BCH OB/GYN PATIENT PORTAL

ALL OF YOUR NORMAL LAB RESULTS WILL COME TO YOU VIA OUR SECURE PORTAL

You will also be able to view your health information, see your medications, request an appointment, see your upcoming appointments or ask your provider questions concerning your health. Get it all, through our FREE and SECURE patient portal.

Steps to join:

- Say "yes" I want to join
- Our staff will send you an invitation
- Click on the link
- To login, create a username with FMH or use your existing Yahoo, G-Mail, Facebook, or Microsoft account, etc.
- You will then agree to use this user name and password to follow your health
- You will have a one time invitation code (the last 4 of your SSN or the year you were born)
- Read our HIPPA statement
- You will then go to your health record
- You can send messages to our office by hitting "messages" and then hit "message icon" (not the one with the plus sign)
- Use the "My Health" tab to access your labs, vitals, and medication list

If you need assistance **Support Hotline: (888) 670-9775**
Email: support@followmyhealth.com

Beaches OBGYN

Follow and be engaged in your health!
Sign up below; you will receive an invitation in your email shortly. Keep this sheet, follow the instructions and be on you way to a convenient way to manage your health!
Get the FREE app in the iTunes or Google Play store.

(Tear here)

Sign up to receive your patient portal invitation (PLEASE WRITE LEGIBLY)

Name _____

Date of Birth _____

Email address _____

North Florida OB/GYN

BEACHES DIVISION

1577 Roberts Drive Suite #[illegible], Jacksonville Beach, FL 32250 Phone: (90[illegible]41-9775 Fax: (904) 249-3638

(Please fill out all information to the best of your ability)

Patient's Name:_____ **Today's Date:**_____ **Age:**_____ **DOB:**_____

Referred by: _____ **Race:** _____ **Marital Status:** _____ **LMP:**_____

Reason for Appt:_____ **Pharmacy:**_____
(Local and Mail Order)

Allergy/Reaction:_____ **Primary Care Physician:** _____
(Please list anything you are allergic to and the reaction it causes.)

Medications & Dosages:_____

Past Medical History: Have you ever had any of the following illnesses? **Circle Yes or No.**

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

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

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

Mo/Yr	ILLNESSES or OPERATIONS	Complications YES or NO

Obstetrical History
Please list the number of:

Premature Births_____ Miscarriages_____

Abortions _____ Times 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-----If yes, please list Family Member/Age below.		Y N Diabetes
Y N Breast Cancer		Y N Heart Disease
Y N Uterine Cancer		Y N High Blood Pressure
Y N Skin Cancer		Y N High Cholesterol
Y N Ovarian Cancer		Y N Blood Disorder
Y N Colon Cancer		Y N Thyroid Disease

Other Significant Family History:_____

Social History

Use of alcohol: **Never/Daily/Moderate**

Drug use: **Y N**

Tobacco Use: **Have you ever smoked? Y N**
Current Smoker: _____packs per day **OR**
Former Smoker: **quit date**_____.
Sexually active: **Y N** Birth control method:_____

History of Domestic Violence: **Y N**

NORTH FLORIDA
ob gyn

Felix N. Acholonu, M.D.
Christina S. Adams, M.D.
Kathi A. Aultman, M.D.
Sarah Campbell Austin, M.D.
Tim Baird, M.D.
Emily L. Balanky, M.D.
Wade Barnes, M.D.
Kathryn F. Bing, M.D.
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Sayra C. Sievert, M.D.
Kelley H. Stoddard, M.D.
Frank E. Trogolo, M.D.
Jason L. VanBennekom, M.D.
Thomas R. Virtue, M.D.
Elizabeth Morgan Walsh, M.D.
Mary Ellen Wechter, M.D.,M.P.H.
David Scott Wells, M.D.
Tracy Wells, M.D.
Amy Wrennick, M.D.

North Florida Central Services
Sandra O. Doolittle, Executive Director
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Website: www.nfobgyn.com

NORTH FLORIDA OB GYN, LLC

Fellows of the American College of Obstetricians and Gynecologists

PATIENT QUESTIONNAIRE

*Patient Name:*_____ *Date:*_____

Family Planning:

Are you finished having children?

Yes_____ No_____ Maybe_____

Would you be interested in permanent birth control with no cutting, no scarring, & no hormones?

Yes_____ No_____ Maybe_____

Heavy Bleeding:

What is the frequency of your period?

<21 days_____ 21-35 days_____ >35 days_____

How long does your period last?

>7 days_____ 5-7_____ <5days_____

How would you describe your period?

Heavy_____ Medium_____ Light_____

Does your period disrupt your life?

Frequently_____ Sometimes_____ Never_____

Urinary Incontinence:

Do you leak urine when you cough, sneeze, laugh, or during physical activities?

Frequently_____ Sometimes_____ Never_____

Do you suffer from urinary frequency?

Always_____ Sometimes_____ Never_____

Do you usually have a strong sense of urgency to urinate?

Frequently_____ Sometimes_____ Never_____

Does the loss of urine or overactive bladder affect your quality of life?

Frequently_____ Sometimes_____ Never_____

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome and Lynch syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

		COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50			
Y	N	Colorectal cancer before age 50			
Y	N	Two or more Lynch syndrome cancers* in the same person or on the same side of the family			

(*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)

		BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Breast cancer at age 50 or younger			
Y	N	Ovarian cancer			
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y	N	Male breast cancer			
Y	N	Triple negative breast cancer† (ER-, PR-, HER2- pathology)			
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			
Y	N	Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain:			

_____ _____

Patient's Signature Date

FOR OFFICE USE ONLY

☐ Candidate for further risk assessment and/or genetic testing: ☐ Lynch ☐ HBOC

☐ Information given to patient to review

☐ Follow-up appointment scheduled Date: _____

☐ Patient offered genetic testing:
☐ Accepted
☐ Declined

_____ _____

Healthcare Professional's Signature Date

† For a better understanding of triple negative breast cancer, please ask your healthcare provider.

Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.myriadtests.com/patient_guidelines

MYRIAD

North Florida OB GYN

Beaches OB GYN

EMR – Patient Update Form

Last Pap Smear: _____

Last Mammogram: _____

Last Bone Density: _____

Last Colonoscopy: _____

Last Pneumo Shot: _____

Last Flu Shot: _____

Patient Name: _____

Patient Signature: _____

Date: _____

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 and 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. North Florida OB GYN, LLC and other PA subsidiaries may share one electronic medical record ("EMR"). To facilitate the provision of my medical care, I consent for North Florida OB GYN, LLC to access my medical records maintained by any other PA subsidiary.

ADDITIONAL INFORMATION

Payment may be made to the PA 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 North Florida OB GYN, LLC. Patient credits are applied to other outstanding patient balances prior to any refunds that may be issued, including balances owed to other wholly owned subsidiaries of the PA.

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 North Florida OB GYN, 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 (North Florida Obstetrical & Gynecological Associates, P.A.). I agree to hold North Florida OB GYN, LLC harmless from 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 _____ Patient's Date of Birth: _____

Patient's Signature: _____ Date signed: _____

Parent, Guardian or Legal Representative Signature: _____

Employee's signature who reviewed intake of form: _____

Patient Name: _____ NORTH FLORIDA OB GYN, LLC FINANCIAL AGREEMENT

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have had the opportunity to review a copy of **North Florida OB GYN LLC's Privacy Notice dated September 01, 2013** ("Notice"). I understand that I am responsible to read this Notice and notify North Florida OB GYN, 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. North Florida OB GYN has the right to revise this Notice at anytime 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.nfobgyn.com. North Florida OB GYN 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 North Florida OB GYN, LLC. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services. For surgery and pregnancy, North Florida OB GYN 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

North Florida OB GYN, LLC is a wholly owned subsidiary of North Florida Obstetrical & Gynecological Associates, P.A. ("PA") who may file a claim for payment and accept assignment with my insurance company as required by contractual agreement. If the insurance company fails to pay in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all fees for collection, including a reasonable attorney's fee.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is **my responsibility** to provide North Florida OB GYN with a copy of my **current insurance** card and, if required by my insurance, **to obtain a referral** from my Primary Care Physician. North Florida OB GYN 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 North Florida OB GYN 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, North Florida OB GYN 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 PA, 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.

(9)

NORTH FLORIDA

ob gyn

NORTH FLORIDA OB GYN, LLC
Fellows of the American College of Obstetricians and Gynecologists

North Florida Central Services
Sandra O. Doolittle, Executive Director
11437 Central Parkway, Suite 105
Jacksonville, FL 32224
(904) 472-2300
Website: www.nfobgyn.com

Notice to Our Patients

*****PT'S THAT ARE *15 MINUTES* LATE FOR AN APPOINTMENT COULD BE RESCHEDULED AT THE DOCTOR'S DISCRETION*****

Due to increasing costs and complexity of regulations, we have found it necessary to charge for some services, which we have provided free in the past. Insurance carriers do not cover these services and we must request payment at the time of service.

These NON-COVERED SERVICES include:

- A "NO-SHOW" charge of **$40.00** for appointments which are missed without notifying this office 24 hours in advance.
- Forms to be completed such as Disability, Life Insurance, Short Term Disability and FMLA, etc. Our fee is **$25.00** per form. Please leave 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: _____

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.

Relationship	Name of person allowed to receive information	Type of information which may be released
Mother	_____	☐ All info ☐ Appts only ☐ STD's/HIV ☐ Preg/Ab ☐ BC
Father	_____	☐ All info ☐ Appts only ☐ STD's/HIV ☐ Preg/Ab ☐ BC
Husband	_____	☐ 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**

_____ _____ _____

Print Patient's Name | Signature Patient | Date

_____ _____ **Division:** _____

Staff Witness | Date

North Florida OB GYN LLC

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 # _____

Employer_____ Patient E-Mail_____ Marital Status _____
(S M D W Sep)

Employment Status _____ (FT PT Ret N/A) Student_____ (FT PT)

How did you hear about our office?_____

Referring Physician _____ Primary Care Physician _____

Emergency Contact _____ Relationship_____ Phone # _____

Spouse's name or other responsible party:_____ Phone # _____

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)

Insurance Address_____
(City) (State) (Zip)

Second Insurance: _____ Subscriber (Insured) Name_____

Subscriber: Date of Birth_____ Social Security # _____ Employer_____

ID#_____ Group Name & #_____ Patient Relationship to Insured_____
(Self, Spouse, Child)

Insurance Address_____

I understand that I am directly and primarily responsible to North Florida Obstetrical & Gynecological Associates, P.A., the parent company of North Florida OB GYN, LLC, for its customary fee for the services rendered to me by North Florida OB GYN, LLC. I realize that if my insurance company fails to pay or if there is any delay in paying North Florida Obstetrical & Gynecological Associates, P.A., it is my responsibility to pay my doctor's bill directly. I further understand and agree if I fail to make timely payments to North Florida Obstetrical & Gynecological Associates, P.A., that I will be responsible for any and all reasonable cost of collection including filing fees as well as any reasonable attorney's fee(s).

For the services rendered by North Florida OB GYN, 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 the party who accepts assignment (North Florida Obstetrical & Gynecological Associates, P.A.). I authorize payment of medical benefits to the physician who submits the claim. I agree to hold North Florida OB GYN, LLC harmless from 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. North Florida OB GYN, LLC and other PA subsidiaries may share one electronic medical record. To facilitate the provision of my medical care, I consent for North Florida OB GYN, LLC to access my medical records maintained by any other PA subsidiary.

I understand the office may employ an Advanced Registered Nurse Practitioner ("ARNP"), Midwife ("ARNP/CNM") or Physician Assistant ("PA"), and if I am scheduled with them, I am willing to see them instead of the doctor. I hereby consent to and authorize the performance of all appropriate procedures and 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. I consent to electronic access to my medication history.

This form was last modified on 02/26/2014. I acknowledge that I have read this authorization and fully understand its contents.

Signature_____ Date_____

Beaches OBGYN

ATTENTION ALL PATIENTS

VERY IMPORTANT INFORMATION

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 lab 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 completely 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 can not provide pricing information for these outside laboratory services. By Signing this form you state you have reviewed this information and understand regarding Outside Labs.

_____ _____

Signature Date

_____

Print Name

_____ _____

Witness (if under 18) Date

Beaches OBGYN

Insurance Notification Form

_____ (Pt. Number)

I, _____ confirm that the insurance listed below is the only Insurance I have. If I have a secondary Insurance I understand I must list this as well on this form so that filing of my coverage during time at Beaches OBGYN can be properly billed and covered. I understand that if I do not list any additional coverage or provide an additional insurance card of updated insurance information at time of my appointments that I may be responsible for the bills denied from the insurance company.

Primary Carrier	ID #	Grp #	Eff. Date of Policy
Secondary Carrier (if have)	ID#	Grp. #	Eff. Date of Policy

New Patient Insurance Information: I, _____ am a new patient of Beaches OBGYN and understand that Beaches OBGYN does not accept Medicaid for new patients. I understand if at any point I get Medicaid as my primary insurance or secondary insurance I will notify Beaches OBGYN. I understand that if I accept Medicaid for my coverage as a new patent that I will have to transfer my care and will be discharged from Beaches OBGYN division.

Patient Name (Printed)	Signature	Date

Signature	Staff Name (printed)	Date

Please note that all OB patients will be given this form at every OB visit at Beaches OBGYN. Should you have any questions you may inquire with Practice Administrator.