# *Florida Women's Health, LLC*

*4600 SW 46th Court, Suite 150, Ocala, FL 34474*
*Phone (352) 369-5999  Fax (352) 629-4227*

## Patient Information:

Name: _____DOB: _____

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 Phone: _____

E-mail: _____

Employer: _____ Phone: _____

Emergency Contact: _____

Phone#/Relationship: _____

***Please note if you are having an ultrasound procedure;** if doppler, PVR or abdominal evaluation is necessary, additional charging may apply. If you have any questions please inquire before ultrasound is performed.

*I understand that by signing this form that I am responsible for the amount that is due at checkout. I also understand it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance or third party within a reasonable period, not exceeding 60 days. Balances that go unpaid for 30 days or more may incur additional charges.

*Lab charges are not filed by *Florida Women's Health, LLC*. We do not pre-collect or perform any billing for the labs. You will receive a separate bill for any charges not covered by insurance.

Signature: _____ Date: _____

# 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 state 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 acknowledgement 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 company before the service is provided.

*If Insurance Is Not In Your Name:*

Primary insured's name: _____

DOB: _____ SSN#: _____

Address: _____

City: _____State: _____ZIP:_____

Phone Number: _____ Relationship: _____

## Lifetime Authorization, Insurance Assignments and Authorization to Release Information

- **Release of information:**
  I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third payor (such as an insurance company or governmental 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 determining a claim for payment for such treatment and/or diagnosis.
- **Physician insurance agreement:**
  I, the below named subscriber, do hereby authorize payment directly to any physician examining 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.
- **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 intermediaries or carries any information needed for this of a related medical claim. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me.
- 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 deductible amount, co-insurance or any other balance not paid for by my insurance or third-party payor within 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 | Specialty |
|---|---|
| | |
| | |
| | |

| Current Medications | Dose/Frequency | Current Medications | Dose/Frequency |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| Allergies | Reaction |
|---|---|
| | |
| | |
| | |
| | |

| Past Medical History/Surgery | Date |
|---|---|
| | |
| | |
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| | |
| | |

**MEDICAL CONDITIONS**

| | | | | |
|---|---|---|---|---|
| ___Abnormal Pap Smear | ___Breast Surgery | ___Glaucoma | ___Migraines | ___Vaginitis (BV) |
| ___Alcoholism | ___Cervical Cancer | ___Gout | ___Osteoporosis | ___Yeast Infection |
| ___Allergies | ___Cervical Dysplasia | ___Gallstones Currently | ___Ovarian Cyst | |
| ___Anemia | ___Clotting Disorder | ___Heart Disease | ___Ovarian Cancer | |
| ___Anxiety | ___Colon Cancer | ___Hepatitis A, B, or C | ___Pelvic Inflammatory Disease | |
| ___Asthma | ___COPD | ___High Blood Pressure | ___Stomach Ulcer | |
| ___AIDS/HIV | ___Diabetes | ___High Cholesterol | ___Substance Abuse | |
| ___Auto-immune | ___DES Exposure | ___HPV | ___Skin Disorder | |
| ___Bipolar Disorder | ___Depression | ___Heart Attack | ___STD | |
| ___Blood Disorder | ___Epilepsy | ___Infertility | ___Thyroid Disorder | |
| ___Blood Transfusion | ___Eating Disorder | ___Joint Disorder | ___Tuberculosis | |
| ___Breast Cancer | ___Fibroids | ___Kidney Disorder | ___Uterine Cancer | |
| ___Breast Lump/Mass | ___Genital Warts | ___Liver Disorder | ___UTI - Frequent | |

Other:_____

Last Colonoscopy Date: _____

- If You Are 65 Or Older, Have You Fallen In The Past Year? ___Yes ___No

If Yes, What Injuries Occurred? _____

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## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I, _____, hereby voluntarily authorize the disclosure of information from my health record.

Date of Birth: _____

**Information Requested:**

_____

_____

**Purpose Of Release:** _____

**The Information Is to Be Provided To Or Requested From:**

Name Of Person/Organization/Facility: _____

Address: _____

Phone Number: _____Fax Number: _____

1. I understand that this authorization will expire on (6 months from sign date) _____.
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying,
   (insert name of practice) _____, in writing.
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may reinspect or copy any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature Or Patient's Representative Date

**YOU HAVE A RIGHT TO RECEIVE A COPY OF THIS FORM.**

*Under HIPPA With Patient's Written Request, Records Must Be Provided Within 30 Days of A Request.*
*Under house bill 300 Texas law with patient's written request, records must be provided within 15 days of a request.*

# *Florida Women's Health, LLC*

Poorti Karve Riley, M.D.
Obstetrics and Gynecology
4600 SW 46th Court, Suite 150, Ocala, FL 34474
Phone (352) 369-5999 Fax (352) 629-4227


## Consent For Pelvic Exam

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 healthcare provider's gloved hand or instrumentation. For purposes of this consent, vaginal sonography is included.

By signing this consent, I _____ authorize and direct

Florida Women's Health, LLC

Poorti Riley, M.D.

Liana Jawad, PA-C, Kelsey Shaner, PA, Bekah Schmitz, PA, Tess Aven, DNP, APRN, Kelly Curington, APRN

Jessica Hughes, Sonographer

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 Print Name and Date