Women's Center of Florida

Emory Medical Corporation 351NE Franklin Street #1125, Lake City. FL32055 Ph (386) 466-1106 Fax (386) 466-1821

REGISTRATION/NICA DISCLOSURE/MEDICAL HISTORY FORM/NOTICE OF PRIVACY PRACTICES

PATIENT INFORMATION: **DATE:** ____________

NAME:______________________________ DATE OF BIRTH:______________
ADDRESS:______________________________ CITY:____________ STATE____ ZIP ________
PHONE: (___)______________ WORK: (___)______________ CELL: (___)______________
SOCIAL SECURITY # ______-______-______ DRIVERS LICENSE # ______________ STATE_____ EXP DATE__________
CHECK APPROPRIATE BOX ☐MINOR ☐ STUDENT ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐DIVORCED
SPOUSE OF PARENT'S NAME: ______________________ PHONE(___)__________ WORK(___)__________
REFERRING PHYSICIAN(PCP)/PERSON:______________ ______________ PHONE(___)______________
EMERGENCY CONTACT: ______________ ______________ PHONE: (___)______________
EMAIL ADDRESS: ______________________ HOW DID YOPU HEAR ABOUT US? ______________
What is your preferred method of communication with us ☐e-mail ☐Cell Phone ☐Home Phone ☐Mail

RESPONSIBLE PARTY & INSURANCE INFORMATION

NAME OF EMPLOYER: ______________________________ WORK PHONE (___)__________
ADDRESS OF EMPLOYER: ______________________ CITY____________ STATE _____ ZIP ________
INSURANCE COMPANY: ______________________ GROUP # ______________ POLICY ID # ______________
DO YOU HAVE ADDITIONAL INSURANCE? ☐YES ☐NO
IF YES, NAME OF SECONDARY INSURANCE: ______________________ POLICY ID # ______________

Medical History:

Are you having or have you EVER had any problems listed below?

Head ______________ Musculoskeletal ______________
Neck ______________ Neurological ______________
Heart ______________ Psychiatric ______________
Breast ______________ Endocrine ______________
Lung ______________ Bladder ______________
Abdomen ______________ Vaginal ______________
Past Medical Problems ______________________________
Any Other Concerns you want us to address or feel we should know______________
Medication taking ______________________________
Allergies______________

NICA DISCLOSURE

PHYSICIAN NOTICE TO OBSTETRIC PATIENT See Section 766.314, Florida Statutes

I have been furnished information on behalf of all Women's Center of Florida physicians who practice obstetrics or perform obstetric services, which has been prepared by the Florida Birth Related Neurological Injury Compensation Association (NICA). I have also been advised that the Women's Center of Florida physicians who practice obstetrics or perform obstetric services are participating physicians in that program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor, delivery, or resuscitation. For specifics on the program, I understand I may contact the Florida Birth-Related Neurological Injury Compensation Association (NICA), Post Office Box 14567, Tallahassee, Florida 32317-4567, 1-800-398-2129. I specifically acknowledge that I have received a copy of the brochure prepared by NICA.

I understand NICA disclosure All of my questions/concerns about NICA have been answered.

I also acknowledge the receipt of HIPAA notice of Privacy Practices. I have read the copy of notice of privacy practices, detailing how my health information may be used and disclosed as permitted under federal and State law, and outlining my rights regarding my health information.

This Consent will be stored electronically and will be valid for all treatment encounters. I willfully and voluntarily give the Information above. I understand that it is my responsibility to keep my contact information current. Any changes made by me after this date will be done so by me in writing only. I also understand all the forms/consents/agreements are available on website (www.myobcare.com) for my review.

Patient Signature ______________________ Witness______________________

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PATIENT CONSENT FORM

The undersigned, herby consent to the following for Emory Medical Corporation and Its Providers.
Administration and performance of any treatments, anesthetics or medication.
Performance of any procedures/biopsies/cultures as deemed necessary or advisable.
Performance of any Lab tests including drug/toxicology testing.
Performance of other medical tests may be done in house or outside facility that may be considered medically necessary or advisable based on the judgments of the attending physician or their assigned designees.
I assume full financial responsibility of the Services/ treatments/tests that I may receive. Having insurance does not terminate that responsibility and I may have to fill paperwork or contact my insurance to facilitate payments.
I understand that I have the right to refuse any service tests or procedure before it's performed.
All cancelled checks are subject to a $35.00 charge. A $20.00 charge placed for all missed or cancelled appointments less than 24 hrs.
Leaving the office without being discharged will be considered leaving against medical advice (AMA).
I may be discharged from the practice if I am not compliant with, treatment/office appointments or for unpaid account.
All unpaid accounts will be turned to collections after 90 days and I will be responsible for all expenses needed to recover.
The address and phone number provided is the address and phone of record and I will be responsible for updating my record.

HIV CONSENT

If I have been offered the blood test for detection of the human immunodeficiency virus (HIV) . HIV is the causative agent of Acquired Immune Deficiency Syndrome (AIDS).
I understand that this test may not be conclusive because a positive result means additional tests may be needed and a negative result does not necessarily eliminate consideration of AIDS.
I have also been informed that the results of this blood test will only be released to those healthcare personal and Insurance companies, providing medical care and coverage to me as allowed by Federal and State law. I understand that these test results will be a part of my medical record and will be released if I have signed an authorization for release of medical information.
I understand that not all health insurance plans will pay for HIV testing. Should my Insurance company decline coverage I understand that I will be expected to pay for it myself.
I am aware that additional information regarding HIV/ AIDS and antibody testing is available at my request and therefore acknowledge that I have had the opportunity to ask any questions I have regarding this test prior to giving my consent.
I herby give my consent for the performance of the HIV blood test and to the release of the results as outlined above.

RELEASE & STORAGE OF MEDICAL RECORDS

I fully understand that I am entitled to my medical records which can be pulled with advanced notice and printed/ or electronically copied for me after I have paid the charges associated with it.
I also understand that medical records can be given to me ONLY IN PERSON or released to my health care provider after a release of medical record consent is obtained.
I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommend the consent will remain in full force for all treatments received past and future until revoked in writing.
All communication with Emory Medical Corporation must be done in Writing via Certified mail ONLY no other form of communication will be considered valid.
I understand that all records are stored electronically by Emory Medical Corporation and are fully backed up daily by vendors to ensure safety but can be lost due to unforseen circumstances beyond our control and Emory Medical Corporation or its providers are not Liable for it.
I understand that Emory Medical Corporation may include consent/records at satellite offices under common ownership.
A Photocopy/Electronic file stored copy of consent/records shall be considered as valid as the original and the paper copies may be destroyed by the Corporation. All contracts and agreements will survive the termination of relationship.
I authorize Emory Medical Corporation to release medical information about me to the social security administration or it's intermediaries for any insurance claims being made for services provided to me.
I assign Emory Medical Corporation benefits payable for services provided to me.
I understand and acknowledge that Emory Medical Corporation will use and disclose my information for the purpose of treatment payment and healthcare operations as described in the notice of privacy practices.
I acknowledge that I have been given the notice of privacy practices & copies of any forms that I have signed by Emory Medical Corporation.
I understand that if I have questions or complains that I should contact the privacy official.

If Pregnant and delivered by a provider I undersigned authorities Emory Medical Corporation to use and display photographs of my baby delivered by its physicians any publication multimedia production display and or advertisement / website.

I certify that I have read and fully understand the above statements and voluntary consent to its content and all my questions and concerns have been fully answered to my satisfaction.

______________________	__________	______________________	__________
Patient/Guardian Signature	Date	Witness	Date

______________________ Physician

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Healthcare Provider-Patient conditions of Admission & Binding Arbitration Agreement

1.Financial Agreement : In consideration of the services to be rendered to the patient, I individually promise to pay the patient's account at the rates stated in Emory Medical Corporation price list (known as the "Charge Master") effective on the date the charge is processed for the service provided, which rates are hearby expressly incorporated by reference as the price term of this agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on Charge master, or if the charge is listed as zero. An estimate of the anticipated charges for services to be provided to the patient is available upon request from the billing department. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services. As a courtesy to you, Emory Medical Corporation will bill your insurance company, but is not obligated to do so. Regardless, you agree that except where prohibited by law, the financial responsibility for the services rendered belongs to you, the undersigned. You agree to pay for any services that are not covered by your insurance company. This includes, but is not limited to, coinsurance, deductibles, non covered benefits due to policy limits or policy exclusions as well as failure to comply with your insurance requirements. If collection is initiated you will be responsible for all collection costs including attorney's fees and court costs or any other cost of litigation.

2. Binding Arbitration Agreement : Any controversy or claim arising out of or related to but not limited to dispute of Diagnosis, Treatment, Care or medical malpractice shall be settled by mandatory binding arbitration in accordance with rules and procedures of alternative dispute resolution and arbitration established by Alternative Dispute Resolution Service of American Health Lawyers association. The parties involved shall make good faith efforts to settle the dispute by negotiations and if this is unable to resolve within 90 days of the date the aggrieved party send written notice of dispute to the other party, and if any party wishes to pursue the dispute, it shall then be submitted to binding arbitration. Such arbitration shall be conducted before a single arbitrator selected by Emory Medical Corporation. The award of the arbitrator shall be final and binding upon the parties and will not exceed provider insurance coverage. The arbitrator shall not be entitled to award punitive, consequential, exemplary, or similar damages or to vary or even ignore the terms of this agreement. The arbitrator shall be bound by controlling law. Neither party shall seek injunctive or any other equitable relief in court in connection with the enforcement of those sections of the agreement that permit actions for injunctive relief. Any dispute arising out of agreement must be submitted to the binding arbitration. The cost of such arbitration (excluding the attorney's fees and cost of each of the parties) shall be shared equally by the parties. To the extent permitted by law, the Parties hearby jointly and severally waive any and all right to trial by jury in any action or proceeding arising out of or relating to medical diagnosis, care and/or treatment. The Parties each represent to the other that this waiver is knowingly, willingly and voluntarily given.

This agreement is irrevocable and effective as of the first date of medical service provided and shall remain effective for all or any care in any setting/location provided past present or future. This agreement is governed by the laws of State of Florida. By signing this agreement the patient acknowledges that he/she has received a copy of this agreement and this is a legal document, and that he or she has the right to consult with an attorney of his/her choice prior to signing this agreement to receive explanations or clarifications of any of the terms of this agreement.

This agreement shall be stored electronically and will be considered as original. This will apply without any limitations to all health care providers of Emory Medical Corporation. All agreements shall survive the termination of relationship. The patient also acknowledges he/she has been given every opportunity to ask questions, concerns and intent of this agreement.

Patient/Guardian	Date	Health Care Provider	Date