Florida Center for Urogynecology

Phone: 954-989-9998
fax: 954-989-9979

www.floridaurogyn.com
info@floridaurogyn.com

4340 Sheridan Street, Suite 201
Hollywood, Florida 33021

Please Print:

First Name / Nombre: _____ **Last Name / Apellidos:** _____

Address / Dirección: _____ **Apt. No:** _____

City /Ciudad: _____ **State /Estado:**_____ **Zip Code /Código postal:** _____

Home # / Casa nº: _____ **Work # / Nº de trabajo:** _____

Employer/Empleador_____ **Occupation /Ocupación**_____

D.O.B/Fecha de nacimiento: _____ **SSN/Número de Social.:** _____

***Please provide a valid Email and Mobile number so we may send follow-up appointment confirmations. ***

Cell No.: _____ **E-Mail:** _____

Emergency Contact Name / Nombre de emergencia: _____

Emergency Contact Phone Number /Teléfono de emergencia: _____

Emergency Contact Relation /Relación contacto emergencia:

Spouse /Esposo **Child /Hijo** **Parent /Padres** **Friend /Amigo** **Other /Otros**

Pharmacy Name & Location/Nombre de la farmacia y ubicación: _____

Pharmacy Phone Number/Número de teléfono de Farmacia: _____

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Patient Name / Nombre: _____ **Date / Fecha:** _____

Physician History/Historial médico :

Primary care Physician/Médico de atención primaria : _____

Address/Dirección : _____

Phone/Teléfono : _____ **Fax :** _____

Referring Physician/Referir a médico : _____

Address/Dirección: _____

Phone/Teléfono: _____ **Fax:** _____

Payment Authorization/Autorización de pago:

I hereby authorize **Florida Center for Urogynecology**, to release any information acquired in the course of my treatment necessary to process insurance claims.

Autorizo a **Florida centro de Uroginecología**, para liberar cualquier información adquirida en el curso de mi tratamiento es necesario para procesar reclamaciones de seguros.

Signature/Firma: _____ **Date/Fecha:** _____

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*****Please write in English / Por favor escribe en ingles*****

Which Problems would you like addressed at the Florida Center for Urogynecology?

¿Qué problemas usted cómo abordar en el centro de Florida para Uroginecología?

_____
_____
_____
_____

Please list all current medications and dosages if known or attach a list.

Por favor una lista de todos los actuales medicamentos y dosis si se conoce o adjuntar una lista.

_____
_____
_____
_____

Please list all previous surgeries. /Por favor una lista de todas las cirugías anteriores.

_____
_____
_____
_____

Please list all allergies. /Por favor una lista de todas las alergias.

_____
_____
_____

Please list any chronic medical problems. /Por favor una lista de cualquier problema médico crónico:

_____
_____
_____
_____

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Receipt of notice of privacy practices written acknowledgement form

I, _____, have reviewed/received a copy of

Florida Center for Urogynecology's Notice of Privacy Practices.

Recibo de la notificación de prácticas de privacidad reconocimiento escrito

_____, He revisado/recibido una copia de

Florida centro de Uroginecología's Aviso de privacidad.

_____ _____

Signature /Firma Date/Fecha

Office Use Only/Uso de oficina solamente

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documents below:

Trató de obtener la firma del paciente en el reconocimiento de este aviso de privacidad prácticas de reconocimiento, pero no pudo hacerlo como documentos a continuación:

Date/Fecha: _____

Initials/Iniciales: _____

Reason/Razón: _____

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Patient's Name: _____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to:

Florida Center for Urogynecology
4340 Sheridan St. Suite 201
Hollywood, FL. 33021

I hereby authorize payment of Medical and/or Surgical benefits to proceed directly to **Florida Center for Urogynecology**, and all associated physicians who may take care of me. I understand I am responsible for any co-payments, non-covered services and any balances my Medicare and/or Insurance does not cover. In the event I do not meet my obligations I will be responsible for collection cost if any, including legal fees and allowed interest.

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows: same as above.

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjusted, or attorney involved in this case. I authorize doctor to initiate a complaint to the insurance company for any reason on my behalf.

Signature: _____ **Date:** _____

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION TO THIRD PARTIES

Florida Center for Urogynecology

Section A: Must be completed for all authorizations

I hereby authorize the use of disclosure of my individually 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.

Please list any relative/friend whom we can release any medical information, if they were to call regarding your care.

Patient Name: _____

Please list the name and relation of the person(s) whom you authorize us to release any information:

Name _____ **Phone Number:** _____

Name _____ **Phone Number:** _____

Name _____ **Phone Number:** _____

Please note by signing this authorization you are giving us consent to release your medical information.

_____ _____

Signature of Patient or Patient Representative **Date**

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CANCELLATION & MISSED APPOINTMENT POLICY

Thank you for choosing our office for your medical care. We value all of our patients and strive to provide compassionate and expert care. Please understand that when we schedule your appointment, we are reserving time for your particular needs. In order for us to assure convenience and accessibility to all of our patients, it is important that patients arrive timely for all scheduled appointments or cancel appointments **48 hours** in advance.

Cancellation and Missed Appointment Policy

You may **cance**l your scheduled appointment by calling us at **(954) 989-9998**. Appointments are in high demand and your early cancellation will give another patient the opportunity to make an appointment.
We consider a "**missed appointment**" when someone does not show up for an appointment and does not cancel the appointment **48 hours** in advance. A "missed appointment" will be recorded in our records.

Fees for Missed Appointments – Financial Agreement

Effective **June 1, 2018**, the Florida Center for Urogynecology will charge patients when they do not present for scheduled appointments.

Failure to cancel or re-schedule the appointment within 48 hours of the scheduled appointment time will result in a fee for a missed appointment. This fee will not be submitted to the health plan; it will be charged to the patient. We understand that flexibility is important. Since missed appointments can occur for a variety of reasons, patients may be allowed one "free" missed appointment charge.

The missed appointment fee structure is **$50** for pelvic floor rehab therapy appointments and **$30** for all other types of appointments. Missed appointment fees are due prior to rescheduling your appointment.

I pre-authorize Florida Center for Urogynecology to use the payment information (debit card and / or credit card) on file to charge for the applicable fees. If there is no payment information on file, I understand that I will be billed for the applicable fee. I acknowledge that I have read and understand the above policy statement regarding the fees for missed appointments.
Please note: Repeated "missed appointments" may result in discharge from the practice.

_____	_____	_____
Patient's Name	*Signature*	*Date*