



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

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Congratulations on your pregnancy! Enclosed please find documents that will need to be filled out and brought with you to your pregnancy confirmation appointment.

Please be sure to have the following items with you:

- Completed information in this packet.
- Current insurance card and photo identification.
- Referral from your primary care doctor if required by your insurance company. If you are not sure if you need a referral, please contact your insurance company.
- If you have been seen at another medical facility for prenatal care for your current pregnancy, these records **MUST** be brought with you or received at our office prior to your visit!
- We will verify your insurance benefits. It is recommended that you check with your insurance company to find out what your responsibility for maternity care will be. If selfpay our staff will let you know your responsibility.

To provide the absolute best care and attention to you, it is required that this completed packet be brought with you to your appointment. If you have any questions, please leave that area blank and our obstetrical coordinator will be happy to assist you! If you are unable to complete this packet before your scheduled appointment, please call (904) 247-5514 to reschedule.

We look forward to providing you with top-notch obstetrical care and getting to know you throughout your pregnancy!

Thank you!

NORTH FLORIDA OBGYN, LLC

CONSENT FOR DELIVERY

PATIENT NAME: _____

Date _____

I hereby authorize the hospital, its employees and agents, and its independent medical and professional staff, including physicians at North Florida OBGYN, LLC- Beaches IV and/or his/her associates and designees to perform the operations and/or procedures listed below. I understand that my physician /provider participates in a call group and that any member of that call group may deliver my baby.

1. PROCEDURES:

Vaginal Delivery

The baby is delivered through the vaginal canal, with the help of the medical provider. The procedure may or may not include an episiotomy (incision in the vaginal opening). At times, the use of a vacuum (suction) device or forceps (special instruments that are placed around the sides of the babies head) are needed to assist the delivery. Most babies are delivered head first, but some are delivered feet or buttocks first. Anesthesia, if required may include IV pain medications, epidural, spinal, pudendal, local or general.

Cesarean Section

The baby is delivered through an incision in the mother’s abdomen and uterus, occasionally with the help of forceps or a suction device. A Cesarean Section may be scheduled or required for many reasons. These reasons include, but are not limited to having a previous Cesarean Section, the baby may not tolerate labor and have drops in the heart rate, or the baby may not be head first which is called “malposition,” or the baby may not be descending through the birth canal properly. Anesthesia may include epidural, spinal, or general anesthesia.

RISKS AT THE TIME OF DELIVERY:

Retained Placenta - The placenta (afterbirth) usually is delivered in one piece but on occasion fragments of the placenta may be retained in the uterus during vaginal or cesarean birth which can cause bleeding, infection, and may require D&C, hysterectomy, and blood transfusions.

Emboli – During vaginal or cesarean birth the amniotic fluid which surrounds the baby may enter the mother’s circulation (amniotic fluid embolus) or a blood clot may form in a vessel, come loose and go to the lung (pulmonary embolus). These are serious complications which may result in maternal and/or fetal death.

Uterine Rupture - I understand that if I have had previous uterine surgery, there may be an increased risk of uterine rupture prior to or during delivery.

Uterine Atony – The uterus may not contract properly after vaginal or cesarean birth causing excessive bleeding or hemorrhage. This can usually be controlled by medications and/or uterine massage.

Maternal and/or Fetal Death - Rarely occurs prior to or during vaginal or cesarean delivery.

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Tissue Injury During Vaginal Birth- Vaginal birth causes extreme pressures on the tissues and organs of the pelvis. This can result in tears of the vagina, rectum, cervix, or uterus which can later cause urinary or fecal incontinence, prolapse of the uterus and vaginal walls, and/or pain with intercourse. Occasionally patients develop a large bruise or hematoma of the pelvis which may require surgery to drain. Sutures used for repair of vaginal tears or episiotomies usually heal quickly but on occasion poor healing or infection may require prolonged treatment. Rarely a fistula (hole) can develop between the vagina and rectum or the vagina and bladder.

Shoulder Dystocia during Vaginal Birth- Rarely after delivery of the baby’s head the shoulders may become entrapped behind the pubic bone and can be difficult to deliver. This condition is called “shoulder dystocia” and is very difficult to predict. Even with proper use of maneuvers to deliver the shoulders, nerve injuries to the baby’s neck and upper extremities are possible. Specific risks or complications associated with these maneuvers include the need for emergency cesarean section, uterine rupture, trauma to the fetus and maternal and/or fetal death.

Risks associated with Forceps and Vacuum Devices- Occasionally vaginal and cesarean deliveries are assisted by the use of forceps or a vacuum apparatus which can be life saving for the baby. These devices when properly applied usually cause no injuries to the fetus but often leave a mark on the baby that is temporary. In rare instances, even with proper use injuries to the baby can occur. Risks include cephalohematoma (swelling under the skin with bruising of the head), cranial (skull) fractures, facial bruises, intraventricular (brain) hemorrhage, retinal hematoma (bruising of portion of the eye) and facial nerve palsy.

Additional Risks of Cesarean Section- Risks and complications include pain, numbness, scarring, dehiscence (separation of incision), hematoma (a collection of blood in the tissues), bruising, need for hysterectomy, risks of anesthesia, bleeding, infections, the formation of adhesions which may cause a bowel obstruction or other problems later, injury to the internal organs such as bladder, bowel, ureters, nerves, blood vessels and the baby itself. These complications are rare but do occur on occasion.

General Surgical Risks – I have been informed that there are risks attendant to the performance of any surgical procedure, such as severe loss of blood, infection, the formation of blood clots which may break loose and go to the lung or other areas, reaction to anesthesia or other medications, cardiac and/or respiratory arrest, complete or partial paralysis, brain damage, injury to internal organs, death and others as well as the specific risks listed above. At times a return trip to the operating room may be required to repair injuries, control bleeding, drain hematomas or abscesses, to cut adhesions, or other reasons. I am aware that the practice of medicine and surgery and the administration of hospital care, are not exact sciences, and I acknowledge that no guarantees have been made to me as to the results of the operations or procedures described.

THE FOLLOWING PROCEDURES MAY BE PERFORMED AND HAVE ADDITIONAL RISKS SPECIFIC TO THAT PROCEDURE:

Induction of Labor: I, _____, understand that induction of labor has the following possible risks:

- I understand that drugs may be used to induce labor; the membranes may be ruptured artificially, or a combination of both may be used.
- I understand that the drug(s) used may over stimulate my uterus and could cause contractions too close together and/or could cause distress in my baby requiring a cesarean section or rarely cause a rupture or tear in the uterus.

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- I understand that I may fail to go into labor despite the medication and may require a cesarean section for delivery.
- I understand that labor may start but I may not make satisfactory progress to deliver vaginally and may need a cesarean section to deliver.

External Cephalic Version (ECV): I understand that External Cephalic Version (ECV) has the following specific risks and limitations:

- I understand that I may have side effects from the drug used to relax my uterus. These side effects are rare but can include nervousness, drowsiness, tremors, palpitations (awareness of my heart beating). I understand these usually only last a few minutes. I understand I may notice some discomfort during the procedure, but if I experience pain, I should alert the physician.
- I understand that even if the ECV has an average success rate of 58% and even if the ECV is successful, my baby may not remain in the head down position.
- I understand that there is a small chance I may need an immediate cesarean section, should my baby's health be seriously affected by the ECV. This would include slowing of the heart rate and bleeding.

1. **Unforeseen and/or Additional Procedures** – I understand that, during the course of the procedures described above, it may be necessary or appropriate to perform additional procedures that are unforeseen or not known at the time of this consent. I, therefore, authorize and request that the above named physician and such assistants or other physicians as may be designated by him/her perform such procedures as are necessary and desirable in the exercise of professional judgment.
2. **Anesthesia** – I consent to the administration of any anesthesia deemed necessary in the course of the procedure.
3. **Recuperation** – I understand my recuperation and the likelihood of achieving my care and treatment goals will vary depending upon my overall health status. I have discussed any questions I may have with my physicians.
4. **Alternatives** – My physician/provider and I have discussed the surgical and non-surgical alternatives to the procedures to be performed. We have agreed upon the procedure and approach that best meets my needs and physical condition. I understand that circumstances encountered may require the physician/provider to alter the planned approach.
5. **Care for Child** – I authorize the above named physician/provider and such assistants as may be designated by him/her to perform such procedures and to render such treatment as are necessary in the exercise of his/her professional judgment to my baby.
6. **Tissue Disposal** – I authorize the hospital to dispose of the placenta, umbilical cord (afterbirth) and any severed tissue, organs, or body parts in accordance with its policies.
7. **Observers and Education** – I consent to the admittance of technical advisors, students, and/or observers, in accordance with ordinary practices of the hospital. I understand that some hospitals use closed circuit television to monitor the progress of patient care in their operating rooms. I consent to the taking of photographs and video tapes and the preparation of drawings and similar illustrative graphic material. I also consent to the use of such photographs and other materials for scientific purposes, provided my identity is not revealed by the pictures or by the descriptive text accompanying them. Materials felt to be pertinent to my care and which will be included in my medical record will be appropriately labeled with my identifying information.
8. **Blood Transfusion and Blood Component Therapy Consent or Refusal** – I, _____, understand that a transfusion of whole blood or blood components may be given for one or more of the following reasons: Red blood cells to correct anemia and to increase the oxygen delivery to the body, or platelets and /or plasma components to help my blood clot and prevent bleeding.

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Risks of not receiving blood component therapy: shock, liver failure, kidney failure, cardiac problems, respiratory problems, neurological problems, and possibly my death and /or the death of my baby.

Risks associated with blood transfusions and blood component therapy:

- **Common reactions** that are usually not dangerous, including: bruising, chills, fever, rash, hives, or other allergic reactions.
- **Less common reactions** but more serious risk including: Kidney failure, heart failure, anemia, or shortness of breath.
- **Very rare reactions** that could be life-threatening including: Acquiring infectious diseases or other conditions such as:
 - 1) Hepatitis (risk of 1:150,000) which is an inflammation of the liver;
 - 1) Human Immunodeficiency Virus (HIV, risk of 1:2,000,000), which causes a decrease in human T cells that are needed to fight off infections and can cause a disease known as Acquired Immune Deficiency Syndrome (AIDS).
 - 2) Risk of death or serious bodily injury
 - 3) Other risks discussed by my physician/provider

Alternatives to transfusions: (Each of which has its own risks)

- 1) Artificial blood components and volume expanders
- 2) My blood that is recycled during surgery. (Only possible for certain types of surgery.)
- 3) Medications to increase the body’s ability to make more blood cells; must be given ahead of time.
- 4) Autologous blood (my own blood donated before surgery) -must be collected 1-3 weeks ahead of time.
- 5) Directed donors (blood donated by people I choose). Requires three business days and has not been found to be safer than the general blood supply.
- 6) Other alternatives discussed by my physician/provider.

Source of blood for transfusions:

I, _____, understand that the hospital is provided blood and blood products by our community blood bank, the Florida-Georgia Blood Alliance, which is licensed and registered with the Food and Drug Administration (FDA). I agree that the blood or plasma supplied for my use is incidental to the rendition of services and that no guarantee or warranty of fitness or quality, express or implied, has been made to me and none is applicable to the blood supplied or the transfusion procedure.

Blood products received by the hospital are stored, prepared, and infused in accordance with the American Association of Blood Bank’s current standards to ensure patient safety. I have had a chance to ask questions and have received answers that satisfy me. No guarantees have been made to me about the outcome of transfusion therapy.

I understand that I have the right to accept or refuse a transfusion or blood component therapy and I understand and accept the consequences of that decision.

I understand that I can change my mind about the transfusion decision I make at any time by telling my physician and signing a new consent/refusal form

Initial the following blanks as applicable:

- ___ **Yes**, I voluntarily consent to the transfusion of blood and blood components, and I agree to accept the risks and consequents of the transfusion.
- ___ **No**, I do not consent to the transfusion of blood and blood components. I agree to accept the risks and consequences of refusing transfusion. I hereby release the hospital, its employees, agents, and representatives, my physician, from all liability for any unfavorable consequence or adverse outcome arising from my refusal to permit transfusion.

MEDICAL HISTORY

Name: _____

Date: _____

PAST PREGNANCY HISTORY

How many times have you been pregnant? (Counting this pregnancy) _____

How many live born babies have you had? _____

Are all of your live born children living? _____

Have you had any of the following?

a. Miscarriage? Yes _____ No _____

b. Stillborn baby? Yes _____ No _____

c. Children born with birth defects? Yes _____ No _____

(Ex: Spinal defect, heart defect, limb defect, Down Syndrome)

FAMILY HISTORY

Your Family

Anyone in your family:

a. Mentally handicapped? Yes _____ No _____

b. Had a child with birth defects? Yes _____ No _____

c. Cystic Fibrosis? Yes _____ No _____

Are there any diseases that "run" in your family? Yes _____ No _____

If "yes" please explain: _____

Father of the Baby's Family

How old is the father? _____

Anyone in his family:

a. Mentally handicapped? Yes _____ No _____

b. Had a child with birth defects? Yes _____ No _____

c. Cystic Fibrosis? Yes _____ No _____

Are there any diseases that "run" in his family? Yes _____ No _____

If "yes" please explain: _____

ETHNICITY

Are you or the baby's father of:

a. Eastern European Jewish origin (Ashkenazi)? Yes _____ No _____

b. Italian, Greek or Southeast Asian origin? Yes _____ No _____

c. African origin? Yes _____ No _____

(Ex: Black, Ethiopian, Haitian, Nigerian, West Indian, etc)

Have you or the baby's father been tested for:

- | | | |
|-------------------------|----------|---------|
| a. Tay-sachs disease? | Yes_____ | No_____ |
| b. Thalassemia? | Yes_____ | No_____ |
| c. Sickle Cell disease? | Yes_____ | No_____ |

CURRENT PREGNANCY

Will you be age 35 or older when the baby is born? Yes_____ No_____

Do you:

- | | | |
|---|----------|---------|
| a. Smoke? | Yes_____ | No_____ |
| b. Drink alcohol? | Yes_____ | No_____ |
| c. Use "recreational" or street drugs? | Yes_____ | No_____ |
| d. Do you have any chronic health problems?
(Ex: Diabetes, heart disease, epilepsy, etc) | Yes_____ | No_____ |

If "yes" please explain:_____

During this pregnancy have you had:

- | | | |
|-----------------------------------|----------|---------|
| a. Any type of illness? | Yes_____ | No_____ |
| b. A high fever? (102° or higher) | Yes_____ | No_____ |

Do you take medications on a regular basis?

- | | | |
|---|----------|---------|
| a. Prescription? | Yes_____ | No_____ |
| b. Non-prescription?
(Medications you can buy over the
counter without a doctor's prescription) | Yes_____ | No_____ |

During this pregnancy have you taken any:

- | | | |
|---------------------------------|----------|---------|
| a. Prescription medication? | Yes_____ | No_____ |
| b. Non-prescription medication? | Yes_____ | No_____ |

Do you:

- | | | |
|---|----------|---------|
| a. Take vitamins? | Yes_____ | No_____ |
| b. Follow a special diet?
(Ex. Vegetarian, macrobiotic, etc) | Yes_____ | No_____ |

Have you had any x-rays or any type of surgery during this pregnancy? Yes_____ No_____

Have you been exposed to any possible toxic chemicals at home or work? Yes_____ No_____

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CONSENT TO TREAT FOR PREGNANCY

The Obstetricians and Certified Nurse Midwives of North Florida OB GYN, LLC wish to welcome you to our practice. We consider this to be a very enjoyable specialty because our patients are generally healthy women eagerly awaiting the arrival of their babies. We believe that good communication and an environment of mutual respect and cooperation help ensure a healthy mother and baby. We want you to be informed about the events and risks associated with pregnancy.

A patient's lifestyle is an important part of her health, pregnant or not. It is important for patients with medical conditions to work with her physicians to become as healthy as possible prior to becoming pregnant. This may include exercising, weight loss or medication changes. Obesity, smoking, poor eating habits, drug use, and lack of exercise can potentially lead to complications for the mother and baby. Patients are ultimately responsible for their lifestyle choices. Approximately 3%-4% of all babies are born with birth defects. Smoking, certain medications, illicit drugs, alcohol, infectious diseases, complications of other medical conditions such as diabetes, and hereditary conditions are a few examples that can lead to birth defects. Often there is no identifiable reason for birth defects. Stillbirth is rare and often there is no obvious cause.

Pregnancy is a normal process for women, but the risk of complications always exists. These infrequent complications may occur with little to no warning despite our best efforts to prevent them. Our goal is to educate our patients and their partners about these risks so that they are aware and better prepared in the unlikely event any of these complications are encountered.

Early Pregnancy

During the first few months of pregnancy nausea and vomiting are common. Occasionally it becomes severe enough to require hospitalization. Miscarriage occurs in approximately 20% of pregnancies. Bleeding with abdominal cramping are usually early signs of potential miscarriage. Early pregnancy loss may require surgery (Dilatation & Curettage). Loss of pregnancy after the first trimester is rare and is most often due to problems with premature cervical dilation or rupture of membranes.

Ectopic Pregnancy: Ectopic pregnancy is a pregnancy located outside the uterus, most commonly in the fallopian tube. Unchecked, tubal ectopic pregnancies can rupture and cause life threatening hemorrhage. Typical signs of ectopic pregnancy include abdominal pain, vaginal bleeding and shoulder pain. Any abdominal pain or bleeding in the first trimester should be reported to your physician. Occasionally medications can be used to treat ectopic pregnancy but more commonly surgery is needed to remove the ectopic pregnancy, tube or ovary.

Medical conditions such as diabetes, heart disease, high blood pressure, and herpes require special attention in pregnancy. It is therefore, extremely important to completely disclose all of your medical and surgical history to your physician. Pregnancy may worsen some conditions. Many of these conditions require more intensive management and may require more frequent visits to properly control. It is the patient's responsibility to keep all scheduled appointments.

Infections, mostly minor are common in pregnancy. These include upper respiratory, urinary tract, and vaginal infections. Infections in the uterus are less common but can be very serious. Any infection that occurs in a non pregnant state can also occur during pregnancy.

It is important that patients inform their physician of any Gynecological procedures they have had in the past, particularly procedures that involve the cervix.

Late Pregnancy

Complications in late pregnancy can include heavy vaginal bleeding due to placental abnormalities or location, or early separation of the placenta from the uterine wall. Other complications in pregnancy can relate to inappropriate growth of the baby, premature birth, incompatibility of baby's and mother's blood. Pregnant women are prone to develop varicose veins, phlebitis, and occasionally blood clots in the legs.

Preeclampsia (Toxemia)

Preeclampsia is a condition resulting in high blood pressure, protein in the urine, and swelling. It may be mild or severe. The hallmarks of preeclampsia are elevated blood pressure, rapid weight gain, swelling of the hands and feet, and spillage of protein in the urine. These symptoms should be promptly reported to you physician. In most cases mild preeclampsia can be managed in the outpatient setting, bur occasionally hospitalization is required. The treatment for preeclampsia is delivery of the baby. Strict pre-delivery management includes bed rest, diet modifications, medications, and fluid management. Sometimes these measures are needed to prolong pregnancy and allow time for the baby to mature enough for a safe delivery.

Eclampsia- is a severe form or preeclampsia characterized by severely elevated blood pressures, seizures, and on occasion coma. Life threatening complications for the mother can include kidney or liver failure, and uncontrollable hemorrhage.

Complications at the time of delivery

Occasionally vaginal deliveries are assisted by the use of forceps or a vacuum apparatus. These are called operative vaginal deliveries and when properly performed can be life saving for the baby. These devices when properly applied usually cause no injuries to the fetus but may leave a mark on the baby that is temporary. In rare instances, even with proper use injuries to the baby can occur. These instruments are not used unless the benefit to the mother and fetus outweigh the risks, and the mother has consented to their use. Risks include cephalohematoma (swelling under the skin with bruising of the head), cranial (skull) fractures, facial bruises, intraventricular (brain) hemorrhage, retinal hematoma (bruising of portion o the eye) and facial nerve palsy.

Rarely after delivery of the baby's head the shoulders may become entrapped behind the pubic bone and can be difficult to deliver. This condition is called "shoulder dystocia" and is very difficult to predict. Even with proper use of maneuvers to deliver the shoulders, nerve injuries to the baby's neck and upper extremities are possible. Specific risks or complications associated with these maneuvers include the need for emergency cesarean section, uterine rupture, trauma to the fetus and maternal and/or fetal death.

The placenta (afterbirth) usually is delivered in one piece but on occasion fragments of the placenta may be retained in the uterus which can cause bleeding , infection, and may require D&C, hysterectomy, and blood transfusions. Other serious complications include amniotic embolus (fluid entering the circulation) or pulmonary embolus (blood clot in the lungs).

Vaginal birth causes extreme pressures on the tissues and organs of the pelvis. This can result in tears of the vagina, rectum, cervix, or uterus which can later cause urinary or fecal incontinence and prolapse of the uterus and vaginal walls. Occasionally patients develop a large bruise or hematoma of the pelvis which may require surgery to drain. Sutures used for repair of vaginal tears or episiotomies usually heal quickly but on occasion poor healing or infection may require prolonged treatment.

Cesarean Section- is the surgical delivery of a baby through an incision through the abdomen and uterus. Cesarean Section may be required for many reasons. The baby may not tolerate labor and have drops in the heart rate. The baby may not be head first called “malposition”. The baby may not be descending through the birth canal properly. Cesarean Section as with any surgery has risks and complications. These include pain, numbness, scarring, dehiscence (separation of incision), hematoma (bruising), placenta retention, hysterectomy, risks of anesthesia, bleeding, infections, injury to the internal organs such as bladder, bowel, ureters, nerves, blood vessels and the baby itself. These complications are rare but do occur on occasion.

Vaginal Birth after Cesarean Section (VBAC) - Women who have had one previous Low Transverse Cesarean Section may attempt a vaginal delivery in a subsequent pregnancy unless her physician indicates otherwise. If VBAC is attempted and unsuccessful, repeat Cesarean Section carries a slightly greater risk of post operative infection of the uterus. The most serious complication of VBAC is uterine rupture which occurs in approximately 1% of cases. If uterine rupture occurs, bleeding which may require blood transfusion may occur as well as bladder injuries and the possible need for hysterectomy. In rare cases uterine rupture can result in fetal or maternal death.

Anesthesia - There are several types of anesthesia used in pregnant patients most commonly local, regional, or general. Any patient could have an adverse reaction to anesthesia or be allergic to the medications used. General anesthesia can rarely result in aspiration pneumonia. Regional anesthetics such as spinal or epidural can cause headaches, leg or back pain, or a drop in blood pressure and possible fetal distress requiring immediate Cesarean section.

Blood transfusions are only given when absolutely needed and can also result in allergic reactions to any of the blood components as well as a risk of transmission of Hepatitis or HIV.

After Delivery

The period of care after delivery is called the “post partum period”. Problems during this period may include itching from sutures after episiotomy or laceration repair, vaginal discharge, infection, depression, breast pain, lack of sleep, and back or leg pain from spinal or epidural anesthesia.

IT IS IMPOSSIBLE TO LIST EVERY SINGLE EMERGENCY OR COMPLICATION OF PREGNANCY. THIS “INFORMED CONSENT” IS NOT INTENDED TO ALARM THE PATIENT, BUT TO REMIND THE PATIENT THAT LIFE AND PREGNANCY ARE NOT WITHOUT RISK. WE ASK THAT YOU AND YOUR PARTNER ACKNOWLEDGE RECEIPT OF THIS INFORMATION BY SIGNING BELOW. THIS DOCUMENT WILL BECOME PART OF YOUR MEDICAL RECORD. WE WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE. YOU MAY REQUEST A COPY OF THIS DOCUMENT FOR YOUR PERSONAL RECORDS.

My condition and the risks of these procedures and alternative treatments have been explained to me. I have had an opportunity to ask questions and I understand the information I have been provided. I agree to follow any and all pre and post procedure instructions given to me and to contact the office if I have any problems.

My provider will test me for chlamydia, gonorrhea, hepatitis B, HIV and syphilis as required by Florida law 64D-3.042. I understand I can refuse any or all of these tests and must inform my provider in writing if I wish to refuse these tests.

I understand my provider may test me for drug/alcohol use and that the test results are considered to be super confidential information. The test results may only be released by specific written authorization, court order or as required by law. I understand that the test results are necessary to provide appropriate care to me and my unborn child.

I acknowledge that I must keep all appointments and call in blood sugars and blood pressures if so directed. It is SOLELY my responsibility and if I do not comply, it will be considered an episode of non compliance and may result in being discharged from the practice.

I, _____, consent to allow the physicians and providers, which may include ARNP and ARNP Certified Midwives of North Florida OB GYN, LLC. to treat me for my pregnancy and understand that they may need to perform certain procedures as described above and any additional procedures they deem medically necessary unless I refuse such procedures at that time.

I specifically authorize the release of all prenatal records, including super confidential information (i.e. HIV-AIDS, sexually transmitted diseases, mental health and drug/alcohol), to the hospital for the purpose of treatment of myself and my unborn child during: (i) my pregnancy, (ii) labor and delivery and (iii) antepartum care.

(Signature of patient or legal guardian)

(Date)

(Signature of partner)

(Date)

(Signature of witness)

(Date)

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: _____

North Florida OBGYN, LLC

Obstetrical Care Financial Information and Contract

Routine Obstetrical Care includes a routine exam, the prenatal (before the birth of the baby) office visits, the delivery of the infant, and post partum (after the birth) care including the postpartum office visit – typically at 6 weeks after delivery. This is often covered under one “Global OB fee.”

Professional services, which are medically indicated, are provided in addition to the global OB fee are billed and paid separately - some at the time of service, others are occasionally billed to your insurance. Examples of services which are in addition to the routine global fee are: High Risk pregnancy, RhoGam injections, ultrasounds, amniocentesis, non-stress tests, biophysical testing, HIV testing, hospitalization during pregnancy, office visits for a problem not related to your pregnancy, anesthesia costs related to delivery, additional costs related to a Cesarean or VBAC (vaginal birth after previous c-section) delivery, assistant surgeon required during delivery, tubal ligation and circumcision of a male infant. Lab work is typically billed by the lab providing the test. If you have had a previous C-section, were considered high risk or are planning a tubal ligation, please advise our office. Co-pays are required for non-pregnancy related (ex – sinus headaches, urinary tract infections, etc.) office visits.

Some services are not covered by your insurance. This would include elective ultrasounds or lab work drawn at our office for your convenience, all forms –disability, FMLA, return to work. The fees for these services must be paid for at the time of the service.

Your Insurance: We verify with your insurance company that you have coverage and what is included in their global fee allowance. We do this, so that we can help you understand your coverage and set up a payment plan as needed. We verify this several times during your pregnancy. The estimate of benefits quoted is not a guarantee of benefits and is based on the current information that you have supplied us. We advise that you check with your insurance company as well. We can not be responsible for any discrepancy between the estimate and the actual payment from your insurance carrier.

If you change insurance or your job, please inform us immediately, so we may help you avoid being denied coverage. We cannot be responsible for any incorrect information or changes. All of the information must be provided to us by you! It is your responsibility to make sure this information is correct and updated at all points of your pregnancy. Please make sure we have the most recent, updated copy of your insurance card, as we will keep a copy in your chart.

The amount you owe for your **co-payments, deductibles and co-insurance** for the delivery and other planned services (tubal ligation, circumcision) **must be paid in full no later than the 28th week** of your pregnancy. Our policy requires a deposit with mutually agreed upon payments, usually on the 16th, 20th, 24th and 28th week or at any visit prior to the 28th week. **Failure to make a payment and meet this responsibility may result in your discharge from our practice.**

We file with your insurance plan for your routine OB care immediately after delivery. If your insurance has not paid within 90 days, you are responsible for the balance. You are ultimately responsible for payment of all services provided.

Referrals, Authorizations and Precertification of Insurance: It is **your** responsibility to obtain any referrals necessary for your primary care physician or as your insurance company requires. We will obtain necessary authorizations, including high-risk authorizations.

Most insurance companies require you to contact their Pre-certification department within 24 hours of delivery. Please verify the Pre-certification department’s phone number and have it available as your expected date of confinement approaches. Failure to pre-certify your delivery can cause a reduction in the payment or denial of your

OB-care claims. The responsibility for the balance is then transferred to you for payment in full. You should contact your insurance company to answer any questions about the pre-certification process.

Circumcisions: If you have a male child who you would like circumcised, you must provide the information needed within 30 days after delivery, including his name and confirmation he has been added to you or your husband's insurance plan. If your child will be added to your spouse's insurance instead of yours – you must supply our office with his insurance information so we might bill correctly. If circumcision is covered, we will bill the insurance company, otherwise you must pay for the service before rendered. If you are a dependent on your parents insurance and have a male and a circumcision is requested, you will be required to pay for the services.

Sonogram Policy: During your pregnancy, we may be performing ultrasound studies on your baby in our office. This includes taking specific measurements and studying the anatomy and the vital organs of your baby. While a complete sonogram will detect many abnormalities, it should not be considered as absolute proof of an absence of fetal defects or problems. It is important the sonographer has a quiet atmosphere in which to concentrate. We ask you bring no more than two (2) guests to your ultrasound appointments. Any children must be mature enough to stand quietly and accompanied by another adult. You may bring a DVDR to have the ultrasound recorded and must be of good quality.

If we are performing an elective ultrasound sonogram or 3D ultrasound – the fee for the service must be paid before or at the time of the procedure. As this is not a medically indicated test, we will not be filling for reimbursement with your insurance carrier.

Medicaid: If you have Medicaid or are applying for Medicaid coverage – please speak to our financial counselor. We will assist you in determining if we can accept the coverage based on our level of participation in either traditional Medicaid or one of the Medicaid HMO or PSN reform plans. **You may be responsible for payment in full if our providers do not participate and accept the Medicaid plan you are enrolled in or are considering enrolling.** Please do not assume your pregnancy will be paid by Medicaid or that we accept Medicaid. Medicaid has very specific guidelines we must follow. This applies to both Medicaid as your primary or secondary coverage. **If you have Medicaid as your secondary insurance, we must bill your primary plan first.**

Transfer of care: If by some chance you transfer to another physician, the cost of care we provided will include only the prorated share for services actually received.

This contract cannot guarantee a successful pregnancy outcome, but only covers the financial responsibilities of your care. Payment responsibilities are calculated on the next page.

I, _____, have read this OB contract and understand the financial policies. I have had an opportunity to ask questions about this contract.

Patient's Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

NORTH FLORIDA OB/GYN LLC

CIRCUMCISION CONSENT FORM

PROCEDURE – CIRCUMSICION

Removal of a portion of the foreskin from the penis, with or without the use of a local anesthetic.

PURPOSE OF THE PROCEDURE

To remove a portion of the foreskin for cosmetic, hygienic or cultural reasons.

POSSIBLE ALTERNATIVES

Do nothing.

RISKS OF THE PROCEDURE:

Bleeding, infection, pain, allergic reaction to medication that may be used for numbing the penis or latex. Possible scarring, injury to the penis or urethra or repetition of the procedure if not enough of the foreskin is initially removed.

RISKS IF PROCEDURE IS NOT DONE:

None unless the procedure is medically indicated.

My child's condition, these procedures, alternative treatments (including no treatment) and the risks of these procedures have been explained to me. I have had an opportunity to ask questions and I understand the information provided.

I understand that any tissue removed will be sent for further evaluation as appropriate and it is my responsibility to make sure I am given those results. I also agree to follow any pre and post procedure instructions given to me and to contact the office if I have any problems.

I, _____, consent to allow North Florida OBGYN, LLC- Beaches IV physician to perform the procedures described above and any additional procedures that they find necessary at the time unless I refuse such procedures at that time.

(Signature of patient or legal guardian)

(Date)

(Signature of witness)

(Date)

Please sign below if you do not wish to have a circumcision performed on your child:

After careful consideration of the risks and benefits of this procedure as well as the risks of not having it done, **I do not** wish to have my child circumcised. I take full responsibility for the consequences of not having the procedure done.

(Signature of patient or legal guardian)

(Date)

(Signature of witness)

(Date)

Routine Obstetrical Care Costs

Basic Comprehensive Obstetrical Care, vaginal delivery	\$3775.00
Basic Comprehensive Obstetrical Care, cesarean delivery	\$4256.00

Not Included in Obstetrical Care

If you choose to have your lab work collected in our office, there is a one time convenience fee of \$50. This fee will include only the collection of blood/urine specimen. The lab will charge your insurance/you a separate fee to run tests. This fee includes most prenatal blood work.

Circumcision- Any additional cost for circumcision will be due before the delivery of your baby boy. The self pay cost of circumcision is \$436. If you are self pay (no insurance) this cost will need to be paid in full by your 36th week. If there is any responsibility with your private insurance (Blue Cross Blue Shield, Aetna, United Healthcare, Tricare, MMSI, etc) it will need to be paid before your 36th week of pregnancy.

Ultrasounds- will be billed to your insurance and depending on your coverage, you may have additional financial responsibility. Ultrasound prices for a single baby are approximately \$200-\$262. You may have an optional 3D sonogram for entertainment purposes only between weeks 26-30 of your pregnancy. The cost of our 3D ultrasound is \$150.

Fetal non-stress tests- this is a test done later in pregnancy due to certain complications and the cost of this test is \$117. It will be billed to insurance and you may have financial responsibility depending on your insurance benefits.

Injections will also be billed separately to your insurance/you. Prices for injections vary depending on the type of injection.

Ultrasound Information

THIS INFORMATION SHOULD BE HELPFUL WITH QUESTIONS YOU MAY HAVE ABOUT YOUR SCHEDULED ULTRASOUND

PREGNANCY ULTRASOUNDS:

(No full bladder is needed unless otherwise instructed)

1. If your doctor has scheduled you for an ultrasound and your pregnancy is less than 12 weeks, you will have a vaginal scan performed.
2. 20 week scans are for checking fetal structure. After the anatomy survey is completed; an attempt will be made to determine gender if desired.
3. 32 week scans are for checking fetal growth and weight.
4. Video taping is permitted for the 20 and 32 week scans only. We are happy to record on flash drive or a DVD-R disc provided by you. If you do not have a DVD-R disc, we can provide one to you at the cost of \$5.
5. Elective, optional ultrasounds (gender determination) are \$75.
6. Elective, optional 3D ultrasounds are \$150.
7. Family and friends are always welcome to accompany you for your ultrasounds.

GYN (non-pregnant) ULTRASOUNDS:

1. If you have ever had sexual intercourse, pelvic ultrasounds are performed vaginally; therefore, no full bladder is required.
2. If you have never had sexual intercourse, pelvic ultrasounds are performed externally and require a full bladder. Please drink 32 ounces of water 1 hour before your scheduled appointment.

If you are on your menses during your scheduled ultrasound, it will not inhibit this procedure from being performed. If you feel uncomfortable, please call our office to reschedule.

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: _____



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

Christina S. Adams, M.D.
Kathryn F. Bing, M.D.
C. Cameron Greene, M.D.
Sayra C. Sievert, M.D.
Elizabeth Morgan Walsh, M.D.
Malinda Moussa, A.R.N.P.

NOTICE TO OBSTETRIC PATIENT

I have been furnished information in the form of a Brochure prepared by the Florida Birth-Related Neurological Injury Compensation Association (NICA), pursuant to Section 766.316, Florida Statutes, by North Florida OB GYN, LLC. Cameron Greene, Kathryn F. Bing, MD, Sayra C. Sievert, MD, Elizabeth M. Walsh, MD & Christina S. Adams, MD.

I have been advised that all the above physicians, the physicians or certified nurse midwives who will join their practice, and other physicians covering for North Florida OB GYN, LLC patients on evenings, weekends, and holidays, all participate in that program.

The program provides certain limited compensation is available in the event certain types of qualifying neurological injuries may occur during labor, delivery or resuscitation in a hospital. For specifics on the program, I understand I can contact the Florida Birth-Related Neurological Injury Compensation Association, P.O. Box 14567, Tallahassee, Florida 32317-4567, 1-800-398-2129.

I further acknowledge that I have received a copy of the Brochure prepared by NICA entitled "Peace of Mind for an Unexpected Problem."

Dated this _____ day of _____, 20____.

Signature

Print Name of Patient

Social Security Number

Attest:

Date: _____



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North Florida OBGYN of Jacksonville Beach
Obstetrical Laboratory Service Agreement

If your insurance is contracted with an “outside” laboratory for your lab work, you can go to their facility and have your blood drawn with no out-of-pocket fee. If you decide to use an outside lab it is essential for you to have your blood work drawn within one week after your initial visit for us to provide you with the appropriate care. **Failure to do so will be considered non-compliance and may be subject to discharge from our practice.**

You are responsible to know which laboratory your insurance is contracted with. However, for your convenience, you may want to have your blood drawn at our office for a one time fee of \$50 to be paid at your first visit. This covers our costs for supplies used during the pregnancy. Our office acts strictly as a “drawing station”. Your labs will be sent to the laboratory designate by your insurance. If at any time during pregnancy your insurance changes, please notify us immediately so that we may send your lab work to the appropriate laboratory.

We cannot control whether or not you receive a bill from that lab for the services rendered. If you have any questions regarding your bill, please contact that laboratory or your insurance company. Please be aware that you will be billed directly by the laboratory for your lab work if you do not have insurance.

Additional testing may be needed that is not recognized by your insurance carrier as usual and customary and is required in order to provide quality obstetrical care. You may get a statement from the laboratory specifying that this is a non-covered service and you may receive a bill.

_____ I agree to pay the one time in office fee of \$50 today

_____ I want to go to an outside laboratory

Patient signature _____

Date _____

Staff Witness _____

Date _____



LABOR & DELIVERY VIDEO TAPING GUIDELINES

Video taping is allowed in labor and delivery according to the following guidelines:

- ◆ **The use of audio-visual equipment, which includes, video cameras, tape recorders, digital or cell phone cameras and still photography, is not permitted during the delivery of the newborn. This includes vaginal deliveries as well as Cesarean sections.**
- ◆ **The use of audio-visual equipment may be used during the course of labor when procedures are not being performed. It also may be used after the delivery of the newborn, when nursing care is completed, as instructed by your nurse.**
- ◆ **Videotaping will be with the consent of the mother. The privacy of all patients will be maintained at all times.**
- ◆ **The camera operator will stop taping at the request of the physicians, nurse or pediatric personnel if complications develop.**
- ◆ **It is recommended that video cameras should be battery operated. The use of electrical cords may cause a safety hazard.**
- ◆ **Videotaping during direct patient care procedures is not allowed. These procedures include: epidurals, spinals, catheterization, etc.**
- ◆ **Labor and Delivery visiting policies will be in effect for anyone transferred to the operating room. Only one support person is allowed in the delivery room. No video camera is permitted in the operating room. Still cameras may be used, but only after nursing care of the newborn is completed. Your nurse will guide you.**
- ◆ **Videotaping in the recovery room may be permitted at the recovery room nurses' discretion. There may be several patients in the recovery room at the same time. Patient privacy will be respected at all times.**
- ◆ **Not everyone wishes to be videotaped. Please be aware of that and ask before taping hospital personnel.**

HELPFUL HINTS

Be familiar with your camera equipment before being admitted to the hospital.

Extra film and batteries may be needed. Have plenty on hand.

Keep video camera batteries charged and ready to use.



Self pay patients OB/GYN
(or in the event you may become a self pay patient)

Please contact Chris Hancock, Maternity OB registration at Baptist Medical Center-Beaches to make payment arrangements prior to your delivery. A \$2000 hospital deposit is required prior to your delivery. You can reach her at (904) 627-2932.

Please contact Kimberly Stewart for payment arrangements regarding anesthesia. The office phone number is (800) 237-6723 ext 2631. Services provided to you by the anesthesiologist are not included in the surgical or hospital fee. It is your responsibility to contact the billing department prior to your scheduled procedure.

Patient signature _____ Date _____

Patient's telephone number _____

Staff witness _____ Date _____

Note: Office staff- please fax this form to Chris Hancock at (904) 627-1129.

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		Ovarian	
Diabetes		Blood Clots		Colon	
Heart Disease		Osteoporosis		Other	
Stroke		Birth Defect			

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.

<u>Relationship</u>	<u>Name of person allowed to receive information</u>	<u>Type of information which may be released</u>				
Mother	_____	<input type="checkbox"/> All info	<input type="checkbox"/> Appts only	<input type="checkbox"/> STD's/HIV	<input type="checkbox"/> Preg/Ab	<input type="checkbox"/> BC
Father	_____	<input type="checkbox"/> All info	<input type="checkbox"/> Appts only	<input type="checkbox"/> STD's/HIV	<input type="checkbox"/> Preg/Ab	<input type="checkbox"/> BC
Husband	_____	<input type="checkbox"/> All info	<input type="checkbox"/> Appts only	<input type="checkbox"/> STD's/HIV	<input type="checkbox"/> Preg/Ab	<input type="checkbox"/> BC
_____	_____	<input type="checkbox"/> All info	<input type="checkbox"/> Appts only	<input type="checkbox"/> STD's/HIV	<input type="checkbox"/> Preg/Ab	<input type="checkbox"/> BC
_____	_____	<input type="checkbox"/> All info	<input type="checkbox"/> Appts only	<input type="checkbox"/> STD's/HIV	<input type="checkbox"/> Preg/Ab	<input type="checkbox"/> 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

Staff Witness

Date

Division: _____

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: _____