Boca Babes OBGYN

"Bring out the Babe within!"

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

625 Casa Loma Blvd, Suite 102, Boynton Beach, Florida 33435

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

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

Name: ____

Birthdate: ______________________ Social Security Number: ____________________

Street Address: ____

City: ______________________________ State: ____________ Zip: ____________

Home phone number: ____________________ Cell phone number: ________________

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

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race: ____________ Ethnicity: ________________ Preferred language: ____________

Emergency Contact: ____________________________ relationship to you: __________

Phone # ________________________________

Primary Care Provider or Referred by: ________________________________

Primary Insurance Policy#: ____________________ Group# number: ________________

Secondary Insurance Policy#: __________________ Group# number: ________________

Employer: __________________________ Occupation: ________________________

Work phone: ________________________ Extension: __________________________

Pharmacy Name and Address: ____________________________________

Pharmacy Phone #: ________________ Preferred Imaging Center: ____________________

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

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.

We offer secure electronic communication between you and our office via our Patient Portal. Secure messages and information can only be read by someone who knows the right password to log in to the Portal site. The communications are automatically encrypted and for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

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.*

Signature of patient or guardian: ______________________________Date: _________________________

No Malpractice Acknowledgement Form

YOUR PROVIDER MAY HAVE 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 **providers at Boca Babes OBGYN may have elected not to carry medical malpractice insurance**. In accordance with F.S. 458.320(5)(g)1 and 459.0085(5)(g)1, we must provide this notice in writing to you as a patient. Please sign below acknowledging you understand we may not carry medical malpractice insurance.

I ________________________________, understand that I will be provided services by any provider at Boca Babes OBGYN and that he or she may have 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: ____

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: Practice Manager
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 of patient or guardian____ 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 or guardian: __________________________**Date:**_________________

Use of Photography

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

Signature of Patient or Guardian: ____________________________ **Date:** __________

Patient Record Sharing

Patient Record Sharing allows us to share and receive your medical records with other providers at connected care locations. By signing below, we may automatically exchange medical records with providers who have cared for you and use the same electronic records system as we do.

Signature of Patient Guardian: ___________________________________ **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):____

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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

As a courtesy to our patients, you will receive text or email reminders for any upcoming appointments.

Any patient who fails to cancel/reschedule an appointment within 24 hours will be subjected to a $35.00 fee. The fee is charged **to you**, not the insurance company, and is due upon receipt of bill or before next visit. After three consecutive no-shows to your appointment, our practice may decide to terminate our relationship with you.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

____

Signature of patient or Parent/Legal Guardian Relationship to Patient

____

Printed Name Date