HIBISCUS
WOMEN'S CENTER

Patient's Last Name	First Name	Middle Initial	Race	Ethnicity	Marital Status

Social Security #	DOB	AGE	Cell phone # (if applicable) (ok to leave message Yes/No)	Home phone # (ok to leave message Yes/No)

Mailing address	City, State, Zip	E-mail address

Patient's Employer	Occupation	Employer's address	Work phone # (ok to leave message Yes/No)

Spouse's/Parent's Name		DOB	Social Security #

Spouse's/Parent's Employer	Occupation	Employer's address	Phone #

In case of Emergency Contact (other than spouse)	Relationship	Phone #

Primary Care Physician Phone #	Referring Physician	Living Will? Yes / No	How did you hear about us? YP, Radio, Internet, Website, Newspaper, Friend or Family

Primary Insurance	Name of Policyholder	ID Number	Group#

Insurance address for claims	City, State, Zip

Policyholders Employer	Policyholders SSN	Policyholders DOB	Policyholders Gender M or F

Secondary Insurance	Name of Policyholder	ID Number	Group #

Insurance address for claims	City, State, Zip

Policyholders Employer	Policyholders SSN	Policyholders DOB	Policyholders Gender M or F

I agree that all charges that are not directly paid by the insurance company will be my financial responsibility. I authorize the payment of benefits, as directed by the company, directly to Hibiscus Women's Center. I authorize the release of any information necessary to process this claim. I also request payment of Government Benefits to myself or to the party who accepts assignment.

_____ _____

Signature of Patient or Legal Representative (Relationship) Date

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WOMEN'S CENTER

CONSENT TO TREAT, INSURANCE ASSIGNMENTS, FINANCIAL AGREEMENT

CONSENT TO MEDICAL AND SURGICAL TREATMENT OR PROCEDURES: The undersigned consents to the medical and surgical care and treatment as may be deemed necessary or advisable in the judgment of my physician or other provider. Which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician.

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATIONS TO RELEASE INFORMATION: In consideration of services rendered, I hereby transfer and assign to Hibiscus Women's Center all rights, title and interest in any payment due to me for services rendered. The office may disclose all or any part of the patient's records and or part of the office's charge, including but not limited to medical service companies, insurance companies.

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 obligates himself/herself to pay the account in accordance with the regular rates and the Financial Policy of the office. This Financial Policy has been provided to me. Should the account be referred to an attorney for collections, the undersigned should pay reasonable attorney's fees and collection expense.

I understand that certain insurance claims maybe filed as a COURTESY. However, if the claim is denied for any reason, I am responsible for payment. Please remember that insurance is considered a method of reimbursing the physician for services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay percentage of the charge, I understand it is my responsibility to pay and DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PAYOR WITH A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS.

_____/_____/_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN RELATIONSHIP DATE

330 E. Hibiscus Blvd., Melbourne, FL 32901 321-724-2229 / 321-728-6681(fax)

Hibiscus Women's Center, PA

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a **Notice of Privacy Practices** that gives a more complete description of information uses and disclosures as well as a description of my privacy rights. I understand that I can review the notice prior to signing this acknowledgement. I understand that the organization reserves the right to change their notice and practices and will provide me a copy of any revised notice.

Patient Name: _____
Print

_____ _____
Signature of Patient or Legal Representative Witness

_____ _____
Date Privacy Notice Date:01/01/2017

HIBISCUS
WOMEN'S CENTER

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

[ ] I authorize Hibiscus Women's Center to disclose my health information, including the diagnosis, treatment and claims information.

This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

I authorize Hibiscus Women's Center to disclose my health information by phone.

Please call [ ] my home _____ [ ] my work _____

[ ] my cell Number: _____ Text messaging: Yes or No

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

Signed: _____ **Date:** ____/____/_____

HIBISCUS
WOMEN'S CENTER

CONSENTS

Patient Record Sharing: _____ YES _____ NO

Patient Record Sharing allows us to share and receive your medical records with your providers at connected care locations.
When "YES" is selected, we will automatically exchange your medical records with providers who care for you.

FL SHOT CONSENT: _____ YES _____ NO

Florida SHOTS is a statewide immunization registry developed by the Florida Department of Health (DOH). Florida SHOTS is designed to access and utilize a statewide immunization database. The registry is part of DOH's initiative to increase vaccination coverage for children across Florida.

Medication History Authority: _____YES _____ NO

Indicate whether the patient has granted the authority to download the patient's medication history automatically from pharmacy benefit managers.

Patient Signature: _____

Date: _____

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Gynecological History:

HPV vaccine YES/ NO Notes_____

Sexually Active YES/NO Notes_____

Sexual Problems YES/NO Notes_____

History of STDs YES/NO Notes_____

Age at first child _____ Notes_____

Most recent mammogram Date:_____ Result:_____

History of Abnormal Pap YES/NO IF YES Date:_____

Date of last menstrual cycle: Date:_____ Definite YES/NO

Menses flow Heavy/ Moderate/ Light

Duration of Flow Days:_____

Menses monthly YES/NO

Age of first period _____

Age at menopause _____

Date of last colonoscopy: _____

Hormone replacement therapy YES/NO IF YES WHAT TYPE:_____

Most recent bone density Date:_____ Result:_____

History of Colposcopy: YES/NO

Last Pelvic Ultrasound Date:_____Facility:_____

BRCA TESTING: YES/ NO DATE:_____

Current birth control YES/ NO Method:_____

Desired birth control method: _____

Sexual Orientation: Heterosexual Homosexual Bisexual Pansexual

Any History of: (Circle) Ovary problems / Fibroids / Infertility / Other gyn issues (notes below)

Please explain:_____

PLEASE LIST ALL SURGERIES WITH APPROXIMATE DATES:

_____

_____

_____

_____

PAST MEDICAL HISTORY- PLEASE CIRCLE IF YOU ARE AFFECTED BY ANY OF THE FOLLOWING:

ABUSE/ DOMESTIC VIOLENCE

ACID REFLUX

ACNE

ALLERGIES (FOOD, SEASONAL, ENVIRONMENTAL)

ANEMIA

ANESTHESIA COMPLICATIONS

ANXIETY DISORDER

IVF (ART)

ARTHRITIS

AUTOIMMUNE DISEASE

BIRTH DEFECTS OR INHERITED DISEASE

BLOOD TRANSFUSION

BREAST CANCER

BREAST PROBLEM

CANCER

DEEP VEIN THROMBOSIS

DEPRESSION/ POSTPARTUM DEPRESSION

DERMATOLOGIC DISORDERS

DIABETES

DRUGS/ LATEX ALLERGIES

EATING DISORDER

ECZEMA

ENDOMETRIOSIS

FIBROMYALGIA

GI PROBLEMS

GESTATIONAL DIABETES

HEADACHES

HEART PROBLEMS

HEMATOLOGIC DISORDERS

HEPATITIS/ LIVER DISEASE

HIGH CHOLESTEROL

HISTORY OF CHICKEN POX OR VACCINE

HYPERTENSION

INFERTILITY

KIDNEY DISEASE

KIDNEY/ BLADDER PROBLEMS

LUNG DISEASE

NEUROLOGIC/ EPILEPSY

ORTHOPEDIC PROBLEMS

OSTEOPOROSIS

OVARIAN CANCER

POLYCYSTIC OVARY SYNDROME

POLYPS

PRE-ECLAMPSIA

PSYCHIATRIC ILLNESS

PULMONARY (TB, ASTHMA)

STROKE

THROMBOPHILIAS

THYROID PROBLEMS

TRAUMA/ VIOLENCE

VARICOSITIES

INFECTIOUS DISEASE

FAMILY HISTORY

DO YOU HAVE ANY PERSONAL OR FAMILY HISTORY OF BREAST/ UTERINE/ OVARIAN/ CERVICAL CANCER?

DO YOU HAVE ANY PERSONAL OR FAMILY HISTORY OF ANY OTHER TYPES OF CANCERS?

If yes please list affected member, age of diagnosis, age of decease (if applicable) and type of cancer:

_____

ARE YOUR FIRST DEGREE RELATIVES AFFECTED WITH ANY MAJOR MEDICAL CONDITIONS: YES/NO

IF YES, PLEASE LIST ANY MAJOR MEDICAL PROBLEMS IN THE FOLLOWING FAMILY MEMBERS:

MOTHER_____

FATHER_____

SISTER_____

BROTHER_____

PLEASE LIST ALL CURRENT MEDICATIONS WITH DOSAGES:

1._____ 4._____

2._____ 5._____

3._____ 6._____

PLEASE LIST ALL PAST PREGNANCY INFORMATION

DATE	WKS	# FETUSES	ANESTHESIA	WEIGHT	M/F	TYPE OF DELIVERY (Vaginal or C/s)
_____	_____	_____	Y/N	_____	_____	_____
_____	_____	_____	Y/N	_____	_____	_____
_____	_____	_____	Y/N	_____	_____	_____
_____	_____	_____	Y/N	_____	_____	_____
_____	_____	_____	Y/N	_____	_____	_____

Please describe any pregnancy related complication/ concerns that you have or would like to discuss with your provider?

_____

_____

Hibiscus Women's Center

Financial Policies

Welcome

Thank you for choosing Hibiscus Women's Center as your healthcare provider. We are committed to providing you with the best possible medical care. We believe that good care for you starts with good communication. Your clear understanding of our practice financial policy is important to our professional relationship.

Fees and Payments

Fees are standard and based on the complexity of your visit. Payment in full is required at the time of your visit. This includes, among other things, copay amounts, deductibles, balances on your account from previously processed claims. Previous balances can be paid prior to appointment by contacting the billing office or on-line through our Patient Portal.

Insurance co-payments are due at the time of service. We will not bill your secondary insurance for co-payments.

While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. If you do not agree with patient responsibility amounts or reimbursement amounts set by your insurance or government program, this is a matter between you and that program, We are happy to provide you with the factual information about your care and billing to help you discuss this with them, but we still require you to promptly pay the entire charge we present to you, even if your issue with the insurance is not resolved. Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract.

Before your visit, contact your insurance company to verify that we are participants in your plan and that the services you intend to receive are covered or if any referrals/authorizations are required. Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurance companies select certain services that they will not cover; therefore we can't guarantee payment of all claims by your insurance company. Some common examples of non-covered services are contraception and infertility. Additionally, some do not cover preventative or obstetrical services. Reduction or rejections of your claim does not relieve you of your financial responsibility. Per your insurance company prior authorization does not guarantee payment and does not release you of your financial responsibility.

PLEASE NOTE: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on coverage by Insurance Companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance company is inappropriate and is considered insurance fraud.

Required at Check-In- ARRIVE AT LEAST 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME

1. Verify Personal Contact Information
2. Present Current Copy of Insurance Card
3. Present Picture ID
4. Credit or Debit Card
5. **PAYMENT OF ANY OUTSTANDING BALANCE**
6. **PAYMENT OF TODAY'S VISIT**

If we are unable to verify your insurance eligibility, you will be considered self-pay and will be responsible for full payment of your visit.

Obstetrics –We have separate policies for your prenatal care and delivery.

Surgical Services –An estimate of your financial responsibility will be collected prior to your surgery based upon your co-insurance and deductible. Payment is required in full prior to elective and non-covered services and procedures.

Self-Pay –In order to address the needs of our patients without insurance and patients with coverage limitations, we offer a 15% discount off our standard fees on the day services are rendered. This discount acknowledges the lower cost involved in billing and collections when a claim does not need to be submitted to a third party payer. In order to qualify, payment needs to be made IN FULL at time of visit. Credit or Debit will be on file to cover any additional charges that may occur. (See Credit Card Policy) This discount is for services only and does not apply to any appliance/devices or miscellaneous charges.

Medicare –We gladly accept Medicare patients and will bill our services at the allowed rate. Medicare regulation requires that you sign an Advanced Beneficiary Notice (ABN) at every visit. This form helps explain which services Medicare may not cover and may be your responsibility.

Annual Exams and Mammography-Please verify that your insurance will cover these preventative services before making your appointment. Depending on your age and the plan, these services may not be covered. Also some insurance companies are very strict in enforcing time limits between visits and may not cover your visit if you are even one day early. When scheduling your mammogram, check with your insurance for participating facility for maximum benefit.

Medical Records –A signed release form must be completed in order for records to be copied. There is a per page charge for your records to be sent to you or another physician. This per page fee schedule is available upon request. If a collaborating physician (Primary Care or Specialist) request portions of your record to assist in your care, there is no charge.

Miscellaneous Charges –

Lab Charges- Depending on your insurance, you may get a separate bill from the lab facility that your lab work is sent to. These charges should be discussed directly with the Lab Facility. We have no way to verify what is allowed by your insurance or obtain any estimated cost for you. There is a minimal lab draw fee that is not filed to your insurance. Ask if you would prefer to go to a different facility for your lab draw.

Cancellation/No Show Charge
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may prevent other patients from getting much needed treatment. Conversely, the situation may arise where other patients fail to cancel and we are unable to schedule you for a visit due to a seemingly "full" schedule.
If an appointment is not cancelled at least 24 hours in advance there will be a thirty dollar ($30) fee. This is charge is not covered by your insurance company and will need to be paid before any appointment is scheduled

Return Check Charge – Non- Sufficient Funds (NSF) checks are subject to fees charged by our bank (in addition to fees from your bank).

Collection Charges – Accounts that are not paid within 90 days from date of service may be sent to an External Collection agency and reported to the Credit Bureau. If a payment plan has been sent up and you fail to make a payment within 60 days, your account will be sent to the External Collection Agency. In addition to your outstanding balance, a charge of $10.00 will be added to cover our cost. In addition, you may be dismissed from the practice.

Please contact the Billing Department 321-724-2229 or through the patient portal, prior to your appointment to discuss any financial issues (i.e. balances, payments, charges, etc.) We do our best to keep appointments with the providers on schedule. Financial discussions with the receptionist at time of your appointment may require rescheduling your appointment.

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