NEW PATIENT INFORMATION

PRIMARY CARE DOCTOR: ____________________ PCP # ____________________ FAX # ____________________

PATIENT NAME: ____________________ **BIRTHDATE:** _____/_____/_____ AGE: __________

SOCIAL SECURITY # ____________________ MARITAL STATUS: ( ) S ( ) M ( ) W ( ) D

HOME TELEPHONE # ____________________ **CELLULAR #** ____________________ RELIGION: ____________________

STREET ADDRESS: ____________________ **APT. #** __________

CITY: ____________________ **STATE:** __________ **ZIP:** __________

PATIENT EMAIL ADDRESS: ____________________

DRIVER'S LICENSE: ____________________ DRIVER'S LICENSE STATE: __________

EMPLOYER/SCHOOL: ____________________ TITLE: __________ PHONE # __________

STREET ADDRESS: ____________________ CITY: __________ STATE: _____ ZIP: __________

SPOUSE NAME: ____________________ **CONTACT TEL. #** __________

TRANSLATOR NEEDED ( ) YES ( ) NO PRIMARY LANGUAGE SPOKEN: ____________________ REFERRED BY: ____________________

****

EMERGENCY CONTACT NOT LIVING WITH YOU:

NAME: ____________________ PHONE # ____________________ RELATIONSHIP: __________

ADDRESS: ____________________ CITY : __________ STATE: _____ ZIP: __________

****

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

MOTHER'S NAME: ____________________ FATHER'S NAME: ____________________

EMPLOYED BY: ____________________ EMPLOYED BY: ____________________

PHONE # ____________________ PHONE # ____________________

****

PRIMARY INSURANCE INFORMATION:

INSURANCE CO. ____________________

ADDRESS: ____________________

CITY/STATE/ZIP: ____________________

PHONE # ____________________

I.D. # ____________________ GRP # __________

INSURED'S NAME OR # ____________________

IS THIS AN EMPLOYER PLAN ( ) YES ( ) NO

INSURED'S SOCIAL SEC. # ____________________ DOB: __________

RELATIONSHIP TO INSURED: SELF HUSBAND WIFE CHILD OTHER

SECONDARY INSURANCE INRORMATION:

INSURANCE CO. ____________________

ADDRESS: ____________________

CITY/STATE/ZIP: ____________________

PHONE # ____________________

I.D. # ____________________ GRP # __________

INSURED'S NAME OR # ____________________

IS THIS AN EMPLOYER'S PLAN ( ) YES ( ) NO

INSURED'S SOCIAL SEC. # ____________________ DOB: __________

RELATIONSHIP TO INSURED: SELF HUSBAND WIFE CHILD OTHER

GUARANTEE OF PAYMENT AND RESPONSIBILTY

I fully understand that I am directly responsible for payment to the physicians in this office for all medical services (consultations, evaluations, follow-up, procedures, treatment, etc.), and/or rendered supplies (IUD, Essure, Implanon, vaccines, etc.). I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made or covered by the insurance plan. Patients with **no** insurance coverage **(Self-Pay)** are responsible for all **laboratory** services (specimens, blood work, general testing, etc.). Patient will be billed *directly* by the laboratory, Genpath (BioReference), LabCorp, Quest Diagnostic, etc. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Physicians in this office to *release* any information acquired in the course of my examination or treatment to my insurance, disability or FMLA company for the purpose of processing any insurance or disability claim.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy for Femlife Healthcare for Women, LLC. The NPP is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996.

ASSIGNMENT OF INSURANCE BENEFITS

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any payment of any benefits to the physicians in this office for medical or surgical treatment rendered to me. In these circumstances, **I understand that I am financially responsible for any charges, services or supplies not covered by insurance.** I permit a copy of the authorization to be used in place of the original.

PERSONAL INFORMATION CONFIRMATION

I confirm that all of the above Information is *current* and *accurate*, and I *consent* to all of the above specifications.

SIGNATURE (Patient's parent if minor): ____________________ **DATE:** _____/_____/_____

PREFERRED PHARMACY

NAME OF PHARMACY: ____

ADDRESS: ____

TELEPHONE # ____

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION*

I, ______________________________(Patient name), *authorize* Femlife Healthcare for Women, LLC to *release* or *discuss* information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named person(s)*

1) ______________________________ Relationship: ____________________

2) ______________________________ Relationship: ____________________

3) ______________________________ Relationship: ____________________

****

* PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL **NOT BE GIVEN** ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.

* YOU ARE **NOT REQUIRED** TO LIST ANY NAME IF YOU DO NOT CHOOSE.

****

Please list any *additional* phone numbers where you would like us to contact you for:

- Results – Lab, X-ray, Ultrasounds, Mammograms, etc.
- Reminder notices
- Changes on scheduled appointments

1. ______________________________ 2. ______________________________

Patient Signature: ______________________________

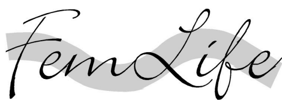
ADVANCE DIRECTIVE

Do you have an Advance Directive / Living Will? ( ) YES ( ) NO
If **yes**, please provide us with a copy for our records.

If **no**, please let us know if you require information.

I was referred to Femlife Healthcare for Women, LLC by:

☐ Friend ☐ Relative ☐ Physician ☐ Insurance
☐ Reputation of LLC's Physician(s) ☐ Existing Patient ☐ Other



Carlos R. Sarduy, MD Pablo E. Uribasterra, MD Monica Daniel, MD
Monica Companioni, MD Jenny Arango-Longo, MD Alvin Martinez, DO Laura J. Paris, CNM, ARNP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices for Femlife Healthcare for Women, LLC. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996.

Effective Date of Notice: April 14, 2003

Patient: ___________________________________ Date: _______/_______/_______

Or

Patient's Representative: ______________________ Date: _______/_______/_______

Relationship to Patient: ______________________

FOR USE BY FEMLIFE STAFF ONLY:

_____ Patient refused to sign

_____ Patient unable to sign

____
Femlife Employee's Initials

_______/_______/_______
Today's Date

17901 NW 5th Street, Suite 202 • Pembroke Pines, FL 33029
Phone: 954-447-1994 • femlifemd.com • Fax: 954-447-1766

Carlos R. Sarduy, MD   Pablo E. Uribasterra, MD   Monica Daniel, MD
Monica Companioni, MD   Jenny Arango-Longo, MD   Alvin Martinez, DO   Laura Paris, CNM, ARNP

PATIENT'S RESPONSIBILITY FOR PAYMENT

Patient's Name:_________________________________ S.S. #:_____________________ Accnt #___________

I am a member of ____ health insurance plan. My plan may or will only provide payment for *certain* covered medical services. I have requested that Femlife Healthcare for Women, LLC provide medical services which my health insurance plan *may* not pay for (Deductible, Members Portion, Out-of-Pocket, Termination of Coverage, etc.). *I agree that I am financially responsible for these services.*

Agreement: I understand that Femlife Healthcare for Women, LLC standard procedure is to bill patients for any non-covered or denied services. If I do not pay for these services within 90 days from the date of service, I agree and permit FHW, LLC to charge the credit card below for the outstanding amount. This credit card agreement will remain active for one (1) year from the signed date.

Credit Card #: ____ Exp.Date: ________ / _________

( ) VISA ( ) MasterCard

____ _______/_______/_______

Signature Date

RESPONSABILIDAD DE PAGO DEL PACIENTE

Nombre del Paciente:_________________________________ S.S.#: __________________ Accnt # __________

Soy participante del plan de seguro medico_______________________________________. Este plan cubre parte o puede no cubrir el pago de *varios* servicios medico (Deducibles, Responsabilidades que provenga de su cuvertura medica o Terminacion de cobertura, etc.). He solicitado que el grupo medico FemLife Healthcare for Women, LLC, me provea servicios medicos por los cuales pueden no estar o no estan cubiertos por mi plan de seguro medico. Personalmente deseo los servicios medicos. *Estoy de acuerdo que soy responsable economicamente por mis servicios medicos.*

Acuerdo: Entiendo que el procedimiento establecido por Femlife Healthcare for Women, LLC es de cobrarle al paciente por cualquier servicio que haya sido negado o no pagado por mi seguro medico. Si yo no pago por estos servicios entre los 90 dias del dia del servicio, autorizo y estoy de acuerdo con que FHW, LLC me cobre a la tarjeta de credito notada aqui por el balance pendiente. Este acuerdo de la tarjeta de credito se mantendra activa durante un (1) ano del dia firmado.

Credit Card # ____ Exp. Date: ________ / _________

( ) VISA ( ) MasterCard

____ _______/_______/_______

Firma Fecha

17901 NW 5th Street, Suite 202 • Pembroke Pines, FL 33029
Phone: 954-447-1994 • femlifemd.com • Fax: 954-447-1766