SUSSMAN OBGYN LLC / TLC WOMENS HEALTH

1301 N Congress Ave Ste. 200 ♦ Boynton Beach, FL 33426 ♦ (561)742-3929 Fax (561)742-3931
7301-A W. Palmetto Park Rd. Suite# 200B ♦ Boca Raton, FL 33433 ♦(561) 394- 4473 Fax (561) 394- 5997

Date: _____

Last Name: _____ **First Name:** _____

Address (NO PO BOX): _____ **City:** _____

State/Zip Code: _____ **Home Telephone:** _____ **Cell Phone:** _____

Social Security: _____ **Date of Birth:** _____ **Age:** _____ **Marital Status: M S D W**

Employer Name: _____ **Occupation:** _____ **Work Phone:** _____

E-mail address: _____ **PHARMACY PHONE #** _____

Primary Care Doctor: _____ **Phone:** _____

Insurance Co. Name: _____ **ID#** _____

Policy Holder: _____ **Social Security** _____

Relationship: _____ **Date of Birth:** _____

By providing an Emergency contact, understand that the individual will NOT have access to medical records.

Emergency Contact 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: _____

I certify that the above information is accurate and I authorize the release of any medical information to my insurance carrier pertaining to a claim made on my behalf. I request that benefits be paid directly to the Doctor for their services, and I am aware that payment is expected at the time services are rendered unless other arrangements have been made. I understand that unpaid accounts will be considered in default after 30 days. Should this become a collection problem, the patient/client assumes all costs of collection including, but not limited to court costs, attorney fees, interest and legal fees. Where Medicare and Medicaid benefits are applicable, I certify that the information given by me for applying for payment under Title XVIII or XLX of the Social Security Act is correct and request this said payment authorized benefits be made payable on my behalf to the Doctors remain financially responsible to the doctors above. I authorize utilization of this application or copies thereof for the purpose of processing claims and effective payments.

I accept full responsibility for any remaining balance on my account for services not covered by my insurance company for both our fees and lab fees. I agree to pay a $25.00 fee if my check is returned by the bank.

My doctor is authorized to disclose all or part of my medical records to my insurance company, organization or agency as they may be responsible for payment for services rendered. Likewise, my insurance company, organization or agency responsible for payment are hereby authorized to disclose all or any medical records including treatment for Drug and Alcohol Abuse, Mental Health, HIV Virus and Sexual Assault. This authorization is given with full acknowledgement that such disclosure may obtain information of a confidential nature and may result in a denial of insurance coverage for services rendered by my doctor.

Under Florida Law, Physicians are generally required to carry Malpractice Insurance or otherwise demonstrate financial responsibility to cover potential claims for medical practice. **YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE.** This is permitted under Florida Law subject to certain conditions. Florida Law imposes penalty against Non-Insured Physicians who failed to satisfy adverse judgments arising from claims of Medical Malpractice. This notice is provided pursuant to Florida Law.

I certify that I have read and understand each of the above paragraphs, and that I am the patient of responsible party with the power to execute this document and accept the terms.

_____ _____

Patient or responsible Party Signature Date

Medical History

Name: _____ Date: _____

Gynecological History

Age at 1st menstrual period _____

Periods every _____days

Number of days of flow _____

First day of last period _____

Have you had multiple sexual partners? Y / N

Last pap smear_____

Last Mammogram _____

Last bone density_____

1. **Obstetrical History**

Number of times pregnant _____

Number of vaginal births _____

Number of cesarean births _____

Number of miscarriages _____

Number of abortions _____

Obstetrical Complications _____

_____

Are you sexually active now? YES NO

With Men

With Women

With Both

BIRTH CONTROL METHOD: please circle which one

Condoms Depo Nexplanon

Patches Rings IUD _____

Pills name: _____

2. **Surgical History**

Appendectomy	YES	NO
Tonsillectomy	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 YES NO

If yes, # packs per day _____

Do you drink alcohol daily YES NO

Do you take street drugs YES NO

4. **Medical History**

Abnormal Pap Smears YES No

when & what type: _____

_____

_____

HPV YES NO

Sexually transmitted infection YES NO

when and what? _____

_____

AIDS/HIV + YES NO

Allergies to Medication YES NO

If yes, please list_____

_____

Asthma YES NO

Cancer YES NO

If yes, what type _____

Diabetes YES NO

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

_____

Current Medications _____

_____

_____

_____

_____

_____

5. **Family History**

Cancer YES NO

If yes which types _____

_____

Heart Disease YES NO

Diabetes YES NO

Other _____

Do you have a living will YES NO

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

Primary Language Spoken _____

Religion_____

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Name: _____

As part of your medical care you may undergo one or more medical procedures. While complications from the following procedures are rare, some of the more common ones are described below:

Obstetrics (pregnancy)

- Vaginal delivery and labor complications include: vaginal laceration, hemorrhage, infection, urethral damage, rectal damage, nerve damage to the baby's arm (Erb's Palsy), cerebral palsy, bladder damage, incontinence, pain and hysterectomy (removal of uterus).
- Labor induction complications include: uterine rupture, placental abruption, fetal asphyxia, fetal injury and death, cerebral palsy, and failure to achieve vaginal delivery.
- Vacuum delivery complications include: scalp lacerations, brain hemorrhage, and nerve damage to the baby's arm (Erb's Palsy), cerebral palsy and other complications from a vaginal delivery.
- Cesarean Section (C-section) complications include: injury to the bladder, injury to the intestines, injury to the ureters, hemorrhage, infection, total abdominal hysterectomy, wound complications such as infection, hernia or dehiscence, fetal lacerations and traction injuries, pain, need for future C-sections, cerebral palsy and other risks of anesthesia. You may elect to have a C-section at any time.
- Cervical Cerclage complications include: preterm delivery, miscarriage, rupture of membranes, infection and bleeding.
- Circumcision complications include: damage to the penis, bleeding, infection, possible need for future surgery.

Gynecology

- Abdominal or vaginal surgery complications from a Hysterectomy, ovarian cyst removal, tubal ligation, laparoscopy, ectopic pregnancies or myomectomy among others, include: injury to the bladder, injury to the ureters, injury to the intestines, hemorrhage, infection, wound infection, incision hernia, wound dehiscence, need for future surgery, failure of the surgery to achieve its desired effect, pain, and all the risks of anesthesia.
- D&C and IUD complications include: damage to the uterus, uterine perforation, infection, hemorrhage, possible need for abdominal surgery with the above-mentioned risks.
- LEEP cone biopsy complications include: cervical incompetence, bleeding, infection, possible need for further surgery.

Signing this form does not mean that you will need surgery, only that you are aware of the risks and complications that can occur.

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**

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Name:_____ DOB:_____

We are committed to providing you with the best care possible. Please read this information about our financial and billing policies. If you do not have insurance, payment due at time-of-service. We accept cash, MasterCard, Visa, or American Express.

It is imperative we have all information so we can bill correctly on a timely manner to avoid denials. Please notify us of all insurances you have.
If you have Medicaid and fail to tell us you also have another insurance, Medicaid will deny and we will bill you.
If you have 2 insurances, please let us know of both. Failure may cause denials and bills that will become your responsibility.
This includes Medicaid, Medicare, Marketplace and private insurance. (etc. United Health, Blue Cross Blue Shield, Cigna, Aetna) Please remember that we are not on all insurance plans. If you fail to inform us and we catch it later on, we may not have enough time to bill the correct insurance and get it covered. Any denied bills because of failure on your behalf will become your responsibility.

If you have insurance coverage, we will file claims on your behalf. We need current, accurate insurance and policyholder information. By providing this information to us, you authorize any services furnished to you by our providers to be paid directly to SUSSMAN OBGYN LLC / TLC WOMENS HEALTH. If your insurance requires co-payment, you must pay that amount at the time of service. You are responsible for paying for any services not covered by your insurance. Any deductible or co insurance is your responsibility. Even if you have insurance, payment to us is your responsibility. It is necessary for you to know what benefits your insurance plan provides for you.

Prior balances must be paid at time of service unless prior payment arrangement has been authorized. SUSSMAN OBGYN LLC / TLC WOMENS HEALTH will send you max of 3 monthly statements. Payment is due upon receipt of the monthly billing statement. If you fail to pay and ignore our calls, you be sent to collections.

By signing, I have understood & agreed to comply with the policies contained in this document

Patient or Authorized Signature: _____

Relationship:_____Date:_____

Notice of privacy Acknowledgement

Sussman OB/GYN LLC / TLC WOMENS HEALTH

I understand that under the health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received, read and understood or given the opportunity to receive a copy of your Notice of Privacy Practices.
I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice Privacy practice.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

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: _____

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Date: _____

Name: _____DOB: _____

Please be truthful when filling out form.

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1. Have you recently traveled to an area with known local spread of COVID-19?

Yes / No

2. Have you come into close contact (within 6 feet) with someone who has been exposed (and is quarantine) or have had a laboratory confirmed COVID – 19 diagnosis in the past 14 days?

Yes / No

3. Have You had a fever OR symptoms such as cough, shortness of breath, difficulty breathing, headache or sore throat within the last week?

Yes / No

4. Are you awaiting results from a Covid-19 test?

Yes / No

Signature:_____ Date:_____