FLORIDA WOMEN'S HEALTH, LLC   PHONE: 352-369-5999 FAX: 352-629-4227
4600 SW 46TH COURT SUITE 150   OCALA, FL 34474

PATIENT INFORMATION

NAME: ____D.O.B: ________________
SSN: ____MARITAL STATUS: ______________
RACE: __CAUCASIAN __ BLACK __ HISPANIC __ ASIAN __ NATIVE AMERICAN __ CHOOSE NOT TO ANSWER
ETHNICITY: ___ LATINO/HISPANIC ___ OTHER ___ CHOOSE NOT TO ANSWER
ADDRESS: ____
CITY: ____ STATE: _________ ZIP: ____________
HOME PHONE: ___________________________________ CELL: ______________________
EMAIL: ____
EMPLOYER: ____ PHONE: ________________
EMERGENCY CONTACT: ____________________PHONE/RELATIONSHIP: _________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

NOTICE TO PATIENT:
WE ARE REQUIRED TO PROVIDE YOU WITH A COPY OF OUR PRIVACY PRACTICES, WHICH STATES HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION. PLEASE SIGN THIS FORM TO ACKNOWLEDGE RECEIPT OF THE NOTICE. YOU MAY REFUSE TO SIGN THIS ACKOWLEDGEMENT, IF YOU WISH.

SIGNATURE: ____ DATE: ____________

PERMISSION FOR RELEASE OF INFORMATION

I, THE ABOVE NAMED PATIENT, GIVE PERMISSION FOR:
NAME: ____ RELATIONSHIP: _______________
TO ACCESS MY MEDICAL INFORMATION ON MY BEHALF.

SIGNATURE: ______________________________________ DATE: _____________________

I CONSENT TO RECEIVING MEDICAL RECORDS ELECTRONICALLY

SIGNATURE: ______________________________________ DATE: _____________________

I CONSENT TO A MEDICALLY INDICATED EXAMINATION INCLUDING BUT NOT LIMITED TO A PELVIC EXAM TODAY AND FOR ALL FUTURE VISITS.

Signature:____DATE:______________________

INSURANCE

AS YOUR HEALTHCARE PROVIDER WE WILL FILE YOUR CLAIMS WITH YOUR INSURANCE COMPANY AS A COURTESY AFTER SERVICES ARE PROVIDED, UNLESS OTHERWISE NOTIFIED. IT IS YOUR RESPONSIBILITY TO UNDERSTAND WHAT SERVICES ARE COVERED UNDER YOUR MEDICAL POLICY. IF YOU HAVE QUESTIONS ABOUT WHETHER A SERVICE IS COVERED, WE URGE YOU TO CONTACT YOUR INSURANCE BEFORE THE SERVICE IS PROVIDED.

IF INSURANCE IS NOT IN YOUR NAME:

PRIMARY INSURED'S NAME: ____

D.O.B: ____________________________ SSN: ____

ADDRESS: ____

CITY: _______________________________STATE: _____________ ZIP: ___________________

PHONE: ___________________________________ RELATIONSHIP: _______________________

LIFETIME AUTHORIZTION, INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I. **RELEASE OF INFORMATION-** I, THE BELOW NAMED PATIENT, DO HEREBY AUTHORIZE ANY PHYSICIAN EXAMINING AND/OR TREATING ME TO RELEASE ANY THIRD PAYOR (SUCH AS AN INSURANCE COMPANY OR GOVERMENTAL AGENCY) ANY MEDICAL, PSYCHIATRIC CONDITION, ALCOHOL OR DRUG RELATED CONDITION AND RECORDS CONCERNING DIAGNOSIS AND TREATMENT WHEN REQUESTED BY SUCH A THIRD PARTY FOR ITS USE IN CONNECTION WITH DETERMINING A CLAIM FOR PAYMENT FOR SUCH TREATMENT AND/OR DIAGNOSIS.

II. **PHYSICIAN INSURANCE AGREEMENT-** I, THE BELOW NAMED SUBSCRIBER, HEREBY AUTHORIZE PAYMENT DIRECTLY TO ANY PHYSICIAN EXAMING OR TREATING ME OF ANY GROUP AND/OR INDIVIDUAL SURGICAL AND/OR MEDICAL BENEFITS HEREIN SPECIFIED AND OTHERWISE PAYABLE TO ME FOR THEIR SERVICES, AS DIRECTED BUT NOT TO EXCEED THE REASONABLE AND CUSTOMARY CHARGE FOR THESE SERVICES.

III. **MEDICARE-** PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII/XIX OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO SOCIAL SECURITY ADMINISTRATION/DIVISION OF FAMILY SERVICES OR ITS INTERMEDIARIESOR CARRIES ANY INFORMATION NEEDED FOR THIS OF A RELATED MEDICAL CLAIM. I HEREBY CERTIFY ALL INSURANCE PRETAINING TO TREATMENT SHALL BE ASSIGNED TO THE PHYSICIAN TREATING ME.

IV. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME INSURANCE COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES AND OTHERS PAY A PERCENTAGE OF THE CHARGE. I UNDERSTAND IT'S MY RESPONSIBILITY TO PAY A DEDUCTABLE AMOUNT, CO- INSURANCE OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD-PARTY PAYOR WITHING A REASONABLE PERIOD OF TIME NOT TO EXCEED 90 DAYS. IN THE EVENT MY ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY OR ATTORNEY FOR COLLECTIONS, I WILL BE RESPONSIBLE FOR ANY AND ALL COSTS INCURRED.

SIGNATURE: ____ DATE: _____________

CURRENT PHYSICIANS **SPECIALITY**

CURRENT PHYSICIANS	SPECIALITY
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

CURRENT MEDICATIONS	DOSE/FREQUENCY	CURRENT MEDICATIONS	DOSE/FREQUENCY
__________________	______________	__________________	____________
__________________	______________	__________________	____________
__________________	______________	__________________	____________
__________________	______________	__________________	____________

ALLERGIES	REACTION
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

PAST MEDICAL HISTORY

SURGERY	DATE	SURGERY	DATE
_____________________	_________	_____________________	_________
_____________________	_________	_____________________	_________
_____________________	_________	_____________________	_________
_____________________	_________	_____________________	_________

Medical Conditions

□Abnormal pap smear	□Blood Transfusion	□Eating Disorder	□HPV	□Substance Abuse
□Alcoholism	□Breast Cancer	□Epilepsy	□Infertility	□Skin Disorder
□Allergies	□Breast Lump/Mass	□Fibroids	□Liver Disorder	□STD
□Anemia	□Breast Surgery	□Gallstones currently	□Kidney Disorder	□Thyroid Disorder
□Anxiety	□Cervical Cancer	□Genital Warts	□Joint Disorder	□Tuberculosis
□Asthma	□Cervical Dysplasia	□Glaucoma	□Migraines	□Uterine Cancer
□AIDS/HIV	□Clotting Disorder	□Gout	□Osteoporosis	□UTI- frequent
□Autoimmune Disorders	□Colon Cancer	□Heart Attack	□Ovarian Cyst	□Vaginitis (BV)
□Bipolar Disorder	□COPD	□Heart Disease	□Ovarian Cancer	□Yeast Infection
□Blood Disorder	□Diabetes	□Hepatitis A,B, or C	□Pelvic Inflammatory	
	□Depression	□High Blood Pressure	□Stomach Ulcer	
	□DES exposure	□High Cholesterol		

(If checked- please give more detail such as date of onset, type of STD, etc.)

Other:____

LAST COLONOSCOPY DATE: ____

*IF YOU ARE 65 OR OLDER HAVE YOU FALLEN IN THE PAST YEAR? ______________ IF YES, WHAT INJURIES OCCURRED? ____

Florida Women’s Health, LLC
4600 SW 46th Court, Suite 150, Ocala, FL, 34474
Telephone: (352) 369-5999 ~ Fax: (352) 629-4227

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ___________________________ ID Number: __________________________
Date of Birth: ____________________________

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/ organizations providing the information:

____
____
____

Persons/organizations receiving the information:

____
____
____

Specific description of information (including dates):

____
____
____

Purpose of requested use or disclosure:

____
____
____

	The patient or patient’s representative must read and initial the following statements:	**Initials**
1.	I understand that this authorization will expire on ___/___/___(DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	
2.	I understand at I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	

____ ______________________
Signature or Patient or Legal Representative Date

____ ______________________
If signed by Legal Representative, Relationship to Patient Signature of Witness

This document will be retained by the providing organization for six years.