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 Address _____
Direccion de la farmacia

Pharmacy Phone _____
Numero de telefono 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

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept most major credit cards. 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 ciertas tarjetas de credito. Su seguro medico es un contrato entre usted y su compañia de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. 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 judgements 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 judgements arising from claims of medical malpractice. This notice is pursuant to Florida law.

Hemos elegido no llevar seguro de negligencia medica o no demostrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (la ley 5) (g). Florida impone penas contra los medicos de los no-asegurado que no pueden satisfacer los juicios adversos que se presentan de demandas de la 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 transferir documentos relacionados a mi tratamiento medico a mi compañia 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 _____

JAIME A. MERCADO, MD & MARIA SUESCUM, MD

BROWARD COMPLETE OB/GYN WELLNESS CENTER LLC

PATIENT NAME: _____ DATE: _____

Due to recent increased prevalence of the Coronavirus Disease (COVID-19) we are asking each of our patients to please fill out the following questionnaire.

_____ Do you currently have symptoms of any respiratory infection such as cough, fever or shortness of breath?

_____ Are you currently under the care of a physician for your symptoms?

_____ Have you recently traveled abroad?

_____ Have you been in contact with a person confirmed to have the Coronavirus Disease (COVID-19)?

If you have answered YES to any of the questions, we advise that you please see your primary care physician to be screened for the Coronavirus Disease (COVID-19).

To further prevent the spread of the Coronavirus Disease and other respiratory infections during the cold and flu season we recommend the following:

- please wash your hands often
- don't touch your eyes, nose or mouth
- avoid contact with sick people
- clean frequently touched surfaces often
- STAY HOME WHEN YOU'RE SICK

JAIME A. MERCADO, MD AND MARIA SUESCUM, MD

BROWARD COMPLETE OB/GYN WELLNESS LLC

NOMBRE: _____ FECHA: _____

Debido al incremento de casos por el Coronavirus (COVID-19) en el pais solicitamos a nuestros pacientes favor de contester las siguientes preguntas:

_____ Tiene usted en estos momentos algun sintoma de infeccion respiratoria como tos, fiebre o dificultad para respirar?

_____ Esta usted recibiendo atencion medica para estos sintomas?

_____ Ha viajado usted recientemente fuera del pais?

_____ Ha estado usted en contacto directo con alguna persona infectada por el Coronavirus (COVID-19)?

Si usted ha contestado SI a alguna de estas preguntas le solicitamos favor de comunicarse con su doctor primario para realizar prueva de descarte del Coronavirus (COVID-19).

Para prevenir el contagio del Coronavirus (COVID-19) y otras infecciones respiratorias se recomienda tomar las siguientes medidas:

-- lavarse las manos las veces que sea necesario

-- no tocarse los ojos, nariz o boca

-- desinfectar sus alrededores

-- evitar contacto con otras personas enfermas

-- PERMANECER EN CASA SI ESTA ENFERMO

"A MEDICALLY INDICATED EXAMINATION INCLUDING BUT NOT LIMITED TO A PELVIC EXAM CONSENT"

I, _____ consent to be treated & examined by Dr. Jaime Mercado / Dr. Maria Suescum-Diaz **(circle one)**

I am aware that my exam may entitle a pelvic exam: examination of external/internal genital organs.

Yo, _____ doy mi consentimiento para ser tratada y examinada por el Dr. Jaime Mercado / Dra. Maria Suescum-Diaz **(círcule uno)**

Soy consciente de que parte de mi examen es un examen pelvico: chequeo de mis órganos genitales externos / internos.

_____

Date / Fecha

_____

Print / Nombre

_____

Sign / Firma

Jaime A. Mercado, MD & Maria A. Suescum-Diaz, MD
Board Certified
260 SW 84th Ave, Ste D
Plantation, FL 33324
Phone: (954)370-7036 Fax: (954)370-7037

OFFICIAL NOTICE

THERE WILL BE A $40 (FORTY) CHARGE FOR EVERY NO SHOW APPOINTMENT THAT IS NOT RESCHEDULED OR CANCELED 48 HOURS PRIOR TO APPOINTMENT DATE.

POR FAVOR TENGA EN CUENTA QUE DEBE AVISAR SI DESEA CAMBIAR O CANCELAR SU CITA CON 48 HORAS DE ANTICIPACION. DE LO CONTRARIO SE HARA UN COBRO DE $40 (CUARENTA).

X _____ _____
Print Name Date

X _____ _____
Patient Signature Date

THANK YOU FOR YOUR COOPERATION

FEMWELL GROUP FINANCIAL POLICY

Thank you for choosing Femwell Group Health as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require for you to read and sign prior to any treatment.

ALL COPAYMENTS AND DEDUCTABLES ARE DUE PRIOR TO YOUR VISIT
WE ACCEPT CASH, CHECK, AND MAJOR CREDIT CARDS

INSURANCE: We will bill your insurance company for your visit as a courtesy to you. Due to difficulty of obtaining payment from your insurance plans, we may ask for your assistance in getting your claim paid. Please be advised that it is the patient's responsability to verify that we are a participating provider of your insurance plan.

HMO/REFERRALS: It is your responsability to obtain a referral from your primary care physician if your insurance carrier requires it for your visit. It is the patient's responsability to know and understand the requirements of their insurance plan. Our office is not responsible to obtain referrals for patients on HMO plans. If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsable for payment of the bill.

RETURNED CHECKS: Any checks returned for any reason will be subject to any bank fees charged to us along with 5% of the face value of the check or $25 administrative fee (whichever is greater).

COLLECTIONS: Should your account become a collection problem, the patient/debtor assumes all costs of collection including but not limited to collection agency fees, court cost, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

NON-COVERED SERVICES: You will be responsable for payment of services "not covered" by your insurance plan. It is your responsibility to understand your insurance plan's benefits and/or limitations.

I HAVE READ AND FULLY UNDERSTAND the Financial Policy. I hereby agree to render payment in accordance with the terms and conditions set forth.

Patient/Responsible Party Signature X _____ Date_ _____

Print Patient Name:_____

Revised 10/29/03 MC

Jaime A. Mercado, MD & Maria A. Suescum, MD
260 SW 84th Ave, Suite D, Plantation, FL 33324
Phone: (954)370-7036 Fax: (954)370-7037

"UNDER FLORIDA LAW , PHYSICIANS ARE GENERALLY REQUIRED TO CARRY MEDICAL MALPRACTICE INSURANCE OR OTHERWISE DEMOINSTRATE FINNCIAL RESPONSIBILITY TO COVER POTENTIAL CLAIMS FOR MEDICAL MALPRACTICE.
YOU DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. THIS IS PERMITTED UNDER FLORIDA LAW SUBJECT TO CERTAIN CONDITIONS. FLORIDA LAW IMPOSES PENALTIES AGAINST NONINSURED PHYSICIAN WHO FAIL TO SATISFY ADVERSE JUDGEMENTS ARISING FROM CLAIMS OF MEDICAL MALPRACTICE. THIS NOTICE PROVIDED PURSUANT TO FLORIDA LAW "

Please Print Name:_____ **Date:** _____

Signature: X_____

Jaime A. Mercado, MD & Maria A. Suescum, MD
260 SW 84th Ave, Suite D, Plantation, FL 33324
Phone: (954)370-7036 Fax: (954)370-7037

Notice of Privacy Acknowledgement

I understand that under the Health Insurance Portability 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 Practice.

Patient Name or Legal Guardian (Print) _____ Date _____

X _____
Signature

Office Use Only

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

Date:_____ Attempt:_____

Staff Name:_____

Jaime A. Mercado, MD & Maria A. Suescum, MD
260 SW 84th Ave, Suite D, Plantation, FL 33324
Phone: (954)370-7036 Fax: (954)370-7037

Notice of Privacy Acknowledgement

I have read and understood the Notice of Privacy Practices.

_____ X _____

Patient's Name Printed **Patient's Signature**

_____

Date

Patient Authorization for Use and Disclosures of Protected Health Information to Third Parties

_____

Name of Practice

Section Must be completed for all Authorizations

I hereby authorize the use of disclosure of my individually protected health information. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name:_____**ID Number:**_____

Persons/Organizations Receiving Information:

	Name	Relationship
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on_____/___/_____
   Initials: _____

2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any effect on any actions they took before they received the revocation. Initials: _____

X _____ _____

Signature of Patient or Representative Date
(Form MUST be completed before signing)

Printed name of Patient's Representative:_____

Relationship to Patient:_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION