Florida Center for Urogynecology

Phone: 954-989-9998
Fax: 954-989-9979
www.floridaurogyn.com

4340 Sheridan Street, Suite 201
Hollywood, Florida 33021
newpatient@floridaurogyn.com

Patient Name: _____ **DOB:** _____/_____/_____

Primary Care Provider:_____ **Height:** _____**Weight:** _____

Reason for the Visit: _____

_____

Past Medical History: Please check all that apply: □ No Medical Problems

□ Depression/Anxiety
□ Reflux
□ Diabetes
□ Asthma
□ Hypertension
□ High cholesterol
□ Obesity
□ Sleep Disorder
□ Thyroid Disease
□ Autoimmune Problem
□ Mitral Valve Prolapse
□ PCOS
□ Anemia
□ Lupus
□ Past Heart Attacks
□ Pacemaker
□ Osteoporosis
□ DVT and/or Pulmonary Embolism
□ Kidney Stones
□ Kidney Disease
□ Arthritis
□ Memory Loss
□ Cancer: _____

□ Other (Medical Problem not listed): _____

_____

Allergies: Please list all allergies: □ No Known Drug Allergies

_____

Current Medications: □ None □ If you have a list, please attach a copy

Please list all current medications (supplements) with dosage that you are taking:

_____

_____

_____

Surgical History: Please list all previous surgeries: □ No Prior Surgery

_____

_____

_____

Family Medical History: Please list condition and relationship to patient:

_____

_____

_____

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Pregnancy History: □ No Prior Pregnancy

Total Pregnancies: _____ Vaginal Deliveries: _____ C-Sections: _____

Miscarriages/Abortions: ____ Living Children: _____

Social History:

Currently using Tobacco Products? □Y □N If yes, quantity per day: _____

Do you exercise regularly? □Y □N If yes, how often?_____

Do you consume Coffee, Tea, and/or Sodas? □Y □N If so, amount: _____

Do you consume Alcohol? □Y □N If so, amount: _____

Are you Sexually Active? □Y □N Marital Status: _____

Healthcare Maintenance:

Date (first day) of Last Menstrual Period: _____

Date of Last Mammogram: _____ Result (normal/abnormal): _____

Date of Last Pap smear: _____ Result (normal/abnormal): _____

Date of Last Bone Density: _____ Result (normal/abnormal): _____

Review of Systems: Please circle all that apply:

General: Weight Gain | Weight loss| Fever | Chills | Problems Sleeping | Daytime sleepiness | Snoring

Psychiatric: Depression | Anxiety | Memory problems | Psychosis/hallucinations

Neurological: Mini Strokes | Strokes |Seizures | Fainting spells | Headaches | Dizziness

Cardiovascular: Chest Pain | Shortness of breath | Heart Murmur | Palpitations | Swelling of the feet

Pulmonary: Cough | Shortness of breath | Sodium production | Emphysema/COPD

Gastrointestinal: Heartburn | Change of Appetite | Vomiting | Diarrhea | Constipation | Change in bowel habits | Black tarry stool | Rectal bleeding

Head/Neck: Vision change | Ear infections | Sinus Infections | Trouble Swallowing | Impaired Hearing

Genitourinary: Pain/Burning while urinating | Blood in urine | Hesitancy | Frequency/Urgency | Incontinence | Nighttime urinating/Number of times: ____

Musculoskeletal: Arthritis | Muscle weakness | Frequent fractures | Osteoporosis | Joint stiffness

Skin: Rashes | Jaundice | Cancer

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Patient Demographics

First Name: **Middle Initial:** **Last Name:**

Address: **Apt. Number:**

City: **State:** **Zip Code:**

Cell Phone Number:( ) - **Home Phone Number:( ) -** **Work Phone Number:( ) -**

Email Address:

Date of Birth: / / **Social Security Number: - -**

Appointment Confirmations

via

Home Cell Text Email

Do you give permission to our physicians/staff to leave messages on your answering machine/voicemail regarding your Personal Health Information (i.e. Test results, Etc.)? (CIRCLE)

Yes | No

If so, what phone number? ( ) -

Emergency Contact: **Relationship:**

Phone Number: ( ) - **Alternate Phone Number: ( ) -**

PHARMACY NAME: **Phone Number: ( ) -**

PHARMACY ADDRESS:

Primary Care Provider: **Phone: ( ) -** **Fax: ( ) -**

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Financial and Administrative Policies and Agreement Form

Thank you for choosing Florida Center for Urogynecology for your medical care. We value all our patients and strive to provide compassionate and expert care. Please see below, our financial and appointment policies. All policies listed are simply to assure quality care and accessibility to all our patients.

Patient Financial Responsibility

All co-payments and any outstanding balances are due at the time of check in unless previous arrangements have been made with our office. This includes both in-person and telemedicine visits. For your convenience, we accept cash, check or credit/debit cards. No postdated checks are accepted.

If you are using your insurance for coverage of your visit, it is your responsibility to understand your insurance plan benefits. Your benefits are outlined in the contract between you and your insurance company.

Patients without insurance coverage or coverage by an insurance in which the office does not participate with your account will be set up as “Self-Pay.” You may be given an estimate of “Self-Pay” cost prior to your visit, but this cost may change depending on the level of care and any procedures required during your visit.

Outstanding balance Policy

All past due accounts are contacted via statements, letter, and/or phone calls within accordance with our internal policy by our billing office. If resolution is not made after these attempts, the account will be sent to our collections agency.

Disability, insurance, and any other forms

There will be a charge of $20.00 for the completion of medical forms. Payment is due upon pick up or sending of the forms.

Appointment Cancellation Policy

We ask that appointments are cancelled at minimum 48 hours in advance if possible. Appointments are in high demand and early cancellation will give another patient the opportunity to make an appointment.

Missed Appointments/Fees

We consider a “Missed Appointment” any appointment for which a patient is not present for or not cancelled as requested above. “Missed Appointments” will be recorded and you will be charged as below. Missed appointment fees are due prior to rescheduling your appointment. This fee will not be submitted to the health plan; it will be charged to the patient. We understand that flexibility is important. Since this may occur for a variety of reasons, we will waive fee once.

Fees for missed appointments are as follows:
$50.00 for Pelvic Floor Rehab Therapy
$30.00 for any other type of appointment(s)
Please note: Repeated "Missed Appointments" may result in discharge from the practice.

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Payment and Insurance Authorization:

For purposes of this agreement, the terms "I" and "my" refer to the patient or responsible party for such patient executing this agreement.

I have read and understand the Florida Center for Urogynecology's financial and administrative policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

I authorize payment of Medical and/or Surgical insurance benefits to proceed directly to Florida Center for Urogynecology. I understand I am responsible for any copayments, non-covered services, and any balances my insurance plan does not cover. In the event I do not meet my obligations, I will be responsible for collections costs, if any, including legal fees and allowed interest. I authorize Florida Center for Urogynecology to release any information acquired during my treatment necessary to process insurance claims. I authorize the physician/practitioner to initiate a complaint to the insurance company for any reason on my behalf.

If my insurance has changed, it is my responsibility to notify the Florida Center for Urogynecology. If I do not notify the Florida Center for Urogynecology of changes in my insurance, then I am responsible for any costs that occur for medical care or procedures that are not covered with the Florida Center for Urogynecology under my new insurance plan or lapsed insurance. This includes any fees for visits, procedures, labs, imaging or physical therapy.

I authorize Florida Center for Urogynecology, to use the payment information (debit card and / or credit card) on file to charge for the applicable fees. If there is no payment information on file, I understand that I will be billed for the applicable fee. Payments will not exceed my indebtedness to the Florida Center for Urogynecology. A photocopy of this assignment shall be considered as effective and valid as the original. I acknowledge that I have read, understand, and agree to the above policy statement regarding the fees for missed appointments.

_____	_____	_____
Patient's Name	**Signature**	**Date**

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION TO THIRD PARTIES

The Health Insurance Portability and Accountability Act (HIPAA) signed into law in 1996, protects the sensitive patient health information from being disclosed without the patient's consent or knowledge.

The Privacy Rule was created to protect your rights as a patient. Under the Privacy Rule you have access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to act if your privacy is compromised by the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

By completing this form, you are authorizing The Florida Center for Urogynecology to release any protected health information requested to the named person(s). This authorization is voluntary, and you may choose to revoke at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Patient Name: _____ **DOB**: _____

I authorize the Florida Center for Urogynecology to release any protected health information requested to any/or all the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Signature of Patient or Patient Representative **Date**

I authorize the Florida Center for Urogynecology to access any protected health information from the hospital electronic medical records available to my provider (Epic, etc) and to contact me about my health information using the indicated following:

- E-mail
- Text message
- Voicemail

_____ _____

Signature of Patient or Patient Representative **Date**

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Receipt of Notice of Privacy Practices

I, acknowledge that I was provided and have reviewed a copy of Florida Center for Urogynecology's Notice of Privacy Practices.

_____ _____

Patient Name **Date**

_____

Patient Signature

Office Use Only

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____

Office Staff Obtaining Signature

Reason Signature and Date was not obtained: Individual refused to sign

•Communication barriers prohibited obtaining the acknowledgement

•An emergency prevented us from obtaining acknowledgement

•Other: _____

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CONSENT FOR PELVIC EXAMINATION AND TREATMENT

A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider's gloved hand or instrumentation. For purposes of this consent, vaginal sonography and pelvic floor rehabilitation therapy is included.

By signing this consent, I _____ authorize and direct

[Print Name]

The Florida Center for Urogynecology and my treating health care provider, to treat my medical conditions and to perform pelvic examination and procedures. I understand that a pelvic examination may be needed while receiving medical care from The Florida Center for Urogynecology in the future, and I hereby agree and acknowledge that this written consent applies to any and all pelvic examinations conducted today, or in the future, by a health care provider with The Florida Center for Urogynecology unless I revoke this consent in writing by hand delivering a copy of the revocation to the practice. By my signature below I acknowledge, that I have read or have had read to me and understand the contents of this form.

Patient/Legal Representative Signature	**Printed Name**	**Date**

Witness Signature	**Printed Name**	**Date**