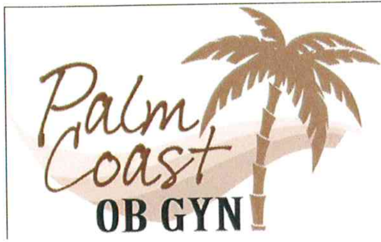


PATIENT REGISTRATION

Patient Information:

Name:_______________ DOB:_______________ SS:_______________

Mailing Address:_______________

City:_______________ State:_______ Zip:_______________ Home #:_______________

Cell #:_______________ Email:_______________ Marital Status: _______ Race: ______

Responsible Party – Only if NOT Patient:

Name:_______________ DOB:_______________ SS:_______________

Mailing Address:_______________

City:_______________ State:_______ Zip:_______________ Home #:_______________

Cell #:_______________ Email:_______________ Relationship to Patient:_______________

Employment Information:

Employer:_______________ Office #:_______________

Address:_______________ Occupation:_______________

Primary Insurance:

Company:_______________ Insured Name:_______________

Claims Address:_______________ Insured DOB:_______________

Phone #:_______________ ID #:_______________ Group #:_______________

Secondary Insurance:

Company:_______________ Insured Name:_______________

Claims Address:_______________ Insured DOB:_______________

Phone #:_______________ ID #:_______________ Group #:_______________

Emergency Notification/Next of Kin (Someone NOT in Household)

Name:_______________ Relationship to Patient:_______________

Home #:_______________ Cell #:_______________ Work #:_______________

Address:_______________ City:_______________ State:_______ Zip:_______

Authorization For Release of Personal Medical Information:

I understand, as outlined in the HIPPA Notice of Patient Privacy Practices, my personal medical information will only be released as it pertains to my medical treatment, payment of charges, or operation of the practice. The practice is also authorized to release my personal medical information to the following individual (s).

Name: _______________ Relationship to Patient: _______________

PALM COAST OB GYN **PATRICIA MODAD M.D., F.A.C.O.G.** **OB & GYN OF PORT ORANGE**

PATIENT:_______________________________ **DOB:**_________________ **SS#:**_________________________

PATIENT CONSENT AND AUTHORIZATIONS

CONSENT FOR TREATMENT: I, the undersigned patient, parent or legal guardian, knowing that I am (the patient is) suffering from a condition requiring medical care, do hereby present myself for treatment at **Patricia Modad M.D., F.A.C.O.G.** Palm Coast OB GYN/OB&GYN of Port Orange, and voluntarily consent to the rendering of such care, including treatments, photographs for treatment evaluations, administration of anesthetics and performance of diagnostic and/or surgical procedures. In the event a medical device is implanted or explanted, I agree to the release of my Social Security number to the manufacturer/FDA for tracing of the device. I understand that I am under the care and supervision of my attending physician and it is the responsibility of the office and its staff to carry out the instructions of such physician. I understand that the physician furnishing services to me expects payment in full upon receipt of a bill and I will assist in billing the appropriate insurance companies if insurance or other benefits are involved. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments and/or examination in the office.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to **Patricia Modad M.D., F.A.C.O.G.** Palm Coast OB GYN/OB&GYN of Port Orange, and the assignment of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Palm Coast OB GYN and for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

RELEASE OF MEDICAL INFORMATION: I, the undersigned patient, parent, or legal guardian, do hereby authorize Palm Coast OB GYN or its employees, to release to any third party payer (such as an insurance company or government agency; Example: Blue Cross/Blue Shield of Florida or Medicare) any medical, psychiatric, alcohol, drug abuse, and/or HIV (AIDS or AISDS related complex) treatment information and records, in accordance with the policy of **Patricia Modad M.D., F.A.C.O.G.** Palm Coast OB GYN/OB&GYN of Port Orange, and any applicable State or Federal Statues, concerning diagnosis and treatment for the above admission when requested by such third party payer for its use in connection with determining a claim for payment for such treatment and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in my care and treatment. I do hereby release **Patricia Modad M.D., F.A.C.O.G.** Palm Coast OB GYN/OB&GYN of Port Orange from all liability that may arise from the information requested.

FLORIDA LAW: Section 817.234 Florida Statutes, stipulates that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

FOR MEDICARE AND MEDICAID PATIENTS ONLY – CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize an holder of medical or other information about me to release to the Social Security Administration or its intermediary-carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to Palm Coast OB GYN physician. I understand that I am responsible for any health insurance deductibles and coinsurance.

__________ **MEDICARE BENEFICIARY NOTICE OF NON-COVERED SERVICES:** Medicare does not cover some inpatient, outpatient, and emergency
(initials) services. Items not covered include, but are not limited to **INPATIENT:** (lotion, toothpaste, deodorant, etc.) **OUTPATIENT AND EMERGENCY:** Medications typically self-administered, annual testing and physicals.

ACKNOWLEDGEMENT OF RECEIPT OF AN IMPORTANT MESSAGE FROM MEDICARE (FOR MEDICARE PATIENTS ONLY): My signature only acknowledges my receipt of this message from **Patricia Modad M.D., F.A.C.O.G.** Palm Coast OB GYN/OB&GYN of Port Orange, as dated below and does not waive any of my right to request a review or make me liable for any payment.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE IN PALM COAST OB GYN.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually hereby obligates him/herself to pay the account of Palm Coast OB GYN in accordance with the regular rates and terms of the physician. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense.

_______________________________ _______________________________

Patient's Signature **Patient's representative/policy holder or spouse**
Indicate relationship_______________________

_______________________________ _______________________________

Witness **Date**

Patient unable to sign due to:____

CONTACT AUTHORIZATION

I, ____, authorize Patricia Modad MD, F.A.G.O.G., Palm Coast OB GYN/Obstetrics & Gynecology of Port Orange to communicate medical information with me in the following manner:

Home Phone: ______________________________

Cell Phone: ________________________________

Leave a message on home phone: Yes No

Leave a message on cell phone: Yes No

Can we send an email: Yes No

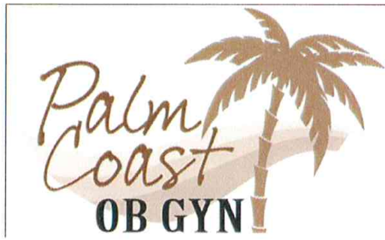
Who may we contact if we are not able to communicate with you and there is a need for an emergency?

Name: ____

Relationship to you: ____

Home Phone: ____

Cell Phone: ____



Acknowledgment of Receipt

HIPAA Notice of Patient Privacy Practices

By signing this Written Acknowledgment of Receipt for HIPAA Notice of Patient Privacy Practices ("Acknowledgment"), I hereby expressly acknowledge my receipt of HIPAA notice of Patient Privacy Practices.

____

Patient, or Legal Representative, Signature

____

Printed Patient, or Legal Representative, Name (or label)

____

Date

Acknowledgment **NOT** obtained because:

_____ Patient, or legal representative, declined Notice of Patient Privacy Practices

_____ Other (briefly describe) ____________________________________

____

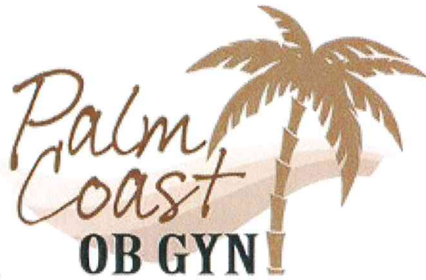
____

Employee Signature

____

Employee Printed Name

____



ATTENTION PATIENTS:

If you are having a Pap Smear, Biopsy, Blood Work, or any other testing done...

- We **DO NOT** collect any money for these services.
- Unless you are told otherwise by the office staff, **the collected fees are only for services done in our office**. Therefore, you **WILL RECEIVE A BILL** from the lab that your test was sent to (blood work, pap smear, biopsy, etc.).
- Rest assured that, to the best of our ability, we send samples to the lab that offers the cheapest prices.
- Also, depending on your insurance policy, you may be responsible for a Deductible, Coinsurance, or Copay which may apply to the lab fees .

If you have any questions regarding these bills, please contact the Lab directly, as we are NOT responsible for any bills generated by the labs.

Thank you for your cooperation!

Dr. Modad's Staff

______________________________ Patient Signature

____________________ Date

______________________________ Staff Signature

____________________ Date

Record Request

Patient Name: ______________________ Date of Birth: ______________ MR#: N/A
Address: ______________________ Phone #: ______________ SS#: ______________
City: ______________________ State: ________ Zip Code: ______________

To be completed by requestor: ◇ Pick Up ◇ Mail ◇Fax ◇ Other ______________
If requested health information is needed for a doctor's appointment please specify date: ______________

The following individual or organization is authorized to make the following disclosure:
Name: ______________________ Phone: ______________
Address: ______________________ Fax: ______________
City: ______________________ State: ________ Zip Code: ______________
Admission/Discharge Date (s): ______________________
Forward to Health Information Management (Medical Records) for:
◇ *Abstract ◇Discharge Summary ◇Operative Report ◇Emergency Room Report
◇Pathology Report ◇History & Physical ◇Laboratory Report ◇Radiology Report
◇Consultation ◇Other (specify) ______________________
Reason for requesting information: ______________________
____

Requests may be subject to a copying fee

This information may be disclosed to and used by the following individual/organization:

Patricia Modad MD, F.A.C.O.G.

Palm Coast OB GYN
50 Leanni Way Suites A3 & A4
Palm Coast, FL 32137
Phone: (386)447-6831
Fax: (386)447-6834

Obstetrics & Gynecology of Port Orange
1165 Dunlawton Ave. Suite 103
Port Orange, FL 32127
Phone: (386)767-1660
Fax: (386)447-6834

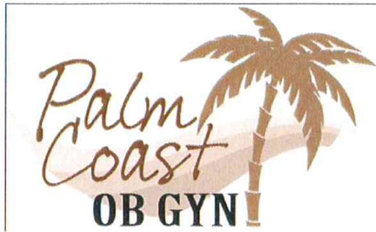
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed 90 days):______________. If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the signed date.**
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also Understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease.

Patient Signature: ______________________ Date: ______________
Authorized Representative/Parent: ______________________ Date: ______________
Printed Name of Authorized Representative/Parent: ______________________
Relationship to Patient: ______________________
Address and Phone # of Authorized Representative/Parent: ______________________

*Abstract consists of facesheet, discharge summary, history & physical, consults, operative notes, emergency record, lab, radiology, EKG reports, and pathology (if available).

AUTHORIZATION FOR USE AND/OR DISCLOSURE AND REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION.



HISTORY INTAKE

Welcome to our practice. Please help us meet all your healthcare needs by completing this form. If you have any questions or need assistance please ask us. We will be happy to help.

Today's Date: ______________________________
Name: ____ Age: __________ Birthdate: _________________________
Referring Provider: ____
How did you find out about our office: ____

Pharmacy: ____

Current Medication (Both Prescription and over the counter):

____
____
____

Allergies (Medication and Environmental):

____
____

Past Pregnancy History:

TOTAL PREG	FULL TERM	PREMATURE	SPONT. AB	INDUCED AB	ECTOPIC	MULTIPLES	LIVING

#	MO/YR	BIRTH WT	WEEKS	DELIVERY TYPE	COMPLICATIONS
1				VAG C-SECT VBAC	
2				VAG C-SECT VBAC	
3				VAG C-SECT VBAC	
4				VAG C-SECT VBAC	
5				VAG C-SECT VBAC	
6				VAG C-SECT VBAC	

Gynecologic History (check what applies):

◇ Frequent vaginal infections ◇ Urine loss or leakage ◇ Hot flashes/Night sweats ◇ Difficulty sleeping ◇ Vaginal dryness ◇ Decreased libido ◇ Frequent bladder infections ◇ Pain with intercourse ◇ Chronic itching ◇ Breast lumps ◇ Breast tenderness ◇ Genital sores

Menstrual History:

Age first started: ___________________ Last menstrual period/Menopause: ____________________
Duration of period: _______________ # days between periods: ____________________ Pain with period: Y N
Sexually Transmitted Disease or Infection (past or present): Y N Type: _________________________________

Pap/Mammo/Bone Density History:

Last Pap Smear: ________________ Result: Normal Abnormal
Last Mammo: ______________Result: Normal Abnormal
Last Bone Density: __________________Result: Normal Abnormal

Medical History: Check what applies (past and present)

◇Abnormal Pap ◇ Anemia ◇ AIDS/HIV ◇ Asthma ◇ Bladder infections ◇ Blood in urine
◇ Blood Transfusion ◇Breast problems/Abnormal Mammogram ◇ Blood clots in legs or lungs
◇ Chronic renal disease ◇ COPD ◇ Diabetes ◇Depression/Anxiety ◇ Genital warts/sores
◇ Heart Disease ◇Hypertension ◇ In Utero exposure to DES ◇ Infertility ◇Kidney Infections
◇ Liver Disease ◇ Lupus ◇Osteopenia/Osteoporosis ◇ Rheumatoid Arthritis ◇STD's ◇ Seizures
◇ TB or TB exposure ◇ Thyroid dysfunction ◇ Uterine anomalies (fibroids, bicornuate uterus, adenomyosis, etc.)

Surgical History: List type of surgery and year

____
____
____
____

Social History: Check what applies

◇Single ◇Married ◇Divorced ◇Separated
◇Smoke How many packs per year__________________ How many years______________ Date quit__________
◇Drink alcohol How many drinks/beers per day__________________
◇Prescription drug use/abuse (Percocet, Oxycodone, OxyContin, etc.)
◇Illicit drug use (◇Marijuana ◇Cocaine ◇Meth ◇PCP ◇Heroin)
◇Exercise: ◇ Occasional ◇ Low ◇ Moderate ◇ High

Advanced Directives: Check what applies

◇Living Will ◇Health Care Surrogate ◇Durable Power of Attorney

Family History: ◇Breast Cancer ◇Ovarian Cancer ◇Colon Cancer
Family Member and which type: ____

List any type of other cancer/illness and which family member (Mom, Dad, Sister, Brother, etc.)

____
____
____