Beaches OBGYN

With you every step of the way

Confidential Patient Information Form - Form must be filled out completely to ensure correct claim processing.

Social Security _____ Patient _____
(Last) (First) (Middle Initial)

Date Of Birth _____ Address _____
(Street #) (City) (State) (Zip)

Home Tel # _____ Work Tel # _____ Patient Cell # _____

(If Cell # is provided, the office may text you appointment reminders) Employer _____

Patient E-Mail _____ Marital Status _____ Employment Status _____
(S M D W Sep) (FT PT Ret N)

How Did You Hear About Your Office? _____ Student _____ (FT PT)

Referring Physician _____ Primary Care Physician _____

Emergency Contact _____ Relationship _____ Phone # _____

Spouse's Name Or Other Responsible Party _____ Subscriber (Insured) Name _____

Pharmacy Name, Phone #, Fax and Address _____

Primary Insurance: _____ Subscriber (Insured) Name _____

Subscriber: Date Of Birth _____ Social Security # _____ Employer _____

ID# _____ Group Name & # _____ Patient Relationship To Insured _____
(Self, Spouse, Child)

Second Insurance: _____ Subscriber (Insured) Name _____

Subscriber: Date Of Birth _____ Social Security # _____ Employer _____

ID# _____ Group Name & # _____ Patient Relationship To Insured _____
(Self, Spouse, Child)

Insurance Address _____

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PRIVACY POLICY ACKNOWLEDGEMENT

I acknowledge that I have had the opportunity to review a copy of Beaches OBGYN LLC's Privacy Notice. I understand that I am responsible to read this Notice and notify Beaches OBGYN, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand the notice included electronic access to my medication history. Beaches OBGYN has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all -times and on their website at www.beachesobgyn.com. Beaches OBGYN will provide me with a copy of its most recent Notice upon my request.

Patient Signature:_____ Date of Birth:_____

Parent, Guardian or Legal Representative Signature: _____

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Beaches OBGYN, LLC. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services. For surgery and pregnancy, Beaches OBGYN LLC will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, procedure or pregnancy, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. Any patient credits will be applied to my other outstanding patient balances prior to any refund issued. I further understand that such payment is not contingent on any insurance, settlement or judgment payment

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is my responsibility to provide Beaches OBGYN, LLC with a copy of my current insurance card and, if required by my insurance, to obtain a referral from my Primary Care Physician. Beaches OBGYN, LLC is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. I will notify Beaches OBGYN, LLC immediately-upon any change to my insurance.

INSURANCE WAIVER, NON-COVERED SERVICES WAIVER and OUTSIDE LAB SERVICES

I understand that if I do not have a copy of a current insurance card and/or valid referral, Beaches OBGYN, LLC is not obligated to see me. But if I still wish to be seen, I can be seen as a "Private Pay" patient. I agree that neither the LLC, nor I, will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan 'Non-Covered Services"; I understand I must pay for Non-Covered Services. If feasible, a waiver will be completed for each Private Pay visit or Non-Covered Service. I understand services sent to an outside lab are billed to my insurance or me by the lab and I will receive a separate invoice from the lab.

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ANNUAL EXAMS (INCLUDING MEDICARE ANNUAL VISITS)

Annual 'Well-women" exams are preventive visits and are not paid for by all insurance carriers. Medicare only pays for a portion of this exam (Pap, Pelvic and Breast Exam) once every two (2) years. I understand I am responsible for payment, if the exam or portion of the exam is not covered by my insurance.

Annual exams do not typically include problems I may be having - as problem visits may require longer time. If I am experiencing problems, the office may be required to reschedule another visit to address these concerns.

CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures, a medically indicated examination, including but not limited to a pelvic exam, courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment.

ADDITIONAL INFORMATION

Payment may be made in the form of: Cash, Check, Debit and Credit Cards. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for Services rendered to me by Beaches OBGYN, LLC. Patient credits are applied to other outstanding patient balances prior to any refunds that may be issued.

I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged if I do not cancel my scheduled appointment for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of Service, for telephone management services, for educational materials, for payment agreements which extend beyond 12 months, and for other administrative expenses not covered by my insurance plan.

ASSIGNMENT OF BENEFITS

For the services rendered by Beaches OBGYN, LLC, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits either to myself or to the party who accepts assignment. I agree to hold Beaches OBGYN, LLC harmless for any and all costs, liability and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient's Printed Name: _____ Patients Date of Birth: _____

Patient's Signature: _____ Date Signed: _____

Parent, Guardian or Legal Representative Signature: _____

Employee's signature who reviewed intake form: _____

obstetrics & gynecology

1577 Roberts Drive | Suite 323
Jacksonville Beach, FL 32250

P 904.241.9775
F 904.249.3638

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Notice to our patients

Patients that are **15 minutes** late for an appointment could be rescheduled at the doctor's discretion.

Some services provided in our office are not covered by insurance carriers and we must request payment at the time of service.

Non-Covered Services Include:

- A No-Show charge of $40.00 for appointments which are missed without notifying this office 24 hours in advance.
- A fee of $25.00 will be charged for completion of forms. Such form include, Disability, Life Insurance, Short Term Disability, FMLA. Please leave the form with us and allow 7-10 business days for completion.
- Copies of Medical Records, requested by the patient: In accordance with Florida Administrative Code 64B8-10.003 the set price is $1.00 per page up to 25 pages, then 25¢ per page for the remaining pages.

Patient Signature:_____ Date:_____

Staff Witness:_____ Date:_____

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CONSENT FOR MEDICAL INFORMATION RELEASE

There are times we are asked to give family members or others information on test results, especially if you will not be available to receive them. If you would like for us to give out information regarding your treatment and/or test results to your family or friends, please fill in their name and their relationship to you. Please designate which type of information each person may receive by checking the items we may release and any item we should not disclose. Make your own notes if necessary for clarification.

DEFINITIONS

All Information: Any and All information we have in our file related to you which may include billing information, appointments, treatment, test results, etc. and information on sexually transmitted disease; HIV/AIDS, birth control, pregnancy and mental health information.

Appointment Only: Only information related to appointment dates and times.

STD's/HIV: Information related to sexually transmitted disease including HIV, AIDS, HPV, dysplasia, abnormal paps, herpes, GC, Chlamydia, syphilis, vaginitis, Trichomonas, etc.

Preg/Ab: Information related to pregnancy and abortion.

BC: Information related to preventing pregnancy including birth control pills, diaphragms, condoms, IUD's, etc.

Employee's signature who reviewed intake form: _____

Relationship	Name of person Allowed to Receive Information	Type of information which may be released (circle selection)				
Mother		All Info	Appts Only	STD's/HIV	Preg/Ab	BC
Father		All Info	Appts Only	STD's/HIV	Preg/Ab	BC
Spouse		All Info	Appts Only	STD's/HIV	Preg/Ab	BC
		All Info	Appts Only	STD's/HIV	Preg/Ab	BC
		All Info	Appts Only	STD's/HIV	Preg/Ab	BC

NO INFORMATION TO BE RELEASED ☐

Patient's Printed Name: _____

Patient's Signature: _____ Date Signed: _____

Staff Witness: _____

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REGARDING YOUR OUTSIDE REFERENCE LABORATORY SERVICES

Please be advised that based on any symptoms you are experiencing and reporting to the Doctors and staff, cultures and/or laboratory specimens may be a necessary part of your treatment. We make every effort to send all specimens to the preferred laboratory for your insurance company as well as provide them with all supporting medical documentation needed for filing a claim with your insurance company. All billing for outside laboratory services are separate from our charges. Dependent on your insurance deductible status, insurance coverage guidelines, insurance plan coverage or other related reasons, you may have financial responsibility and receive a separate bill from the laboratory. Our office staff cannot provide pricing information for these outside laboratory services. By Signing this form, you state you have reviewed this information and understand regarding Outside Labs.

Patient Signature:_____Date:_____

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Patient Update Form

Last PAP Smear: _____

Last Mammogram: _____

Last Bone Density: _____

Last Colonoscopy: _____

Last Flu Shot: _____

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Date: _____

Patients' s Name: _____ Marital Status: _____ DOB: _____ Age: _____ Race: _____

Referred by: _____ Primary Care Physician: _____

Reason for Appt: _____ Pharmacy: _____
(Local And Mail Order)

Allergy / Reaction: _____
(Please list anything you are allergic to and the reaction it causes)

Medication & Dosages: _____

Past Medical History: Have you ever had any of the following illnesses? Tick Yes Or No.

Y N Have you ever had a blood transfusion? Y N Are you willing to have a blood transfusion to save your life?

Y N Ever had an abnormal Pap Smear? If yes, treatment_____ Year(s): _____

Y N Heart Trouble	Y N Osteoporosis	Y N Diabetes	Y N Gonorrhea/Chlamydia
Y N Kidney/Bladder Problems -Or- Urinary Incontinence	Y N Fibroids	Y N Bleeding Disorders/ Blood Clots	Y N Hepatitis
Y N High or Low Blood Pressure	Y N Pelvic Prolapse	Y N Breast Discharge/Problem	Y N HIV
Y N Migraine Headaches	Y N Depression/Anxiety	Y N Hemorrhoids	Y N Herpes
Y N Thyroid Problem	Y N Endometriosis	Y N Anesthesia Problems	Y N Genitial Warts
Y N Rectal Bleeding	Y N Seizures	Y N Heart Murmur/MVP	Y N Syphilis
Y N Ulcer	Y N Anemia	Y N Antibiotic for dental work	Y N HPV
Y N IBS	Y N High Cholesterol	Y N Polycystic Ovarian Syndrome (PCOS)	Y N Abnormal Mammo
Y N Infertility	Y N Anxiety	Y N Ovarian Cysts	History of Cancer: _____

Mo/Yr	ILLNESSES or OPERATIONS	Complications YES or NO

Obstetrical History

Please list the number of:

Premature Births _____ Miscarriages _____

Abortions _____ Time Pregnant _____

Living Children _____

Pregnancy History: Please list all pregnancies (including: ectopic/miscarriage/abortion).

Date	Delivery Type (vaginal/cesarean)	Sex	Lbs/Oz	Complications

Family History: Please list illnesses of these family members: children/mother/father/siblings/grandparents

Cancer Type	Family Member/Age
Y N Breast Cancer	
Y N Uterine Cancer	
Y N Skin Cancer	
Y N Ovarian Cancer	
Y N Colon Cancer	

Y N Heart Disease
Y N High Blood Pressure
Y N High Cholesterol
Y N Blood Disorder
Y N Diabetes
Y N Thyroid Disease

Other Significant Family History: _____

Social History

Use of alcohol: Never/ Daily/ Moderate

Tobacco Use: Have you ever smoked? Y N

Current Smoker: _____ packs per day OR History of Domestic Violence: Y N

Drug use: Y N

Former Smoker: quit date_____.

Sexually active: Y N Birth control method: _____