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*

Race/Ethnicity _____
Raza/Etnia

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

☐ Other _____
Otro

Employer _____
Empleador

Work Phone (____) _____
Telefono de Trabajo

Home Address _____
Direccion del Hogar

City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*

Email Address _____

Home Phone (____) _____ Cell Phone (____) _____
Telefono del Hogar *Telefono Cellular*

I was referred to: _____ by / *por*
Fui recomendado por

☐ Friend _____ ☐ Relative _____
Amigo *Familiar*

☐ Physician _____ ☐ Insurance _____
Médico *Seguro*

☐ Reputation of the LLC's Physicians _____
Reputación de los Médicos del LLC

☐ Existing Patient of the LLC _____
Paciente Existente de la LLC

☐ Other _____
Otro

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 ☐ Worker's Compensation ☐ Other _____

Insurance company _____
Compañia 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 ☐ Worker's Compensation ☐ Other _____

Insurance company _____
Compañia 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:*

Social Security # _____
Numero de Seguro Social

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*

Last Name _____
Apellido

Sex _____
Sexo

Home Phone (____) _____
Telefono del Hogar

Work Phone (____) _____
Telefono del Trabajo

Pharmacy - *Farmacia*

Pharmacy _____
Farmacia

Pharmacy Phone _____
Numero de telefono de la farmacia

Pharmacy Address _____
Direccion de la farmacia

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 *Estado* *Codigo Postal*

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

Daytime Phone (____) _____
Teléfono durante el dia

Employer _____
Empleo

Address _____
Direccion

City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*

Signature Required Please See Reverse Side
Firma Requerida. Por Favor mira al Dorso

ADVANCED OBGYN INSTITUTE

Welcome to Advanced OBGYN Institute. For those of you who have been to our practice before, we appreciate your support and the confidence you have in our practice. For those of you who are new, 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.

Please note that Dr Kompal Gadh, Dr Tahnie Danastor, Dr Caroline Mignacca, and Dr Keysha Pietri Mattei share the on-call coverage and will be available in case of any unforeseen emergency.

Once again, we welcome you to our practice. Please do not hesitate to ask any questions or voice any concerns.

_____ _____

Patient Name Date

_____ _____

Patient Signature Witness

603 N. Flamingo Road, Suite 360 • Pembroke Pines, FL 33028
1040 Weston Road, Suite 105 • Weston, FL 33326
Phone: (954)-499-4570 • Fax: (954)-889-0027

ADVANCED OBGYN INSTITUTE

PATIENT FINANCIAL RESPONSIBILITY FORM

PATIENT NAME: _____ **DOB:** _____

Thank you for choosing Advanced OBGYN Institute. We are honored by your choice and are committed to provide you with the highest quality health care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

- We are pleased to assist patients by billing the contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated.
- We will verify your insurance prior to your appointment. Your insurance may require a copayment that you will be responsible to pay on the day of the service.
- **Patients are also responsible for payment of coinsurance, deductibles and all other procedures or treatments such as Pap smear and laboratory studies not covered by their insurance plan. The same applies for self-pay patients as well**
- Final payment for all charges is the patient's responsibility (or patient's guardian, if minor) and should it be necessary for this account to be turned over to either an attorney or collection agency for collection. The patient understands that they will be liable for any charges incurred, including attorney's fees and court costs.
- 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 malpractice. This notice is pursuant to Florida Law.
- Payment is due at the time of service, and for your convenience, we accept cash, check and most major credit cards at our office.
- Patients may incur, and are responsible for the payment of additional charges at the discretion of Advanced OBGYN Institute. These charges may include (but are not limited to):
  - Charge for returned check _____(initial)
  - Any costs associated with turning unpaid accounts over to our collection agency_____(initial)
  - If unable to keep your appointment, please notice us **24 hours** in advance so that we may offer that time to another patient. A patient with repetitive "**no show**" or **late cancellations may regretfully result in an assessment of a cancellation/no show fee of $50.00 each incident.** _____(initial)

I have read the policy regarding my financial responsibility to the practice for providing medical services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits; or, if applicable, any amount due later payment has been made by my insurance carrier. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits

_____ _____

Signature of Patient or Legal Guardian Date

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ADVANCED OBGYN INSTITUTE

PELVIC EXAMINATION INFORMED CONSENT

PATIENT NAME: _____DOB: _____

I understand by Florida Law my health care provider requires written informed consent to perform a pelvic examination on me. I have been informed that I will be receiving a pelvic examination.

Description of the Examination

A "pelvic examination" means an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combinations of modalities which may include, but may not be limited to, the health care provider's gloved hand or instrumentation.

I have been informed as to the nature and process of the pelvic examination. Any and all questions have been answered to my satisfaction.

I hereby give my informed and voluntary consent to receive a pelvic examination.

_____ _____

Signature of Patient or Legal Guardian Date

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ADVANCED OBGYN INSTITUTE

Patient_____ Date: _____

Review of Systems

Constitutional

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other_____		

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other_____		

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other_____		

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Other_____		

Endocrine

Excessive Thirst	Y	N
Too Hot/Too cold	Y	N
Tired/Sluggish	Y	N
Other_____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburns	Y	N
Other_____		

Cardiovascular

Chest Pain	Y	N
Varicose Vein	Y	N
High Blood pressure	Y	N
Other_____		

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other_____		

Musculoskeletal

Joint Pain	Y	N
Knee Pain	Y	N
Back pain	Y	N
Other_____		

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore throat	Y	N
Sinus Problem	Y	N
Other_____		

Genitourinary

Urine retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Other_____		

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of breath	Y	N
Other_____		

Hematologic/Lymphatics

Swollen Glands	Y	N
Blood clotting Problem	Y	N
Other_____		

Psychiatric

Are you Unhappy with life?	Y	N
Do You feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other_____		

Do you know or have you had any problems related to the following systems? Circle Yes or NO

Advanced OBGYN Institute
603 N. Flamingo Rd, Suite 360, Pembroke Pines, FL, 33028
954-499-4570

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I – Authorization

I, _____, give my permission for **Advanced OBGYN Institute** to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II - Health Information

I would like to give the above healthcare organization permission to:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.
Or

☐ Disclose my complete health record except for the following information:
☐ Mental health records
☐ Communicable diseases including, but not limited to, HIV and AIDS
☐ Disclose Alcohol/drug abuse treatment records
☐ Genetic information
☐ Other: _____

Form of Disclosure:

☐ Electronic copy or access via a web-based portal
☐ Hard copy

Section III – Reason for Disclosure

Please detail the reason(s) why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in Section II of this document to be shared with the following individual(s) or organization(s):

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

This document will be retained by the providing organization for seven years.

Advanced OBGYN Institute
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954-499-4570

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section V – Duration of Authorization

This authorization to share my health information is valid:

☐ From_____ to _____
Or
☐ All past, present, and future periods
Or
☐ The date of the signature in section VI until the following event: _____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

_____ _____
Patient Name (Print) Date

_____
Patient Signature

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form: _____
_____

This document will be retained by the providing organization for seven years.

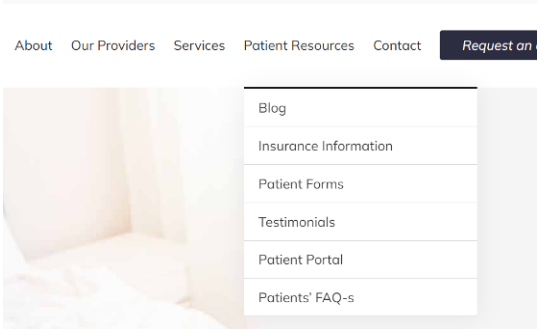
ADVANCED OBGYN INSTITUTE

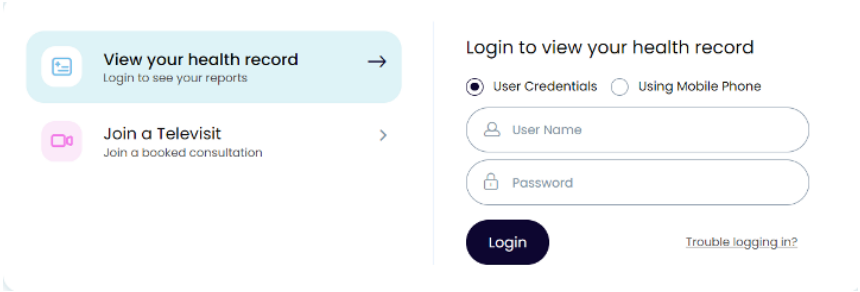
PATIENT PORTAL INFORMATION

Patient can now access their laboratory results through the portal. Please let the staff know your email address to help you activate your account. The portal can be accessed either via the website or via the Healow app. The patient portal is a secure, convenient, and easy way to access your health information.

Via the website

- Go to: https://www.toplinemd.com/advanced-obgyn-institute/
- Then click on Patient Resources, then Patient Portal





Via the Healow app

- Set up the Healow smartphone app in four easy steps
  - Download the Healow app from App Store (iPhone) or Google Play (Android Phone)
  - Search our practice "Advanced OBGYN Institute" by entering the practice code:
  - Enter your portal username and password login
  - Set up your PIN to securely access your health records

Practice Code
BECBCA

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