

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 INFORMATION:

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 RESPONSIBILITY

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



HEALTHCARE FOR WOMEN

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. #: Acct #

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.#: Acct #

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 cobertura 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



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NICA INFORMATION

I have been furnished information by FemLife Healthcare for Women, LLC prepared by the Florida Birth-Related Neurological Injury Compensation Association, and have been advised that Dr. Carlos R. Sarduy, Dr. Pablo E. Uribasterra, Dr. Monica G. Daniel, Monica Companioni, MD, Jenny Arango-Longo, MD, and Alvin Martinez, DO are participating physicians in the program, where in certain limited compensation is available in the event certain neuro-logical injury may occur during labor, delivery or resuscitation. For specifics on the program, I understand I can contact the Florida Birth-Related Neurological Injury Compensation Association (NICA), 1435 Piedmont Drive East, Suite 101, Tallahassee, FL 32312. 1-800-398-2129. I further acknowledge that I have received a copy of the brochure prepared by NICA.

DATED this _____ day of _____, 20_____.

Signature

Name of Patient

Social Security

Attest:

Witness

_____/_____/_____
Date

SEE SECTION 766.316, FLORIDA STATUTES



HEALTHCARE FOR WOMEN

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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