Today's Date: ________________________

PATIENT INFORMATION

Name (Last, First, Middle): ____________________

Email Address: ____________________ Date of Birth: ____________

Marital Status: Married Single Divorced Other Social Security #: ____________

Ethnicity: Hispanic non-Hispanic Refused Other: ____________

Race: African American Asian/Pacific Caucasian Hispanic Other: ____________

Address: ____________________
Street Apt.#

____
City State ZIP

Cell Number: ____________ Home/Other Number: ____________

*** May we send you a text voice call message on your phone numbers provided? Yes No**
*** May we leave you a detailed message on your voicemail for the phone numbers provided? Yes No**

***TO EXPEDITE ANY FUTURE PRESCRIPTIONS, YOU MUST PROVIDE A PHARMACY**

Pharmacy Name: ____________ **Cross Streets/Address:** ____________ **Phone:** ____________

EMPLOYEMENT: Employed Retired Unemployed Self

Occupation: ____________ Employer Name: ____________

Employer Phone: ____________ Ext: ____________

Employers Address: ____________________
Street City State ZIP

EMERGENCY CONTACT

____
Name Relationship Phone#

INSURANCE

Primary Insurance: ____________________

Insured ID: ____________ Group #: ____________

Insurance Phone Number: ____________ Effective Date: ____________

Subscriber: Patient Responsible Billing Party Other Subscriber Social Security #: ____________

Subscriber/ Policy Holder's Name: ____________ Subscriber DOB: ____________

Relationship to Patient: ____________

Secondary Insurance: ____________________

Insured ID: ____________ Group #: ____________

Insurance Phone Number: ____________ Effective Date: ____________

Subscriber: Patient Responsible Billing Party Other Subscriber Social Security #: ____________

Subscriber/ Policy Holder's Name: ____________ Subscriber DOB: ____________

Relationship to Patient: ____________

How did you hear about US? ____________________

Patient/Parent-Guardian's Signature: ____________________

If Parent/ Guardian, please Print Name: ____________________

We make every reasonable effort to obtain pre-approval, prior authorization, and referral information. Your co-payment, co-insurance and/or deductible are due in full at the time of service. We will bill your insurance as a courtesy to you. On denied worker compensation claims, the patient's private/group health insurance may be billed. Ultimate financial responsibility remains with the patient and if the insurance company or worker compensation carrier denies payment, the bill is your responsibility. If you are unsure of any of these issues, please ask the staff before you see the physician.

Welcome!

We are pleased to participate in your healthcare and look forward to establishing a lasting relationship as your health care provider. These policies and procedures will establish the expectation that you will receive from our providers and what we expect from you as our patient. To create understanding we request that you carefully read & the financial policies and procedures of Omni Medical Center for Women.

INFORM CONSENT

INFORMED CONSENT: I hereby authorize Omni Medical Center for Women's staff, including physicians, practitioners, nurses, and medical assistants of this medical office to render medical care to the patient indicated on this form and to fulfill the orders of the physician, including consults, associates, and assistance of the physician's choice.

What All Expect at Omni Medical Center for Women

Confidentiality and Patient Privacy Policies: I understand that information about my health conditions, and the treatments I receive are private. Omni Medical Center for Women's privacy policies always follow U.S. Federal policy rules. If I have questions, my partitioner will give me a copy of private practice policies.

Acknowledgement: My partitioner has explained this consent form to me and the information that it contains any questions that I have were answered I have received a copy of this form to keep upon request. I consent to receive treatment through Omni Medical Center for Women.

By signing below, I acknowledge my understanding of the information listed within this document. I further acknowledge my full comprehension of the document that I am signing.

By signing below, I consent to treatment through Omni Medical Center for Women

Prescriptions

We require 24-72 hours to process your prescription refills. This 24-72 hour excluded weekends and holidays. If you are running low on your medication, please call ahead of time to allow us the proper amount of time to refill your prescriptions.

Patient Name: ____

Patient Signature: ____________________________________ Date: ___________________

Authorization to Treat Minors

As the parent/guardian of (Patient Name): ____, I hereby give permission to the doctor to evaluate and treat the minor mentioned above. Also, I give my permission to evaluate entry if a medical emergency arises, and I am unable to personally consent to the treatment. I also agreed to be responsible to the doctor for the charges created by the medical services rendered.

Parent/Guardian Name: ____

Parent/Guardian Signature: ____________________________________ Date: ___________________

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully. Under the health insurance portability and accountability act of 1996 HIPAA you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer or use or share your information for marketing or advertising purposes or share private notes about your health and care without your written consent.

As one of your providers, it is our responsibility to keep your information safe and secure. This practice is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health conditions end the care and treatment you receive from the practice period the creation of a record detailing the care and services you receive helps this office to provide you with quality healthcare. This notice details how your PHI may be used and disclosed to third parties. This notice also details your right regarding your PHI.

The privacy of PHI in files will be protective when the files are taken to and from practices by placing the files in a box or a briefcase and kept within the custody doctor or employee of the practice authorized to remove these files from the practice's office. Electronic documents will be encrypted, locked and used by those directly associated with Omni Medical Center for Women, no consent required the practice may use and disclose your PHI for the purpose of: (a) treatment in order to provide you with the health care you require, Omni Medical Center for Women may provide your PHI to those healthcare professionals whether on the Omni Medical Center for Women staff or not, directly involved in your care so that they may understand your health conditions and needs. (b.) Payment- To get paid for services provided to you, the office of Omni Medical Center for Women will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant of their billing and payment acquirements. (c.) Health Care Operations- For Omni Medical Center for Women to operate in accordance with applicable law, and insurance requirements and in the order for PAG to continue to provide quality and efficient care, it may be necessary for the practice to compile, user and/ or disclose your PHI. The practice may use and or disclose your PHI without a written consent from you and the following additional instances: (a.) De-identified information- Information that does not identify you and even without your name, cannot be used to identify you (b.) Business Associates- To a business associate if the practice obtained satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assist the practice in undertaking some essential functions, such as a billing company that assists the office in submitting claims for payment to insure companies or other payers. (c.) Personal Representative- To a person who, under applicable law, has the authority to represent you in making decisions related to your health care. (d.) Emergency Situations- (i) For the purpose of obtaining or rendering emergency treatment to you if PA attempts to obtain your consent as soon as possible: or (ii) To a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency. (e.) Communication Barriers- If, due to a substantial communication barrier inability to communicate, the practice has been unable to obtain your consent and the practice determines, in the exercise of its professional judgment, that your consent to receive treatment is clearly inferred from the circumstances. (f.) Public Health Activities- An example of such activities includes information collected by public health authority, as authorized by law to prevent, or control disease and does not identify you, even without your name cannot be used to identify you. (g.) Abuse, Neglect, Or Domestic Violence-To a government authority if the practice is required by law to make sure such a disclosure. If the practice is authorized by law to make such a disclosure it will do so if it believes that the disclosure is necessary to prevent serious harm. (h.) Health Oversight Activities- Such activities, which must be required by law involve government agencies and may include criminal investigations, disciplinary actions, or general oversight activities relating to the community's healthcare system*

The practice reserves the right to change its privacy practices that are described in this privacy notice, in accordance with applicable law.

I understand that, and consent too, the following appointment reminders that will be used by the practice: telephoning my home and leaving a message on my answering machine or with the individual answering the phone and text messages.

I understand that I have a right to request that the practice restrict how my PHI is used and or disclosed to carry out treatment, and or healthcare operations. However, the practice is required to agree to any restriction that I have requested. If the practice agrees to requested restriction it is binding on the practice

I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me. The practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent and has encouraged me to read the Privacy Notices carefully prior to my signing this consent.

Patient Name: ____

Patient Signature: _____________________________________ Date: ___________________

Financial Policy

Insurance:

1) According to your insurance plan you are responsible for all copayments, deductibles, Co insurances and non-covered services. All patient responsibility is due at time services are rendered.
2) Is your responsibility to keep us updated with your correct insurance information. If the insurance company, you designated is incorrect you will be responsible for the payment of the visit and to submit the charges to the correct plan for reimbursement.
3) It is your responsibility to understand your benefit plan regarding, for instance covered services and participating laboratories. For example:
   a) Not all plans cover annual healthy well routine physicals, radiology, and laboratory screenings. If these are not covered, you will be responsible for the payment.
   b) Some plans limit as to the number of allowed well routine visits services screenings per year. If the number of visits is exceeded your insurance company will not pay; And you will be responsible for the payment.
4) It is your responsibility to know if a written referral or authorization is required to see a specialist, whether a prior authorization is required prior to a procedure and what services are covered.

Payment:

1) If you do not have health insurance, do not provide an insurance card, or do not provide a Social Security number at time of service you will be considered a self-pay patient. Self-pay patients are required to pay for services in full at the time of the visit.
2) If we do not participate in your insurance plan, payment in full is required from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
3) Patient balances are billed immediately on receipt of your insurance plans explanation of benefits period your remittance is due within 10 days of your receipt of your bill.
4) For scheduled appointments, prior balances must be paid prior to the visit.
5) We accept cash, checks, visa, and MasterCard, and debit
6) **If you participate with a high deductible health plan (over $1000), we may require a copy of the health savings account debit or credit card or a copy of a personal credit card to remain on file**.
7) Copays, coinsurance, deductible, and or any outstanding balances are patient responsibility and are due at time of service
8) Patient is responsible for all services not covered by their insurance company

Fees:

1) If you are not able to keep an appointment, we would appreciate a 24-hour notice. There is a $35.00 charge for missed appointments or for cancellations less than 24 hours of an appointment.
2) Cancellations of less than seven days for a procedure or surgery are subject to a $250 fee. It must be paid before you are rescheduled.
3) There is a $50.00 fee for FMLA/Disability to be completed. Please allow up to 10 business days.
   This is noninsurance covered service.
4) Non physician request for medical records will be assessed administration fees of $15 according to the current regulations. There will be a charged $1 per page as per Source: Fla. Stat. 395.3025 https://www.flsenate.gov/laws/statutes/2016/395.3025
5) All copayments, deductibles, Co insurances and non-covered services. All patient responsibility is due at time services are rendered.
6) Any account balance outstanding longer than 28 days will be charged 1% interest for each 28-day cycle.
7) Any balance outstanding longer than 90 days will be forwarded to a collection agency. You agree to reimburse us the fees of any collection agency, which may be used on a percentage of 28% of the account balance, and all cost and expenses including reasonable attorney's fees, we incur in such collection's efforts
8) $50.00 fee will be charged for any checks returned for insufficient funds
9) If an insurance company mandates that a prior authorization/pre-authorization is required for a medication, a fee of up to $50.00 may be charged.

- I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.
- I understand that my insurance policy is a contract between myself and my insurance company.
- I also understand that I am financially responsible for any services not covered by my insurance company. I
- understand a fee of $50 will apply for disability/FMLA forms.
- I understand that all labs and radiology services will have a separate charge.

Patient Name: ______________________________________

Patient Signature: ___________________________________ Date: __________________