TOPLINE MD
HEALTH ALLIANCE

RELATIENT'S MESSAGING SERVICES

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events and to leave a detailed message on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

Signature: _____ Date: _____

TOPLINEMD
HEALTH ALLIANCE

RELATIENT'S SERVICIOS DE MENSAJERIA

Al proporcionar mi número de teléfono, número de teléfono móvil, dirección de correo electrónico y cualquier otra información de contacto personal, autorizo a mi proveedor de atención médica a utilizar un sistema automatizado de mensajería y extensión para utilizar mi información personal, el nombre de mi proveedor de atención médica , la hora y el lugar de mi cita programada, y otra información limitada, con el propósito de notificarme de una cita pendiente, una cita perdida, un examen de bienestar vencida, saldos debidos, resultados de laboratorio o cualquier otra función relacionada con la atención médica. También autorizo a mi proveedor de atención médica a revelar a terceros, que pueden interceptar estos mensajes, información de salud protegida limitada con respecto a mis eventos de atención médica y dejar un mensaje detallado en mi correo de voz, contestador automático o con otra persona si no estoy disponible en el número proporcionado por mí.

Firma: _____ Fecha: _____

PREFERRED PHARMACY

NAME OF PHARMACY: _____

ADDRESS: _____

TELEPHONE # _____

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION*

I, _____(Patient name), *authorize* Signature Women's Healthcare, 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. _____

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.

Patient Signature: _____ Date: _____/_____/_____

I was referred to Signature Women's Healthcare, LLC by:

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

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

PATIENT FINANCIAL CONSENT

Your care often requires the use of laboratory studies, imaging studies, or pathology evaluation. These studies are not performed at our practice. If your care does require the use of any of these modalities, you will receive a separate bill from the laboratory, physician, or center providing that specific service. Please understand that we do not control these costs. *If you have any questions regarding these costs, please ask your physician prior to your procedure.*

If you have a health insurance plan, your insurance policy is a contract between you and the insurance company. It is an agreement that your insurance will pay for *covered* medical services. They may not pay for every bill or services. It is very important that you know which medical treatments they will pay for and which expense they will not cover. Please note, verification of benefits is NOT a guarantee of payment. *We recommend you contacting your health insurance plan for questions regarding covered benefits under your plan.*

Please do not hesitate to contact any of our staffed employees to assist you with any questions.

I acknowledge that I have read and fully understand that I am directly responsible for any and all services provided.

_____
Patient Name

_____
Patient Signature

ID #_____

Date: _____/_____/_____

03/04/15