



SOUTH MIAMI
OB-GYN
ASSOCIATES

Patient Registration
Registracion del Paciente

Date: _____

Patient Information/*Informacion del Paciente:*

Social Security#: _____
Numero de Seguro Social

First Name: _____
Primer Nombre

Last Name: _____
Apellido

Date of Birth: ____/____/____
Fecha de nacimiento

Race/Ethnicity: _____
Nacionalidad

Marital Status: _____
Estado Civil

Employer: _____
Empleador

Email Address/*Direccion Electronica*

Home Address/*Direccion del Hogar:*

City: _____ State: _____ Zip: _____
Cuidad EstadoCodigo Postal

Home Phone: (____) _____
Telefono del Hogar

Cellular Phone: (____) _____
Telefono de Celular

Work Phone: (____) _____
Telefono del Trabajo

Allergies to Meds/ Allergias a Medicinas:

Pharmacy Name & Phone / Farmacia:

Referred By/ Referido Por:

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST- POR FAVOR
ENTREGUE SU TARJETA DE SEGURO A LA RECEPCIONISTA.

Insurance Information / *Informacion del Seguro:*

____ Commercial ____ Medicare ____ Other _____

Insurance Company: _____
Compania de Seguro

Insured/Card Holder's Name: _____
Nombre del Asegurado

Relationship: _____
Relacion

Policy#: _____
Numero de Poliza

Insurance Phone #: (____) _____

Group#: _____

Primary Insurance Holder / *Primario del Seguro:*

Social Security#: _____
Numero de Seguro Social

Date of Birth: ____/____/____
Fecha de Nacimiento

Relationship: _____
Relacion

Daytime Phone: (____) _____
Telefono durante el dia

First Name: _____
Primer Nombre

Employer: _____
Empleo

Last Name: _____
Apellido

Address: _____
Direccion
City: _____ State: _____ Zip: _____

Emergency Contact / *En Emergencias, contactar a:*

First Name: _____
Primer Nombre

Home Phone: (____) _____
Telefono del Hogar

Last Name: _____
Apellido

Work Phone: (____) _____
Telefono del Trabajo

Relationship to patient: _____
Relacion al paciente

Cellular Phone: (____) _____
Telefono de celular



7300 S.W. 62nd Place, 3rd Floor
South Miami, Florida 33143
Tel: (305) 665-1133
Fax: (305) 666-0258
www.southmiamiobgyn.com

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept Visa, Master Card and American Express. 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 Visa, Master card and American Express. 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 reponsabilidad. 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 para no llevar seguro de negligencia medica o para no demostrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (laley 5) (gla ley de la Florida impone penas contra los medicos no-asegurados que no pueden satisfacer los juicios adversos que se presentan por demanda de 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 tranferir 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

DOB: _____



7300 S.W. 62nd Place, 3rd Floor
South Miami, Florida 33143
Tel: (305) 665-1133
Fax: (305) 666-0258
www.southmiamiobgyn.com

Dear Patient:

Physicians have always protected the confidentiality of health information and have refused to reveal such information. Today, state and federal laws are also attempting to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by physicians, hospitals and other health care providers and plans.

The new regulation, effective April 14, 2003, protects virtually all patients, regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to a hospital, fill a prescription or send a claim to a health plan, those professionals will need to consider the privacy rule. All health information, including paper records, oral communication and electronic formats (such as E-mail and electronic claim filing) are protected by the privacy rule.

The *Notice of Privacy Practices*, which is available in our waiting room, contains information about how your confidential health information is protected by this office and describes how you can exercise your rights with regard to your health information. The privacy rule provides you certain rights, such as the right to have access to your medical records; however, because there are exceptions to these rights, they are not absolute. We encourage you to read the *Notice of Privacy Practices* as your signed consent is required.

Please let us know if you have any questions about the *Notice of Privacy Practices*. To contact our Privacy Officer, Call (305) 665-1133.

PRIVACY ACKNOWLEDGMENT

_____ I have read and understand the *Notice of Privacy Practices*.

Date

Printed Name

Signature

DOB: _____



7300 S.W. 62nd Place, 3rd Floor
South Miami, Florida 33143
Tel: (305) 665-1133
Fax: (305) 666-0258
www.southmiamiobgyn.com

FOR YOUR INFORMATION

There are times when our physicians will recommend laboratory tests or diagnostic ultrasound for management of your care. Some insurance companies may consider the test to be “screening” and not fit within their reimbursement guidelines and will not pay. Therefore, please be aware that should your insurance company deny the claim, you will be responsible for payment to the laboratory and/or office.

____ Yes, I understand I may be financially responsible.

EXCLUDED TESTS MAY INCLUDE GC & CHLAMYDIA SCREENING

Name: _____ Date: _____

DOB: _____



SOUTH MIAMI
OB-GYN
ASSOCIATES



TopLine MD Alliance

CONSENT FOR GYNECOLOGY EVALUATION

Written consent of the patient, or the patient's legal representative or guardian is required prior to a Gynecological examination. Part of your GYN evaluation may include, but is not limited to, a breast examination as well as a pelvic examination and diagnostic samples may be taken as a result (pap smear).

A pelvic examination is defined by and includes an examination of the vulva, vagina, cervix, uterus, fallopian tubes, ovaries, uterus, rectum or external genitalia, or pelvic organs using a combination of modalities, which may include, but not be limited to, the healthcare provider's gloved hand or instrumentation.

I understand and consent to a **"MEDICALLY INDICATED GYN EXAMINATION INCLUDING BUT NOT LIMITED TO A PELVIC EXAMINATION"**. This may be performed by the doctor, physician assistant, and/or medical resident.

Patient Name: _____ Date: _____

Patient Signature: _____

Signature of Legal Representative or Guardian: _____
(If patient is under the age of 18)

Witness Signature: _____ DOB: _____



Patient Information Notice

Pathology Laboratory Services

As part of the medical care you receive at this Practice, your healthcare provider may order pathology laboratory services for processing, testing, and diagnosis. The Practice frequently works with:

MediPath Laboratory

Preferred clinical pathology laboratory used by many TopLine MD Alliance providers.

MediPath may process certain specimens or biopsies or perform laboratory testing in connection with your care. Depending on your insurance coverage and benefits, you may receive a separate bill directly from **MEDIPATH** for these services.

Important Information

- Laboratory services are billed separately from your office visit.
- Coverage and patient responsibility for laboratory services vary by insurance plan.
- If you have questions regarding billing, insurance participation, or payment options, please contact MediPath directly at:

MediPath Pathology Services

Phone: (786) 464-0749

Website: <https://www.toplinemd.com/medipath-pathology-services/>

Patient Services Hours: 7am-6pm M-F

By signing below, I acknowledge that I have been informed by the Practice that laboratory services related to my care may be performed by MediPath LLC and may result in a separate bill for such services.

Signature: _____

Patient Name: _____

Date of Birth: _____

Practice Name: South Miami OBGYN Associates, LLC

Date: _____



Patient Financial Agreement

PLEASE READ THOROUGHLY AND SIGN BELOW

Upon receiving services from South Miami OB/GYN Associates, you agree:

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our billing department. We are dedicated to providing the best possible care and service to you. We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract.
- We will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable length of time (within 90 days), you may be responsible.
- All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**
- Upon check-out, we will collect your deductible, co-pay, and payment for any uncovered services as well as the patient's portion as determined by insurance. We accept cash, check, and credit card of Master Card, Visa, Discover, American Express, and Care Credit.
- If your account is more than 90 days past due, you will receive a letter stating that you have 14 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, it may be sent to a collection agency. If an account is sent to collections, it is the policy of this office to refrain from providing further medical care until the balance is paid in full.

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines.

X _____
PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY

Date _____

X _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DOB: _____



HPV CONSENT

Your healthcare provider may perform a routine test in conjunction with your Pap Smear to screen for the presence of HPV (Human Papilloma Virus) approximately 80% of women are exposed to this virus at some point in their lives and screening is highly recommended by our doctors to assist in the detection and prevention of cervical cancer.

Your insurance may or may not cover this additional screening test. If the test is not covered by your insurance provider, the additional out of pocket cost is approximately \$120.00

_____ I choose to include HPV with the Pap Smear.

_____ I choose to decline HPV screening with Pap Smear.

Patient Name (please print)

Date of Birth

Signature

Date

7300 S.W. 62nd Place, 3rd Floor • South Miami, Florida 33143

8405 N.W. 53rd Street, Suite E102 • Doral, Florida 33166

Tel: (305) 665-1133 • Fax: (305) 666-0258

www.southmiamiobgyn.com