My GYN Care

JOYCE R. MILLER, MD · KAREN V. SEETAL KIHEI, APRN
9700 S. Dixie Highway, Suite #1060
Miami, FL 33156

Date: _____

Reason for Visit:
Annual Well-Woman Exam (Please be advised if you have additional problems during your annual, a copay, co-insurance, and/or deductible will be charged) Yes or No

Problem Visit Yes or No
List Problem(s): _____

Patient Name: _____ DOB: _____

Email Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home: _____

Employer: _____Work: _____

Emergency Contact: _____Relationship: _____

Phone: _____

Insurance: _____ ID#:_____ Grp: _____

Subscriber Name: _____ Subscriber DOB: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Patient Signature: _____

IF YOU HAVE FILLED THIS OUT WITHIN THE LAST 12 MONTHS AND HAVE NO NEW CANCERS TO REPORT, CHECK HERE AND STOP FILLING OUT FORM: ◯

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____

Provider: Joyce Miller, MD Karen Seetal Kihei, APRN

If you answer Yes to any of the below, please LIST whether relative is maternal or paternal side using (M) for MOTHER or (P) for FATHER side and for these relatives only: Parents, Siblings, Children, Aunts/Uncles, Grandparents, Nieces/Nephews

Please circle YES or NO			Specify Relative(s) or Self	Specify Type of Cancer	Age of Diagnosis
Y	N	BREAST cancer diagnosed at age 49 or under			
Y	N	OVARIAN cancer (any age)			
Y	N	3 of the following cancers on the same side of the family: BREAST, PROSTATE, PANCREATIC (any age)			
Y	N	Male BREAST cancer (any age)			
Y	N	COLON or ENDOMETRIAL cancer in YOURSELF age 49 or under			
Y	N	3 of the following cancers on the same side of the family: COLON, ENDOMETRIAL, OVARIAN, GASTRIC, PANCREATIC, BRAIN			
Y	N	Ashkenazi Jewish Ancestry with a BREAST, PROSTATE or PANCREATIC cancer (any age)			
Y	N	Pancreatic Cancer (any age)			

FOR OFFICE USE ONLY

Patient is appropriate for GC consult: Y / N

Patient completed GC consult: Y /N

Patient accepted genetic testing: Y / N

MD Signature: _____

JOYCE R. MILLER, MD · KAREN V. SEETAL KIHEI, APRN

MEDICAL TEST RESULTS POLICY

We appreciate your confidence in us, and we strive to make every effort to inform you of your test results in a timely manner. Our practice is to advise you of any results (blood work, imaging studies, diagnostic procedures, etc.) within two weeks of the test being done. If you do not hear from us within two weeks of your test being performed, please contact us. In some rare instances, the test may not be processed or the results may be misdirected or misplaced. That is why it is important for you to call our office if you have not received your test results within two weeks of the test being performed. It is your responsibility to inform us if you have not received your results.

24-HOUR CANCELLATION & NO-SHOW FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, My Gyn Care reserves the right to charge a fee of $75.00 for all missed or no-show appointments or appointments not canceled with 24 hours advanced notice.

No-Show fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple no-show appointments in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand BOTH policies.

Print Name: _____ DOB: _____

Signature: _____ Date: _____

Joyce R. Miller, M.D. • Karen Seetal Kihei, APRN
9700 South Dixie Highway, Suite 1060
Miami, FL 33156
786.453.0332 Fax 786.453.0394

CONSENT FOR VOICE AND TEXT MESSAGING COMMUNICATION

Name _____ DOB _____

Please select all that apply:

☐ You have my permission to leave a detailed voice message:

Telephone _____

☐ Text Message @ _____

☐ I authorize the office of My GYN Care to discuss my medical care with the following:

Name _____ Relationship _____

Telephone _____

Name _____ Relationship _____

Telephone _____

☐ I authorize to receive emails regarding special events, new services, or promotions from My GYN Care

Email Address _____

☐ Please DO NOT release ANY medical information to anyone other than myself.

Patient Signature _____ Date _____

Witness _____

FINANCIAL POLICY

Thank you for choosing Joyce R. Miller, MD, LLC DBA My GYN Care as your healthcare provider. We are committed to building a successful physician-patient relationship. The following is a statement of our Financial Policy. Our office will be happy to answer any questions or concerns you may have.

PAYMENT IS DUE AT THE TIME OF SERVICE
ALL COPAYMENTS, CO-INSURANCE AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECK, VISA/MASTERCARD, DISCOVER AND AMERICAN EXPRESS

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the doctor. We must obtain proof of identification i.e. valid driver's license or passport, and current valid insurance card to provide proof of insurance. If, at the time of your service, you fail to provide us with the correct insurance information or fail to notify us about changes to your insurance policy, you will be responsible for the balance of the claim. We are in network with most major insurance carriers; however, it is the patient's responsibility to verify that we are a participating provider of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. As part of the contract with your insurance company, all copayments, co-insurances, and deductible must be paid at the time of service. Failure on our part to collect co-payments, co-insurances and deductibles from patients can be considered fraud.

PAYMENTS: The patient is responsible for payment of all services rendered, including all copayments, co-insurances, and deductible, services not covered by insurance, and amounts for which the patient is deemed responsible. Interest may be charged on all unpaid balances beginning 45 days after the date of service(s) is rendered. Interest will accrue at a rate of 18% per annum (1.5% per month) from the date of service until paid.

HMO/REFERRALS: It is the patient's responsibility to obtain a referral form from your primary care physician, if your insurance carrier requires it for your visits. If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.

MINOR PATIENTS: A parent, guardian, or responsible party over the age of 18 is required for all minor patients. The responsible party must sign the financial agreement accepting responsibility. All financial obligations, otherwise attributed to the patient in this financial agreement, becomes the obligation of the responsible party.

MISSED APPOINTMENTS: All appointments must be cancelled at least 24 hours in advance. If you cancel your appointment with less than 24 hours' notice or miss a scheduled appointment, there is a $75.00 fee. Please help us serve you better by keeping scheduled appointments.

THIRD PARTY SERVICES: The medical provider may request services from a laboratory for diagnosis and treatment. These services are not considered part of the office visit and may or may not be covered by insurance. The patient authorizes the medical provider to perform and request laboratory tests. The costs of the laboratory work may be billed to the patient directly from the laboratory company. The patient is responsible for payment for all services performed.

NONCOVERED SERVICES: Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. All estimates given to the patient by this office are quotations and not a guarantee of coverage, amount due or payment. If the insurer denies payment for any reason, the patient is responsible for all charges.

RETURNED CHECKS: Any check returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) along with a service fee in accordance with Florida Statute § 68.065(2).

COLLECTION POLICY: Should your account become past due, the patient/debtor assumes all costs of collection, including but not limited to, attorney fees, collection agency fees, court costs, interest, and other expenses incurred as a result of actions taken to collect unpaid balances.

FORMS: There is a flat fee of $15.00 for each set of forms the office completes on your behalf.

I HAVE READ AND FULLY UNDERSTAND the Financial Policy and all my questions regarding this policy have been answered. I hereby agree to render payment in accordance with the terms and conditions set forth. If this agreement is signed by a Responsible Party, all financial obligations otherwise attributed to the patient in this financial agreement becomes the obligation of the responsible party.

Date: _____

Patient Name (Print): _____ DOB: _____

Patient Signature: _____

Parent/Legal Guardian Name (Print): _____

Parent/Legal Guardian Signature: _____