburn **O** Constipation

O Decrease or loss of appetite **O** Gas or bloating

Genitourinary: O Fecal Incontinence

O Blood in the urine **O** Pelvic pain

O Pain with intercourse **O** Painful periods

O Excessive menstrual flow **O** Painful Urination

O Urinary incontinence **O** Frequent urination

Other: _____

Signature: _____

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CONSENT FOR PELVIC EXAM

Dear Patient:

Effective July 1, 2020, Florida law requires a written consent to be obtained from the patient in order to perform critical components of your health examination and that includes the female pelvic exam.

This bill (s. 456.51, F.S.,) requires that a health care practitioner must have the written consent of a patient or a patient's legal representative to perform a pelvic examination.

In certain conditions, a health care practitioner may conduct a pelvic examination without written consent if:

- A court orders the performance of the examination for the collection of evidence;
- The examination is immediately necessary to avert a serious risk of imminent, substantial, and irreversible physical impairment of a major bodily function; or
- The examination is indicated in the standard care for a procedure that the patient has consented to.

By signing this document, you are permitting us to perform all components of your routine physical exam including pelvic exam (see below) in an office or hospital setting.

Pelvic Exam: "The series of tasks that comprise an examination of: the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation."

You may withdraw this written consent at any time by providing a written notice.

_____
Name

Date: _____

_____
Signature

Camil Marrero MD
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Dear Patient:

We now offer our patients the only FDA-approved high-risk HPV test. This new test is a highly sensitive viral test used in conjunction with a Pap test for cervical cancer screening in women aged 30 and older. Persistent infection with high-risk human papillomavirus (HPV) is the primary cause of cervical cancer. A few important things to know about HPV and cervical cancer screening:

- Most women will have HPV at some point during their lives but very few will develop cervical cancer.
- Cervical cancer develops if an HPV infection persists for many years.
- The Pap test looks for abnormal cell changes on the cervix that occur as a result of a persistent high- risk HPV infection. The HPV test looks for an HPV infection.
- When used together, these tests can show with nearly IOO% certainty that you do not have cervical disease. Women who test negative for high-risk HPV, and have a normal Pap test, have virtually no risk of developing cervical cancer before their next scheduled visit.
- Knowing your HPV status helps you and your provider determine how often you should be screened. Early detection of pre-cancerous cell changes is the key to preventing cervical cancer.
- Your HPV status is not a reliable indicator of you or your partner's sexual behavior. HPV can lie dormant in cervical cells for many years before becoming an active infection.

Most insurance companies cover the high-risk HPV test when used with a Pap test for cervical cancer screening of women 30 or older. However, the individual benefits you or your employer purchased may or may not cover the test. If the test is not paid for by your insurance company, you will receive a bill from the laboratory. If you ask your provider for the approximate cost of the HPV test they will tell you **the price may range from $ 100 to $180 but most insurance companies cover the HPV test these days.**

☐ I have read the above information and **AGREE** to have the HPV test with my Pap test. I also agree to pay for the HPV test should my insurance not cover the cost.

☐ I have read the above information and **DO NOT** wish to have the HPV test at this time.

X _____ Date: _____
Patient Signature

_____ Patient
Name (please write legibly)