Burton Danoff, MD F.A.C.O. G
Gynecology and Women's Health

New Weston Location!
2771 Executive Park Dr. Suite#1
Weston, Florida 33331
Ph: 954-391-5444
F: 954-391-5155

Broward Health Physician Building
1625 SE 3rd Ave #715
Ft. Lauderdale, Florida 33316
Ph:954-761-8602
F:954-391-5155

PURPOSE OF VISIT AND BILLING CONSENT

Well Woman:

I,_____ am here today for a well woman exam and I understand that if I have any minor problems found they will be billed to my insurance company as a problem visit as well as a well woman, and any copays or deductibles that apply to the visit are based upon my insurance coverage or lack thereof. If I'm found to have any major problems, I realize I will have to return for my well woman exam. An annual well woman visit may include a full examination including pelvic exam, breast exam, and rectal exam, pap smear and HPV testing, mammography, ultrasounds, stool and bone density screening as well as other testing the doctor feels necessary according to my history and the recommendations for yearly evaluation. It is my responsibility to find out what tests are covered by my insurance and what my out of pocket expenses may be.

Signature:_____ Date:_____

Follow up:

I,_____ am here today for a follow up visit based upon previously identified problems(s) or procedure(s) that need to be rechecked or to review test results. I understand that copays and deductibles will be applied to this visit based upon my insurance or lack thereof. I also understand that I will schedule an appointment for my well woman exam at a later date or any future follow up appointments based upon my results. It is my responsibility to find out what tests are covered by my insurance and what my out of pocket costs may be.

Signature:_____ Date:_____

Problem Visit or Consultation:

I,_____ am here today for a problem visit or consultation and understand that copays and deductibles will be applied to this visit based on my insurance or lack thereof. I also understand that I will need to schedule my well woman exam at a later date and may need to come in for a follow up visit based upon the findings at this visit and/or tests ordered by the physician. It is my responsibility to find out what tests are covered by my insurance or what my out of pocket costs may be.

I am here today for:_____

Signature:_____ Date:_____

Procedure:

I, _____ am here for a(n)_____ and understand that copays and deductibles will be applied to this visit based upon my insurance or lack thereof. I also understand that I will need to schedule my well woman exam and any follow up appointments based upon my results at a later date.

Signature:_____ Date:_____

Burton Danoff, MD F.A.C.O. G
Gynecology and Women's Health

Broward Health Weston
2300 N. Commerce Pkwy. #113
Weston, Florida 33326
Ph: 954-217-8866
F: 954-217-2712

Broward General Medical Center
1625 SE 3rd Ave #715
Ft. Lauderdale, Florida 33316
Ph: 954-761-8602
F: 954-217-2712

Well Woman Visit

I am here today for a **well woman exam only**. I am not experiencing any problems or issues I want to discuss with the doctor.

Well Woman exam can include:
* A full examination
*Pelvic exam
*Breast exam
*Rectal exam (for women over 40)
*HPV testing
*Stool testing
*STD screening
*And any other testing the doctor feels is necessary

<u>ANY</u> other problems found will be billed to the insurance company as a problem visit, and any copays or deductibles that apply to the visit are based upon insurance coverage or lack thereof. It is the patient's responsibility to find out what tests are covered by insurance and what the out of pocket expenses may be.

NAME: _____ DOB: _____

SIGNATURE: _____ DATE: _____

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PATIENT INFORMATION

NAME:_____DATE OF BIRTH:_____

ADDRESS:_____
STREET UNIT CITY ST ZIPCODE

PHONE: Please check (✓) 1st preference for calls from the office.
☐ Cell:_____ ☐ Home:_____ ☐Work:_____

E-MAIL:_____
Consent to send appointment reminders and normal lab results via e-mail: ☐ Yes ☐ No

EMERGENCY CONTACT:
Name:_____Relationship:_____Phone:_____

PRIMARY CARE PHYSICIAN: ☐None
Name:_____ Phone:_____ Fax:_____

PREFERRED PHARMACY: (We will use this information to call in any necessary prescriptions)
Name:_____ Phone:_____

NO SHOW POLICY

1. I understand that a 48 hour notice (in absence of true emergency) is required for cancellation of an appointment. A $25.00 administrative fee will be charged to my account if at least 48 hour notice is not given.

CONSENT AND GENERAL INFORMATION

1. I consent to medically necessary tests, treatments and procedures as recommended by my doctor.
2. I authorize my doctor to release or make my medical information available for review to federal, state and regulatory agencies, insurance companies and third party payers, or providers of ancillary services when the information is requested for review for payment, care, services, medical review or utilization review.
3. I understand that all communications are held in the highest regard for privacy of health information and according to HIPPA (Health Information Privacy Policy Act) guidelines.
4. I understand that results of laboratory or imaging testing will be communicated with the patient only after review by my doctor or nurse practitioner. Normal results will be conveyed either by phone or e-mail. Abnormal results will be given personally to the patient either during an office follow-up visit or via telephone. The office will make every attempt to make contact. I will respond to attempts and keep the office updated with change of phone number or address to ensure smooth and timely communications. **If I have not responded to the offices repeated attempts in the case of vital information, I agree that the office will send a certified letter with a fee of $8.00 posted to my account.**

SIGNATURE:_____ DATE:_____

NO SHOW AND CANCELLATION POLICY

CANCELLATION OF APPOINTMENT:

In order to be respectful of the medical needs of our patients, please notify the office if you are unable to attend an appointment.
The cancelled appointment time will be given to someone who is in urgent need of treatment.
If it is necessary to cancel your scheduled appointment, we require you call 48 business hours in advance.

HOW TO CANCEL YOU APPOINTMENT:

To cancel an appointment, please call (954) 217-8866 or (954) 761-8602. If you do not reach the receptionist, you may leave a detailed message on the voicemail.

LATE CANCELLATION AND NO SHOW POLICY

There will be a fee charged to your account for late cancellations of less than 48 hours in advance of an appointment or missing an appointment ("no show").
The first late cancellation or no show will be a $0 charge.
The second late cancellation or no show will be a $25 charge.
Three or more late cancellation or no show will be a $50 charge.

This fee will need to be paid in full before scheduling any more appointments.

Thank you for helping us to take good care of you.

NAME: _____ DOB: _____

SIGNATURE: _____ DATE: _____

Patient:_____ D.O.B. _____ Date:_____

Review of Systems

Are you currently having any problems related to the following systems? Circle Yes or No

General

Are you having fever, chills**,** or sweats?	Y	N
Hot Flashes	Y	N
Night Sweats	Y	N
Other_____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Have you lost vision?	Y	N
Other_____		

Allergic/Immunologic

Latex	Y	N
Drug Allergies: (if Yes:)_____	Y	N
Infections	Y	N
HIV	Y	N
Lupus	Y	N
Other_____		

Neurological

Seizures	Y	N
Trouble sleeping	Y	N
Headaches	Y	N
Other_____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other_____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Diarrhea	Y	N
Other_____		

Cardiovascular

Chest pain	Y	N
Palpitations	Y	N
Varicose veins	Y	N
Other_____		

Ear/ Nose/ Mouth/ Throat

Ear Pain	Y	N
Sores in mouth / throat	Y	N
Sinus problems	Y	N
Other _____		

Genitourinary

Painful/ Frequent Urination	Y	N
Vaginal Dryness	Y	N
Irregular menstruation	Y	N
Vaginal discharge/ itching	Y	N
Pain during/ after sex	Y	N
Other_____		

Respiratory

Asthma	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other_____		

Hematological/Lymphatic

Anemia	Y	N
Swollen glands	Y	N
Blood clotting problem	Y	N
Other_____		

Psychiatric

Are you **unhappy** with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other_____		

Musculoskeletal

Joint pain	Y	N
Swelling in your joints	Y	N
Arthritis	Y	N
Other_____		

Integumentary

Skin rash/ open areas	Y	N
Nipple discharge	Y	N
Persistent itch	Y	N
Other_____		

Family History of a Cancer:

Breast	Y	N
Ovarian	Y	N
Colon	Y	N
Uterine	Y	N

Comments:

_____

_____

_____

_____

Physician reviewed:_____

Dr. Burton Danoff

Risk Assessment for Lyn[illegible] Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician: Burton Danoff, MD

Date of Birth: _____ Today's Date: _____

This is a screening tool for cancers that run in families. Please consider these family members when completing the form:

Mother/Father/Sister/Brother/Children = **1st Degree Relatives**

Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Relatives**

Cousin/Great Grandparent = **3rd Degree Relatives**

Have you or any of your relatives been tested for a hereditary cancer syndrome (BRCA/Colaris) in the past? YES NO

Have you ever been diagnosed with cancer? What site: _____ Age: _____

		COLON AND UTERINE CANCER (Lynch Syndrome/Colaris)	SELF	YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	***EXAMPLE: Two or more relatives with a Lynch syndrome cancer; one under age 50***			***Aunt-colon Sister-uterine***	***47 yrs 60 yrs***
Y	N	Have **YOU** been diagnosed with uterine (endometrial) or colorectal cancer before age 50				
Y	N	Two or more relatives on the same side of the family w/ any of the following, one diagnosed before 50 **(please circle):** *colon, uterine/endometrial, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter and renal pelvis*				
Y	N	Three or more relatives on the same side of the family w/ any of the following diagnosed at any age **(please circle):** *colon, uterine/endometrial, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter and renal pelvis*				
Y	N	10 or more **LIFETIME** Colon Polyps (Specify #)				
		BREAST AND OVARIAN CANCER (HBOC/BRACAnalysis)	**SELF**	**YOUR RELATIONSHIP TO FAMILY MEMBER w/ CANCER**		**AGE AT DIAGNOSIS**
				MOTHER'S SIDE	**FATHER'S SIDE**	
Y	N	Breast cancer at age 45 or younger (in self, first or second degree family members)				
Y	N	Ovarian cancer at any age (in self, first or second degree family members)				
Y	N	Two relatives on the same side of the family with breast cancer—with one under the age of 50				
Y	N	Three relatives on the same side of the family with breast, aggressive prostate, pancreatic or ovarian at any age				
Y	N	Multiple breast cancers in the same person (in the same breast or in both breasts)				
Y	N	Male breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with breast, ovarian, aggressive prostate or pancreatic cancer at any age				
Y	N	Triple Negative breast cancer under age 60 (Estrogen receptor, Progesterone receptor and Her2 negative)				

Is there any other cancer in you or any family members not listed above (provide site, relationship and age):

_____

Patient's signature: _____ **Date:** _____

FOR OFFICE USE ONLY

☐ Patient is appropriate for further risk assessment and/or genetic testing

☐ Patient offered genetic testing: Accepted OR Declined

☐ Information given to patient to review Follow-up appointment scheduled on _____

☐ Patient does not have risk factors HCP Signature: _____

FINANCIAL POLICIES

NAME:_____ DOB:_____

1. It is the patient's responsibility to be aware of and understand their insurance policy's terms, requirements, benefits, and limitations including co-pay amounts and deductibles.

2. Your insurance company will be billed for the physician visit by our office.

3. The patient is responsible for payment of services not covered by the insurance plan, including amount of visit if there is a deductible which has not been met at the time of the visit. **All co-pays and visit fees not covered by insurance are to be paid at the time of the visit unless other arrangements have been made through Dr. Danoff.**

4. If the insurance policy requires that you have a referral from your primary care physician for a visit to the gynecologist or specialist, it is the patient's responsibility to obtain the referral. If you do not have a necessary referral at the time of the office visit, the visit will be rescheduled until you have obtained the referral.

5. A parent or guardian accompanying a minor is responsible for financial obligations.

6. Any check which is returned for any reason will be subject to any bank fees charged to the office along with 5% of the face value of the check or $25.00 (whichever is greater) administrative fee.

7. If the account goes into collection services for non-payment (either by the patient or the insurance carrier), the patient assumes all costs of collections including but not limited to collection agency fees, court costs, interest, and legal fees.

INSURANCE AUTHORIZATION

1. I agree to the terms above.

2. I hereby authorize the physician to furnish information to my insurance carrier concerning my condition and/or treatments and I hereby irrevocably assign the physician all payments for medical services rendered to myself or to my dependent.

3. I understand that I am financially responsible for all charges whether or not covered by insurance.

4. I also authorize the office to obtain copies of my medical records from other physicians if necessary.

SIGNATURE: _____ DATE: _____

Notice of Privacy Practices
Burton Danoff, MD, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Burton Danoff, MD, LLC
Weston, FL 33326

Office: 954-217-8866
Fax: 954-217-2712

Attn: Compliance Contact

Please sign the accompanying "Acknowledgement" form

Notice of Privacy Acknowledgement

Burton Danoff, MD, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____