North Florida OB/GYN, LLC
1361 13th Avenue, South Suites 190 &110
Jacksonville Beach, FL 32250 Phone: (904) 247-5514 Fax: (904)247-3363

Patient's Name_____ **DOB:** _____/_____/_____ **Date:** _____
Age:_____ **Race** _____ **Referring Physician** _____
Reason for this Appt_____
Pharmacy _____telephone#_____

Menstrual History

Last Period _____ **Age at onset** _____ **Regular** Yes No **Flow** Light Mod Heavy
Cycle Length _____ days (from start to start) Duration: _____ days **Postmenopausal** Yes No
Date of last Pap smear: _____ **Current Birth Control Method** _____

Bleeding between menses Vaginal discharge PMS
Bleeding after intercourse Vaginal irritation Large Clots
Night Sweats / Hot Flashes Irregular Bleeding Pains / Cramps
Other: _____

Family History:

Please √ if any of these have been found in any of your close relatives (parents, grandparents, brother, sister or children)

	Whom?		Whom?		Whom?
High Blood Pressure		Tuberculosis		**Cancer**	
Kidney Problems		Alzheimer's / Dementia		Breast/Age	
High Cholesterol		Depression		Melanoma	
		Suicide			
Diabetes		Blood Clots		Ovarian	
Heart Disease		Osteoporosis		Colon	
Stroke		Birth Defect		Other	

Any Drug, Food, Latex or Iodine Allergies **List ALL OTC/Prescribed medications you are currently taking**

Drug	Reaction

Drug	Dose	How Often

Drug	Dose	How Often

Past Medical History:

Have you ever had a blood transfusion? Yes No
Would you have a blood transfusion to save your life? Yes No
Do you have an advanced directive? (Do Not Resuscitate) Yes No
Have you ever had any of the following illnesses? Circle all that apply

Heart Trouble	Osteoporosis	Chronic Fatigue	Breast Problems / Nipple Discharge
Kidney / Bladder Problems	DES exposure	Anemia	Hemorrhoids
High Blood Pressure	Dysplasia / HPV	Cholesterol	Anesthesia Problems
Low Blood Pressure	Fibroids	Hepatitis	Heart Murmur / MVP
Thyroid Problems	Pelvic Prolapse	Anxiety	Prophylactic antibiotics before procedures
Migraine Headaches	Depression	Varicose Veins	Polycystic ovarian syndrome
Rectal Bleeding	Endometriosis	Diabetes	Genital Herpes Genital Warts
Stomach Trouble /Ulcer/ IBS	Seizures	Blood Disorders	Abnormal pap smear

STD type_____Cancer (type) _____ Are you HIV positive?_____

Surgical History: (Including Hospitalizations)

Pregnancies _____ **Miscarriages** _____ **Abortions**____

Date	Procedure

Date	Delivery Type	Sex	Lbs/Oz	Complications

Smoker? **No** **Former Smoker** **Current Smoker (packs per day_____)**
Social History: **Use of alcohol** Drinks per week_____ **Illegal Drugs** Yes No
Currently sexually active No Yes / **With opposite sex** **Same sex / Same Partner** Yes No
Single _____ **Married** _____ **Divorced**_____ **Widowed** _____
History of Domestic Abuse: No Yes explain: _____

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 _____ 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_____
(City) (State) (Zip)

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.

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 01/**01/2013**. I acknowledge that I have read this authorization and fully understand its contents.

Signature_____Date_____

NORTH FLORIDA OB GYN LLC

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**

This consent to release information will remain in effect until revoked in writing.

_____ _____ _____
Print Patient's Name Signature Patient Date

_____ _____ Division: _____
Staff Witness Date

January 2013

North Florida OB/GYN
Of Jacksonville Beach

Well Woman Annual Examination Consent

It is our understanding that your appointment today is for an "Annual Well Woman Examination." This does not include treatment for a problem and only provides you with a preventative check up to ensure you do not have any problems that need to be addressed during a future visit.

If you wish to have both an annual exam and treat for a problem or if a problem is discovered during your annual exam, your charges will include evaluation of both (in consideration of doctor's schedule that will allow time for both). However, if your insurance company requires a referral or authorization for the problem visit and you do not have one, it will then become your financial responsibility.

Please sign below indicating that you are here for an "Annual Well Woman Examination" and will be responsible for any charges not covered by your insurance policy. **Any co-payments, co-insurance and/or deductibles will also be your responsibility**. Payments are due at time of service. Please speak with check-in staff if you have any questions.

Patient Name:_____ Account #:_____

Patient Signature:_____ Date:_____

Staff Witness:_____ Date:_____

Notice to Our Patients

Effective August 2015

****Patients that are 15 minutes late for an appointment may 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 for 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 the form with us and **allow 7-10 business days for completion.**
- Copies of your Medical Records. 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.
- Return to Work or School, Proof of Pregnancy and Dental letters are $5.00 per letter.
- Elective optional ultrasounds (gender determination) are $75.00. 3D ultrasounds are $150.00.
- DVD for ultrasound recording is $5.00.

Patient Signature:_____ Date:_____

Staff Witness:_____ Date:_____

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 costs of 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.

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:_____