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Patient Information Sheet

Today's Date____________

Name: ____ Date of birth___________

Address: ____

City: ___________________________________ State:______________ Zip:_______________

Cellphone: _____________________________ Email: _________________________________

Marital Status: ___________ Primary Language: _______________ Race: __________________

Emergency Contact Name/ Cellphone:____

Pharmacy: ____

Malpractice Insurance Notice: Your doctor has decided not to carry medical malpractice insurance. This notice is pursuant to Florida law F.S. 458-320. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgements arising from claims of malpractice.

Initial ________

Statement of Financial Responsibility: I certify that the above information is correct and further authorize the release of any medical information to my insurance carriers for any claim. I request payment of authorized benefits to the physician or mid-level provider furnishing the service or authorize the physician to submit a claim for me**. I, the undersigned, realize that all medical and surgical charges incurred by me or my dependents for services rendered by Patricia Chen, MD, Lindsay Leider, CNM, APRN & Jessica Hernandez, CNM, APRN are my financial responsibility.** I also agree that should my account be referred to any agency or attorney for collection, I will be responsible for all attorney fees, collection fees and court costs. I understand that payment is expected when services are rendered, unless prior arrangements have been made.

Initial________

Medicare Lifetime Authorization: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician organization to submit a claim to Medicare for payment.

Initial________

Additional Fees:

$25.00 FEE to complete any patient forms/ packets such as FMLA, Disability, Physical Examination, Hospital Indemnity & Return to Work.

$25.00 charge for NO-SHOW- missed appointment without notifying this office in advance.

Late Arrival Policy: **If you are more than 10 minutes late, you will need to reschedule.**

I have read and agree to these statements.

Signature:____ Date:____________________

HIPAA Compliance Patient Consent Form: Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. A copy is located at the check-in desk. Your signature ascertains that you have reviewed our notice before signing this consent.

*Protected health information may be disclosed or used for treatment, payment or healthcare operations. The practice reserves the right to change the privacy policy as allowed by the law. The patient has the right to restrict the use of information, but the practice does not have to agree to those restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical results/ condition with anyone besides yourself? Yes or No

This includes results related to sexually transmitted diseases, pregnancy or psychiatric disorders and will only be given to this person by special permission.

If YES, please indicate the name of authorized person (s) and specify the relation to you:

I authorize Bloom ObGyn & Midwifery to contact me with laboratory or diagnostic results at:

Cellphone:_______________________________ Ok to leave a voicemail? YES or NO

Email:___________________________________

Reviewed by (print name please):____

Patient signature: ____ Date:________________