Woman's Health Centers | GYN Oncology OF OSCEOLA | MFM of Central FL

# OSCEOLA OBGYN II

AVALON PARK OVIEDO KISSIMMEE HUNTERS CREEK POINCIANA CELEBRATION

**PHONE:** 407-453-2072 **FAX:** 407-601-1053 **// PHONE:** 407-518-1074 **FAX:** 407-518-9056

| PATIENT INFORMATION: | | | | |
|---|---|---|---|---|
| LAST NAME: | FIRST NAME: | MIDDLE NAME: | GENDER: ☐ F ☐ M | |
| STREET ADDRESS: | | CITY: | STATE: | ZIP CODE: |
| HOME PHONE #: (____) OKAY TO CALL? ☐Y ☐N | CELL PHONE #: (_____) TEXT MESSAGE? ☐Y ☐N | EMAIL ADDRESS: | | |
| DATE OF BIRTH: _____/_____/_____ | AGE: | MARITAL STATUS: ☐SINGLE ☐MARRIED ☐WIDOW ☐DIVORCED ☐SEPARATED ☐PARTNER | | |
| ETHNICITY: ☐HISPANIC ☐NON-HISPANIC ☐OTHER ☐DECLINE | | | | |
| RACE: ☐ASIAN ☐BLACK/AFRICAN-AMERICAN ☐NATIVE HAWAIIAN/PACIFIC ISLANDER ☐WHITE ☐DECLINE | | | | |

| EMERGENCY CONTACT: | | | |
|---|---|---|---|
| LAST NAME: | FIRST NAME: | RELATIONSHIP: | PHONE #: |

| PREFERRED PHARMACY: | |
|---|---|
| NAME: | PHONE: |

| PRIMARY CARE PROVIDER: | |
|---|---|
| DOCTOR'S NAME: | DOCTOR'S PHONE: |

| INSURANCE INFORMATION: | | |
|---|---|---|
| PRIMARY INSURANCE: | POLICY NUMBER: | GROUP NUMBER: |
| SUBSCRIBER NAME: | D.O.B/GENDER: | ADDRESS: |
| SECONDARY INSURANCE: | POLICY NUMBER: | GROUP NUMER: |
| SUBSCRIBER NAME: | D.O.B/GENDER: | ADDRESS: |

WHO REFERRED YOU TO OUR PRACTICE:

WERE YOU REFERRED TO OUR PRACTICE? ☐YES ☐NO

IF YES BY WHOM? _____

_____

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURNACE I AM ULTIMATALY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL THE INFORMATION AND COMPLETED THE ABOVE ANSWERS. I CERTIFY THAT THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY THIS OFFICE OF ANY CHANGES IN MY HEALTH OR IN THE INFORMATION.

SIGNATURE_____ DATE _____

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## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____hereby authorize Osceola OBGYN II to release my medical, alcohol, drugs, and/or HIV, and/or AIDS information contained in my records as indicated below:

***Note:*** *If you only want your financial records released please note below.*

| **Name of Person** | **Relationship** |
|---|---|
| **1._____** **(Last name , First name)** | **_____** |
| **2._____** **(Last name , First name)** | **_____** |
| **3._____** **(Last name , First name)** | **_____** |

**Purpose of Disclosure**_____

I understand that this consent is revocable upon written notice to the doctor, except to the extent that action by the doctor has been taken in reliance on this authorization, and this authorization shall remain force for a reasonable time _____, in order to effect the purpose for which it is given.
**(Expiration Date)**

Alcohol and drug abuse information, if present was disclosed from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR, Part II) prohibit, making any further disclosures of such information without a specific written authorization of the undersigned, or as otherwise permitted by such regulations.

HIV testing, and/or AIDS diagnosis information, if present has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosures of such information without a specific written consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT for this purpose.

| | |
|---|---|
| _____ Patient Name | _____ Patient Signature |
| _____ Date | _____ Witness |

# OSCEOLA OBGYN II

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## CONSENT FOR TESTING OF HIV ANTIBODIES

**Florida State Law requires that each health care provider offer counseling and request patient consent prior to HIV screening**

Screening for HIV involves a blood sample to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is associated with Acquired Immune Deficiency Syndrome (AIDS).

I understand that positive results from this test would indicated the presence of antibodies in my blood which react with the HIV antigen. Positive results do not conclusively indicate whether or not the virus is present in my blood, nor does a positive result mean that I have AIDS. I also understand that a positive result does not predict whether or not I will develop AIDS in the future.

I understand that a negative result from this test does not conclusively exclude the possibility of infection with the HIV virus.
All positive test results will be confirmed by a second confirmatory test.

I understand that **Osceola OBGYN II, LLC** will take precautions to protect the confidentiality of these antibodies test results. There will be no disclosure to any unauthorized third party without my written consent and release, other than required by law.

I understand, however, that the results of this test will be recorded in my medical record and that the results will be released to persons or entities to whom I specifically authorize the release of medical records.

I specifically agree to release test results to applicable third party payers in order to obtain reimbursement for my medical expenses.

I also understand and agree that the results may be disclosed as necessary to assure appropriate follow-up testing and care of healthcare workers who may be exposed to my blood or other body fluids.

After the test results are obtained, my physician will discuss these matters with me and if necessary, refer me to appropriate medical, physiological and social counseling.

I have been given the opportunity to ask questions which have been answered to my satisfaction. I have read and understood the information above. I am aware of the test's limitations and the potential consequences of positive and negative test results. My signature indicates that I give my informed consent to have the HIV screening test.

**(PLEASE INITIAL ONE):**

____ I hereby **DO** give permission to test my blood for presence of antibodies to the Human Immunodeficiency Virus (HIV), which is associated with Acquired Immune Deficiency Syndrome (AIDS).

____ I hereby **DO NOT** give permission to test my blood for presence of antibodies to the Human Immunodeficiency Virus (HIV), which is associated with Acquired Immune Deficiency Syndrome (AIDS).

_____ _____ _____

Patient signature Date Witness

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# OSCEOLA OBGYN II

AVALON PARK OVIEDO KISSIMMEE HUNTERS CREEK POINCIANA CELEBRATION

## OUR FINANCIAL POLICY

Welcome to our office. Thank you for choosing OSCEOLA OBGYN II, LLC Our staff are committed to provide you with the highest quality of healthcare. The following is a statement of our Financial Policy which require you to read and sign prior to any treatment. **PAYMENT IS DUE AT THE TIME OF SERVICE**

We accept Cash, Debit or any of the following Credit Cards:
VISA, MASTER CARD, AMERICAN EXPRESS, DISCOVER, CARE CREDIT

## INSURANCE ASSIGNMENT & STATEMENT OF FINANCIAL RESPONSIBILITY

_____I authorize the release of any medical information necessary to process my insurance claims. I request that all payments be made on my behalf and that all benefits are assigned for physician service to **OSCEOLA OBGYN II, LLC.** I authorize this request to apply to all services provided after the date below. I understand I am responsible for payment of any balance not paid by my insurance company as outlined in my schedule of benefits and as applicable under law. IT IS MY RESPONSIBILITY TO GO TO MY INSURANCE'S AUTHORIZED LABORATORY, HOSPITAL, AND X-RAY FACILITIES.

## FOR PATIENTS WITH INSURANCE

_____We accept assignment of insurance benefits. We cannot bill your insurance company unless you give us your correct insurance information and a valid insurance card. *YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT*. *If your insurance company has not paid your account in full within 45 days of submission of the claim, due to coordination of benefits issues, the balance will automatically be billed to you.* Please be aware that some of the services provided may be non-covered services and not considered reasonable by your insurance policy.

**Regarding insurance plans where we are a participating provider:** All co-pays and deductibles are due at the time of treatment. If your insurance coverage changes to a plan where we are not Participating Providers, refer to the paragraphs above.

## MINOR PATIENTS

_____The adult accompanying a minor and the parents (or guardian) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been preauthorized to cash or check at the time of services. Also, all minors must have their parent or guardians complete a consent form prior to treatment.

## AUTHORIZATION FOR TREATMENT

I, the undersigned, have consented to the treatment & examination considered necessary by OSCEOLA OBGYN II, LLC Authorization is hereby granted for such treatment. I certify that I have read the above authorization and understand the same, and also certify that no guarantee or assurance has been made as to the results that may be obtained.

_____ _____ _____

Patient Signature Date Witness

## ACKNOWLEDGEMENT FOR ADVANCE DIRECTIVES

As your physician, we need to know if you have executed an Advance Medical Directive:
Yes _____ No _____

If yes, this Directive is in the form of:
_____ Living Will
_____ Durable Power of Attorney for Healthcare
_____ Designation of a Healthcare Surrogate
_____ A"Do Not Resuscitate" (DNR) order

If you answered YES, could you please provide us with a copy of the forms at your earliest convenience and sign below.

If you answered NO, please read the following statement and sign below.

In the event you become unable to tell your physician and family how you want to be treated, federal and state laws provide ways for you to make your wishes known, the Federal Patient Self Determination Act states that each competent adult patient has the right to prepare a written “advance directive” regarding healthcare decisions. The advance directive is typically expressed in one or more of three basic types or forms; a Living Will declaration, a durable Power of Attorney for healthcare, or a Designation of Healthcare Surrogate, or representative to make healthcare decisions for you, the patient, when the patient becomes incapable of making those decisions. The Living Will enables you to indicate your wishes regarding, healthcare treatment and life-prolonging procedures and circumstances under which you wish these procedures to be withdrawn or withheld, and you may also designate a surrogate to carry out your wishes. Through a Durable Power of Attorney you can name a person to communicate your wishes regarding medical, legal and financial matter should you become incapacitated to make decisions regarding medical treatment.

Advance directives can help protect your right to make medical choices that can affect your life. The stress on your family during a difficult time can be considerably reduced because your family will be relieved of the responsibility of trying to decide what your wishes would be. Your family and physician will have clear guidelines concerning your wishes for your care.

_____ _____
Signature/Date Witness

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# OSCEOLA OBGYN II

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## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was provided with a copy of OSCEOLA OBGYN II, LLC Notice of Privacy Practices.

_____ _____

Name Signature/Date

If completed by a patient's personal representative, please print and sign your name in the space below.

_____ _____

Name/Relationship Signature/Date

**OFFICE USE ONLY**: I have made a good faith effort to obtain a written acknowledgement of receipt Osceola OB/GYN P.A Notice of Privacy Practices but was unable to for the following reason:

□ Patient refused to sign □ Patient unable to sign □ Other _____

Employee Name/Date

## NOTICE OF PATIENT COLLECTION POLICY RECEIPT

I acknowledge that I was provided with a copy of OSCEOLA OBGYN II, LLC Patient Collection Policy

_____ _____

Name Signature/Date

If completed by a patient's personal representative, please print and sign your name in the space below.

_____ _____

Name/Relationship Signature/Date

**OFFICE USE ONLY**: I have made a good faith effort to obtain a written acknowledgement of receipt Osceola OBGYN II Notice of Patient Collection Policy but was unable to for the following reason:

□ Patient refused to sign □ Patient unable to sign □ Other _____

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# Patient Collection Policy

In accordance with our Financial Agreement patients have affirmed acknowledgment of and assume full responsibility to pay for those services in accordance with the rates that are in affect at Osceola OBGYN II. Patient(s) have consented to full responsibility of balances owed that are not limited to balance after insurance, non-covered services, co-pays, and deductibles.

**Payment Policy**

**Osceola OBGYN II** requires any patient with a balance equal to or less than $25 to render payment in full in no greater than 30 days from the date the balance was transferred to the patient. Patients with balances greater than $25 may qualify for a payment plan/ arrangement. Payment plans/arrangements are setup directly with the billing department at Osceola OBGYN II.

**Payment Plans or Card on File**

To qualify for a payment plan, patients must:

- Agree to an initial payment of $25 or 10% of the entire balance owed (whichever is greater)
- Provide a credit/debit card to securely store on file
- Provide a valid email address
  - By providing an email address patients will receive an email communication advising payment date (within 5 days from email receipt)
  - By providing an email address patients will receive notification to register on the patient portal
- Sign a payment agreement highlighting terms and conditions

Patients not wanting to obtain a payment plan are encouraged to provide a card on file for automatic payment, pay balances in full, and/or register for the patient portal and render payment directly on the patient portal. Portal payments require the use of a debit or credit card.

**Patient Balances Greater Than 30 Days**

Patients with balances greater than 30 days are subject to collection calls, balances requiring payment in full prior to being scheduled for another appointment, and/or accounts being placed with a third-party collections agency. In order to avoid these actions, it is recommended that a patient agrees to a payment plan, card on file, or render payment in full.

In accordance with our Financial Agreement patients have acknowledged and provided consent that any balance not covered or paid for by insurance policies is the legal responsibility of the patient.

Please refer to the Osceola OBGYN II Policy and Consent Form Section I: Financial Agreement & Assignment of Benefits. Patients may request a copy of the signed consent form for their financial record.

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## Notice of Privacy Practices for Protected Health Information

## Osceola OBGYN – Woman's Health Centers are committed to protecting patient's health information as well as any personal identifiers.

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!**

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

**Example of uses of your health information for treatment purposes:** A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctordetermines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtaininput.

**Example of use of your health information for payment purposes:** We submit a request for payment to your health insurance company. The health insurance company requests information from usregarding medical care given. We will provide information to them about you and the care given.

**Example of Use of Your Information for Health Care Operations:**We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcomeevaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, andinsurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

**Your Health Information Rights**

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs toyou. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office.We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by deliveringthe request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial beattached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written requestto our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures madeto you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by deliveringthe request in writing to our office;
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action hasalready been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our administrator, in person or in writing, during normal hours. S[he]will provide you with assistance on the steps to take to exercise your rights.

**Our Responsibilities**

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request;
- Accommodate your reasonable requests regarding methods to communicate health information with you.We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact newprovisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice.You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

**To Request Information or File a Complaint**

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, youmay contact our office administrator.Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering thewritten complaint to our office administrator. You may also file a complaint by mailing it or e-mailing it to the Secretary of Healthand Human Services whose street address and e-mail address is

**200 Independency Ave. S.W. Washington, D.C., 20201, phone # 1-877-696-6775, http://HHS.gov**

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services(HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

**Other Disclosures and UsesNotification**

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member,personal representative, or other person responsible for your care, about your location, and about your general condition, or yourdeath.

**Communication with Family**

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify,health information relevant to that person's involvement in your care or in payment for such care if you do not object or in anemergency.

**Food and Drug Administration (FDA)**

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects,or post-marketing surveillance information to enable product recalls, repairs, or replacements.

**Workers Compensation**

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extentnecessary to comply with laws relating to Workers Compensation.

**Public Health**

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing orcontrolling disease, injury, or disability.

**Abuse & Neglect**

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

**Correctional Institutions**
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health informationnecessary for your health and the health and safety of other individuals.

**Law Enforcement**
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a courtorder, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

**Health Oversight**
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversightactivities.

**Judicial/Administrative Proceedings**
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or requiredby law, with your consent, or as directed by a proper court order.

**Other Uses**
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with yourwritten authorization and you may revoke the authorization as previously provided.