Boca Babes OBGYN

"Bring out the Babe within!"

Ty K. Swartzlander, MD, FACOG Charla J. O'Neil, CNM, ARNP Rachanee Yaemsang, CNM, ARNP

880 NW 13th St, Suite 330, Boca Raton, Florida 33486

4793 N Congress Avenue, Suite 202, Boynton Beach, Florida 33426

Telephone: 561 413 2832 Fax: 561 439 2505 BocaBabesOBGYN.com

Obstetrics • Gynecology • Infertility • Menopause • Minimally Invasive & Robotic Surgery

Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home phone number:_____ Cell phone number:_____

Email address (we do not give it out):_____

Birthdate:_____ Social Security Number:_____

Referred to practice by:_____

Employer:_____ Occupation:_____

Work phone:_____ Extension:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Spouse/Next of Kin:_____ Phone #:_____

Race:_____Ethnicity:_____

Preferred language:_____

Nearest Friend/Relative:_____ Phone #:_____

Pharmacy:_____ Phone #:_____

Name of Primary Care Provider:_____

Primary Insurance/Policy/Group number:_____

Secondary Insurance/Policy/Group number:_____

As a courtesy to our patients, our office will submit all charges incurred to your insurance company on record. It is the sole responsibility of the patient to notify our office, in writing, of any changes to their insurance policy. Any account balance remaining after sixty (60) day period shall become the responsibility of the patient.

I certify that the above information is correct and further authorize the release of any medical information to your insurance carrier(s) for any claim. I request payment of authorized benefits for provider's services to the provider furnishing the service, or authorize the provider to submit a claim for me. I also agree that should this account be referred to any agency or attorney for collection, I will be responsible for all collection fees, attorney fees and court costs. There will be a minimum charge of $50.00 for all balances sent to collections. I am also aware that **payment is expected when services are rendered,** unless prior arrangements have been made.

Signature:_____Date:_____

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Contact Authorization and Preferences

I, _____ authorize Boca Babes OBGYN, physicians and or office staff, to notify me of my diagnostic or lab results, upcoming appointments, and bills due by any of the below means of contact unless I specify otherwise.

Phone Number:_____ Alternate Phone Number:_____

OK to text you? ☐ Yes ☐ No

Email: _____

**by providing your email address, you agree to receive an invitation to the patient portal where you can look up your labs, update your chart, review notes, and communicate with our office regarding your visits.*

If you have special requests for contacting you, please check one or more of the following options:

☐ Leave a message with my results at my phone number designated above if I am not available.

☐ Leave a message containing my results with anyone answering my phone or alternate phone.

☐ I authorize another person to accept results for me.

Name of person:_____Relationship:_____

☐ Speak with me only.

☐ **Do NOT call me with any results**. I will call the office or go to the patient portal if I want test results.

Signature:_____Date:_____

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No Malpractice Acknowledgement Form

YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. The following notice is provided pursuant to Florida law.

Please understand that **Dr. Ty K. Swartzlander has elected not to carry medical malpractice insurance**. In accordance with F.S. 458.320(5)(g)1 and 459.0085(5)(g)1, he must provide this notice in writing to you as a patient. Please sign below acknowledging you understand he does not carry medical malpractice insurance.

I _____, understand that I will be provided services by Ty K. Swartzlander, MD, Charla J. O'Neil, CNM, ARNP, or Rachanee Yaemsang, CNM, ARNP, or any other provider at Boca Babes OBGYN and that Dr. Swartzlander has chosen not to carry medical malpractice insurance. I would still like to receive medical services provided by providers at Boca Babes OBGYN.

Thank you,

Signature:_____ Date:_____
(Signature of Parent or Legal Guardian if above named patient is a minor and indicate relationship below)

Parent or Legal Guardian, please print your name:_____

Relationship to patient:_____

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Consent for use and disclosure of health information

Patient Name:_____

Address:_____

Phone Number:_____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Ty K. Swartzlander, M.D.
Telephone: 561-413-2832 Fax: 561-439-2505
Address: 880 NW 13th St, Suite 330, Boca Raton, FL 33486

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.
Authorization

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature:_____ Date:_____
If a personal representative on behalf of the patient signed this Consent, complete the following:

Personal Representative's Name:_____

Relationship to patient:_____

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YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have read and/or received a copy of the
(Print Patient Name)
Boca Babes OBGYN, LLC Notice of Privacy Practices**.**

Signature of Patient:_____Date:_____

For Office Use ONLY Below this Line

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for one or more of the following reasons:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify):_____