RETURNING PATIENT INFORMATION & CONSENT FORM

Date: ______________

Patient Name: ____**DOB:** ______________

Phone: _____________________________________ **Email:** _________________________________

Address: ____

Employer / Occupation (if changed): ____

Pharmacy Phone #: _________________________________**PCP**_________________________________

Insurance Company: __________________________________**Policy ID #:** _________________________

Policy Holder Name & DOB: ______________________________

EMERGENCY CONTACT *(Does NOT grant access to medical records)*

Name: ______________________________**Relationship:** ____________**Phone:** ________________

PERSONAL RELEASE OF RECORDS

I authorize and request that my medical information may be released to the below Individuals, including lab results, picking up medical records, prescription, or samples to, I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. The information released in response to this authorization may be re-disclosed to other parties. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or 1 of 2 immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

Name: ______________________________Phone#: _______________________ Relationship: ____________

Name: ______________________________Phone#: _______________________ Relationship: ____________

AUTHORIZATION & FINANCIAL RESPONSIBILITY

I confirm that my demographic, insurance, and medical information on file remains accurate unless updated above. I authorize my physician to: Release medical information as necessary for treatment, payment, and insurance processing. Disclose medical records to insurance carriers or entities responsible for payment I understand and agree that: Payment is due at the time of service unless prior arrangements are made. I am responsible for any balances not covered by insurance, including lab fees. Accounts unpaid after 30 days may be sent to collections, and I am responsible for all associated costs a $25.00 fee will be charged for returned checks I authorize payment of insurance benefits directly to the physician.

MEDICAL RECORDS RELEASE

I authorize disclosure of my medical records, including records related to mental health, drug or alcohol abuse, HIV/AIDS, sexually transmitted diseases, and sexual assault, as permitted by law.

FLORIDA MEDICAL MALPRACTICE NOTICE

Under Florida law, physicians are generally required to carry medical malpractice insurance. **Your physician has chosen not to carry medical malpractice insurance.** This is permitted under Florida law and subject to specific conditions.

PATIENT ACKNOWLEDGMENT

I have read and understand this form and agree to its terms.

Patient / Responsible Party Signature: ________________________________**Date:** __________

Financial and Billing Policy

We are committed to providing you with the best care possible. Please review our financial and billing policies carefully.

- If you do not have insurance, payment is due at the time of service.
- We accept cash, MasterCard, Visa, and American Express.

It is imperative that we receive **complete and accurate insurance information** to bill correctly and in a timely manner and to avoid claim denials.

- **Please notify us of all insurance plans you have**.
- If you have Medicaid and fail to disclose additional insurance coverage, Medicaid may deny the claim and you will be billed.
- If you have two insurance plans, both must be provided. Failure to do so may result in claim denials and patient responsibility.

This includes, but is not limited to: Medicaid, Medicare, Marketplace plans, and private insurance (e.g., United Healthcare, Blue Cross Blue Shield, Cigna, Aetna). Please note that we are **not contracted with all insurance plans**. If insurance information is not provided in a timely manner and billing deadlines are missed, any denied charges will become your responsibility.

If you have insurance coverage, we will submit claims on your behalf. By providing your insurance information, you authorize payment for services rendered to be made directly to **Sussman OB/GYN LLC / TLC Women's Health**.

- Required co-payments are due at the time of service.
- You are responsible for all deductibles, co-insurance, and any services not covered by your insurance.
- Even if your insurance does not pay, **you remain financially responsible** for all services provided.

Prior balances must be paid at the time of service unless a prior payment arrangement has been authorized. We will send a maximum of **three (3) monthly statements**. Payment is due upon receipt. Failure to pay or respond to billing communications may result in your account being sent to collections.

By signing below, I acknowledge that I have read, understand, and agree to comply with the policies outlined above.

Patient or Authorized Signature: ______________________________ Name: __________________________

Relationship: _______________________ **Date:** __________________

CONSENT TO TREAT INCLUDING A PELVIC EXAM

I, ___________________________________ hereby consent to a medically indicated physical examination, and/or pelvic/transvaginal ultrasound. This may include but is not limited to a pelvic examination. This will be performed by Sussman Obgyn LLC / TLC WOMENS HEALTH providers & ultrasound technicians. This consent will remain active until I withdraw my consent in writing.

_____________________________________ _____________________________

SIGNATURE **DATE**

Medical History: Gynecological History

Periods every ________________________days

Number of days of flow ______________________

First day of last period ______________________

Last Mammogram __________________________

Last bone density__________________________

1. **Obstetrical History**

Number of times pregnant ______Vaginal ______

C-section______ Abortion _____Miscarriage ______

BIRTH CONTROL METHOD: Please circle which one

Condoms Depo Nexplanon Patches

Rings IUD (specify)____________________

PILLS NAME__________________________

2. **Surgical History**

Appendectomy .... YES NO

Tubal Ligation................................ YES NO

Gall Bladder................................... YES NO

Removal of Breast Mass .... YES NO

Hysterectomy................................ YES NO

Other Surgeries ______________________________

____

3. **Social History**

Do you Smoke/Vape/e-cigarettes YES NO

Do you drink alcohol daily YES NO

Cannabis/Cannabinoids YES NO

Do you take street drugs YES NO

Allergies to Medication YES NO

If yes, please list ____________________________

Medications:

____

____

Weight:__________Height:__________

GLP-1e.g--Ozempic,Wegovy,Rybelsus YES NO

NO4.Abnormal Pap Smears .... YES NO

when & what type: ___________________________

HPV .... YES NO

Sexually transmitted infection .... YES NO

When and what? ______________________________

AIDS/HIV + ... YES NO

Asthma .... YES NO

Diabetes .... YES NO

If yes, What type ____________________________

Patient Name: ______________________________

Date :________________

Cancer .... YES NO

If yes, what type ____________________________

Heart Disease .... YES NO

Hypertension .... YES NO

Kidney Disease.............................. YES NO

Liver Disease................................. YES NO

Seizure Disorder .... YES NO

Thyroid Disease.............................. YES NO

Other Medical Conditions:

____

Circle one: Caucasian (White) - Asian - Black - Hispanic – Other:

____

Primary Language Spoken ____________________

Religion: _____________________________________

NOTICE OF PRIVACY PRACTICES

https://www.toplinemd.com/practice-terms-policies/

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") provides me with certain rights regarding the privacy of my protected health information. I acknowledge that I have been provided access to the Practice's Notice of Privacy Practices through a QR code and/or website link and have been given the opportunity to review it. I understand that the Practice may revise its Notice of Privacy Practices from time to time and that I may access the most current version by using the QR code and/or website link.

Patient Signature:

____

Patient or Legal Guardian Name (print):

____

Date: __________

Office Use Only

We have made the following attempt to obtain the patient's

signature acknowledging receipt of Notice of Privacy Practices:

Date: ______________ Attempt: ______________________

Staff Name: ___________________________________