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: _____

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 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		
	☐DES exposure	☐High Cholesterol	☐Stomach Ulcer	

(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.

CONSENT FOR PELVIC EXAMINATION

A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider's gloved hand or instrumentation. For purposes of this consent, vaginal sonography is included.

By signing this consent, I _____ authorize and direct
[Print Patient's Name]

Florida Women's Health, LLC

Poorti Riley, M.D., Michelle Wood, M.D., Naia Rodriguez, PA-C, Holly Grisales, APRN, Cortney Aubertine, APRN, Suzette Boyette, APRN

to perform a pelvic examination, including vaginal sonography, as described above. By my signature below I acknowledge that I have read and understand the contents of this form.

Patient/Legal Representative Signature — Printed Name and Date

Witness Signature — Printed Name and Date