PATIENT INFORMATION

WEST KENDALL OBGYN
Obstetrics & Gynecology

Date				
Patient's Name	Social Security Number / /	Sex ◯ Male ◯ Female	Date of Birth / /	Age
Street Address ◯ Permanent ◯ Temporary	Apt/Suite/Unit	City / State /	Zip Code	Country
Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated ◯ Domestic Partner	Race (check all that apply) ◯ White ◯ Black/African American ◯ American Indian/Alaskan Native ◯ Native Hawaiian/Pacific Islander ◯ Asian ◯ Other		Ethnicity (check one) ◯ Hispanic ◯ Non-Hispanic	
Primary Language ◯ English ◯ Spanish ◯ Other	Mobile Phone	e-mail		
Patient's Occupation	Patient's Employer	How long employed	Preferred method of communication ◯ Call ◯ Text ◯ e-mail	
Driver's License Number	Employer's Street Address	City / State /	Zip Code	
Primary Care Physician Name	Phone Number	Fax Number	How did you hear about us? ◯ Referring Provider ◯ Friend or Family ◯ Internet ◯ Walk In	

Spouse/Domestic Partner Name	Spouse/Partner Employer	How long employed	Spouse/ Partner Occupation
Spouse/Partner's Employer Street Address	City / State /	Zip Code	Spouse/Partner Mobile Phone

Emergency Contact Name	Relationship to Patient		Emergency Contact Mobile Phone	
Emergency Contact Street Address	Apt/Suite/Unit	City / State /	Zip Code	Country

IF THE PATIENT IS A MINOR OR STUDENT

Mother's Name	Street Address	City / State /	Zip Code
Mother's Occupation	Mother's Employer	How long emplyed	Mother's Mobile Phone
Mother's Employer Street Address	City / State /	Zip Code	Mother's Alt Phone
Mother's Social Security # / /	Mother's Date of Birth / /	Mother's Drivers License Number	Mother's Business Phone

Father's Name	Street Address	City / State /	Zip Code
Father's Occupation	Father's Employer	How long emplyed	Father's Mobile Phone
Father's Employer Street Address	City / State /	Zip Code	Father's Alt Phone
Father's Social Security # / /	Father's Date of Birth / /	Father's Drivers License Number	Father's Business Phone

INSURANCE INFORMATION

Insurance Company	◯ PPO ◯ POS ◯ HMO ◯ EPO ◯ INDEMNITY ◯ MEDICARE/MEDICAID ◯ W/C ◯ SELF PAY		
Primary Insurance Holder	Date of Birth / /	Employer's Street Address	Policy Holder Street Address

PHARMACY INFORMATION

Primary Pharmacy Name	Pharmacy Address	Pharmacy Fax	Pharmacy Phone

PHYSICIAN RELEASE AND ASSIGNMENT

I hereby authorize payment directly to Sirven & Associates Allergy and Asthma Center of benefits due to me from my insurance company otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim as required by law. I request payment of medical insurance benefits either to myself or to Sirven & Associates Allergy and Asthma Center who accepts assignment. I understand that I am financially responsible for charges regardless of coverage.

Patient's / Guarantor's Signature: _____ Date _____/_____/_____

INFORMACIÓN DEL PACIENTE

WEST KENDALL OBGYN
Obstetrics & Gynecology

Fecha					
Nombre del paciente	Número de seguro social / /	Sexo ◯ M ◯ F	Fecha de nacimiento / /	Edad	
Dirección ◯ Permanente ◯ Temporaria	Apt/Suite/Unidad	Ciudad / Estado /	Código postal	País	
Estado Civil: ◯ Soltero ◯ Casado ◯ Viudo ◯ Divorciado ◯ Separado ◯ Compañero Domestico	Raza (marcar todos los que apliquen) ◯ Amerindia or nativo de Alaska ◯ Indioasiática ◯ Blanca ◯ Negro/Afroamericana ◯ Nativo de Hawái ◯ Otra raza		Etnia (marcar uno) ◯ Hispano ◯ No-Hispano		
Primer Idioma ◯ Inglés ◯ Español ◯ Otro	Celular	Correo electrónico			
Ocupación del paciente	Empleador del paciente	Tiempo de empleo	Método preferido de comunicación ◯ Llamada ◯ Texto ◯ Correo electrónico		
Número de Licencia de Conducir	Dirección de empleo	Ciudad / Estado /	Código postal		
Nombre del Médico Primario	Teléfono	Fax	¿Cómo supo de nosotros? ◯ Proveedor ◯ Familiar o Amigo ◯ Internet ◯ Otro		

Nombre del cónyuge	Empleador del cónyuge	Tiempo de empleo	Spouse/ Partner Occupation	
Dirección de empleo del cónyuge	Ciudad / Estado /	Código postal	Celular del cónyuge	
Nombre de pariente mas cercano	Relación con el paciente		Celular del pariente	
Dirección del pariente	Apt/Suite/Unidad	Ciudad / Estado /	Código postal	Pais

PACIENTE MENOR DE EDAD O ESTUDIANTE

Nombre de la madre	Dirección	Ciudad / Estado /	Código postal	
Ocupación de la madre	Empleador de la madre	Tiempo de empleo	Celular de la madre	
Dirección de empleo de la madre	Ciudad / Estado /	Código postal	Otro teléfono de la madre	
Número del seguro social de la madre / /	Fecha de nacimiento de la madre / /	Número de Licencia de Conducir de la madre	Teléfono de trabajo de la madre	

Nombre del padre	Dirección	Ciudad / Estado /	Código postal
Ocupación del padre	Empleador del padre	Tiempo de empleo	Celular del padre
Dirección de empleo del padre	Ciudad / Estado /	Código postal	Otro teléfono del padre
Número del seguro social del padre / /	Fecha de nacimiento del padre / /	Número de Licencia de Conducir del padre	Teléfono de trabajo del padre

PACIENTE MENOR DE EDAD O ESTUDIANTE

Seguro primario	◯ PPO ◯ POS ◯ HMO ◯ EPO ◯ INDEMNITY ◯ MEDICARE/MEDICAID ◯ W/C ◯ SELF PAY		
Nombre del suscriptor	Fecha de nacimiento del suscriptor / /	Dirección de empleo del suscriptor	Dirección del suscriptor

INFORMACION DE FARMACIA

Farmacia Preferidad	Dirección de la farmacia	Fax de la farmacia	Teléfono de la farmacia

AUTORIZACION

I hereby authorize payment directly to Sirven & Associates Allergy and Asthma Center of benefits due to me from my insurance company otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim as required by law. I request payment of medical insurance benefits either to myself or to Sirven & Associates Allergy and Asthma Center who accepts assignment. I understand that I am financially responsible for charges regardless of coverage.

Firma del paciente/garante: _____ Fecha _____/_____/_____

WEST KENDALL OBGYN
Obstetrics & Gynecology

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient Authorization

Name _____ Address _____

Phone _____ City/State/Zip Code _____

Date of Birth _____ email _____

SECTION B: To The Patient (Please read the following statements carefully):

Purpose of Consent: By signing this form (Consent), you will consent to the use and disclosure by West Kendall OBGYN of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read West Kendall OBGYN's Notice Privacy Practices (Notice) before you decide whether to sign this Consent. West Kendall OBGYN's Notice provides a description of West Kendall OBGYN's treatment, payment activities, and healthcare operations, of the uses and disclosures West Kendall OBGYN may make of your protected health information, and of other important matters about your protected health information. A copy of West Kendall OBGYN's Notice accompanies this Consent. West Kendall OBGYN encourages you to read it carefully and completely before signing this Consent.

West Kendall OBGYN reserves the right to change its privacy practices as described in its Notice. If West Kendall OBGYN changes its privacy practices, a revised Notice will be issued, which will contain the changes. Those changes may apply to any of your protected health information that West Kendall OBGYN maintains.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any lime on our website, or by contacting

West Kendall OBGYN's Office Management Staff
8200 SW 117th Ave, Suite 410, Miami, FL, 33183 | 305·226-5651

Right to Revoke. Please understand that revocation of this consent will not affect any action West Kendall OBGYN took in reliance on the consent before feMe received your revocation. However, revocation of this consent will result in West Kendall OBGYN being prohibited from sharing your PHI with your health insurance carrier, if applicable, and, thus, West Kendall OBGYN's inability to bill your medical treatment to that insurance carrier. Therefore, patients that either refuse to sign this consent or revoke it after signing it will be required to self.pay for all medical treatment provided by West Kendall OBGYN and then seek reimbursement directly from the medical insurance carrier for such treatment.

Additional Person Authorized to Access PHI: I authorize the following person(s) access to my PHI:

Name	**Relationship**	**Date**	**Date Revoked**

SIGNATURE

I, _____ , have had full opportunity to read and consider the consents of this Consent and have received a copy of West Kendall OBGYN's Notice of Privacy Practices. I understand that, by signing this Consent, I am giving consent to West Kendall OBGYN's use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I also understand I'm agreeing to allow West Kendall OBGYN to request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Signature _____ Date _____ / _____ / _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

You are entitled to a copy of this consent after you sign it.

For Office Use ONLY: ◯ Individual refused to sign ◯ Emergency situation prevented us from obtaining acknowledgment
◯ Communication barriers prohibited obtaining the acknowledgment ◯ Other

WEST KENDALL OBGYN
Obstetrics & Gynecology

PATIENT RECORD DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by means such as sending correspondence to an address other than home.

I wish to be contacted in the following manner (check all that apply):

MOBILE Telephone:

- ◯ OK to leave message with detailed information
- ◯ Leave message with call back number ONLY
- ◯ Fax to this number: _____

WRITTEN Communications:

- ◯ OK to mail HOME address
- ◯ OK to mail WORK address

WORK Telephone:

- ◯ OK to leave message with detailed information
- ◯ Leave message with call back number ONLY

OTHER:

- ◯ OK to email this address:

  _____

_____
Signature

_____ / _____ / _____
Date

_____
Print Name

_____ / _____ / _____
Date of Birth

NOTICE OF PRIVACY PRACTICES

This notice of privacy practices (notice) describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review this notice carefully. The privacy of your health is important to West Kendall OBGYN.

THIS NOTICE COVERS THE FOLLOWING HEALTH CARE PROFESSIONALS PROVIDING YOUR CARE THROUGH West Kendall OBGYN: All employees, physicians, physician assistants, nurse practitioners, nurses, administrative staff and any other health care professionals providing you care through West Kendall OBGYN must abide by this Notice of Privacy Practices. West Kendall OBGYN may share your information with our workforce to help them provide medical care to you.

PART 1 - West Kendall OBGYN Legal Duty

West Kendall OBGYN is required by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA, to (i) maintain the privacy of your protected health information, (ii) provide you notice of West Kendall OBGYN's legal duties and privacy practices with respect to protected health information, and (iii) notify affected individuals following a breach of unsecured protected health information. West Kendall OBGYN is required to abide by the terms of the Notice currently in effect. Your health information is anything West Kendall OBGYN has created or received regarding your health or payment for your healthcare. It includes both your medical records and personal information such as your name, social security, address and phone

PART 2 - How West Kendall OBGYN May Use and Disclose Health Information About You

Generally, **West Kendall OBGYN** may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, West Kendall OBGYN must use or disclose your personal health information in accordance with the specific terms of that permission. The following are the circumstances under which West Kendall OBGYN is permitted by the law to use or disclose your personal health information:

A. Without Your Consent for Treatment Payment and Operations

Without your consent, West Kendall OBGYN may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, West Kendall OBGYN is permitted to disclose your personal health information within and among its workforce in order to accomplish these same purposes. However, even with your permission, West Kendall OBGYN is still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of Treatment Activities. West Kendall OBGYN may use or disclose your health information to a physician, nurse, or other healthcare professional providing treatment to you. Treatment activities include: (a) the provision, coordination, or management of health care and related services by health core providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of Payment Activities. West Kendall OBGYN may use and disclose your health information to obtain payment for services West Kendall OBGYN provides to you, including billing and collection activities and related data processing.

Examples of Healthcare Operations. West Kendall OBGYN may use and disclose your health information in connection with West Kendall OBGYN's healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

B. As Required by Law

We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information or inmate or patient under certain circumstances.

C. Miscellaneous Permitted Activities

We may also use or disclose medical information when contacting you by phone, email, text message or mail to remind you of appointments, treatments, referrals, authorizations and test results.

D. All Other Situations With Your Authorization

Except as otherwise permitted or required, as described above and set forth in HIPAA, West Kendall OBGYN may not use or disclose your personal health information without your written authorization. You may give West Kendall OBGYN written authorization to use your health information or to disclose it to anyone for any purpose. Uses and disclosures not described in this Notice will be made only with your authorization. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

E. Communicating with a Patient's Family, Friends, or Others Involved in the Patient's Care

Even though HIPAA requires health care providers, like West Kendall OBGYN, to protect patient privacy, providers are permitted, in most circumstances, to communicate with the patient's family, friends, or others involved in their care or payment for care. This section is intended to clarify these HIPAA requirements so that West Kendall OBGYN does not unnecessarily withhold your health information from these persons.

Patient is Present and has the Capacity to Make Health Care Decisions. If the patient is present and has the capacity to make health care decisions, a health care provider may discuss the patient's health information with a family member, friend, or other person if the patient agrees or, when given the opportunity, does not object. A health care provider also may share information with these persons if, using professional judgment, he or she decides that the patient does not object. In either case, the health care provider may share or discuss only the information that the person involved needs to know about the patient's care or payment for care.

The following are a few examples:

- West Kendall OBGYN may discuss a patient's bill with the patient's adult daughter who is with the patient at the patient's medical appointment and has questions about the charges .
- West Kendall OBGYN may discuss the drugs a patient needs to take with the patient's health aide who has accompanied the patient to a medical appointment .
- A nurse may discuss a patient's health status with the patient's brother if she informs the patient she is going to do so and the patient does not object.

BUT:

- A nurse may not discuss a patient's condition with the patient's brother after the patient has stated she does not want her family to know about her condition.

Patient is Not Present or is Incapacitated. If the patient is not present or is incapacitated, a health care provider may share the patient's information with family, friends, or others as long as the health care provider determines, based on professional judgment, that it is in the best interest of the patient. When someone other than a friend or family member is involved, the health care provider must be reasonably sure that the patient asked the person to be involved in his or her care or payment for care. The health care provider may discuss only the information that the person involved needs to know about the patient's care or payment. West Kendall OBGYN will also use its professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

The following are a couple of examples:

- West Kendall OBGYN may give information regarding a patient's drug dosage to the patient's health aide who calls the provider with questions about the particular prescription.

BUT:

- A nurse may not tell a patient's friend about a past medical problem that is unrelated to the patient's current condition.

PART 3 - Patient's Rights

In addition to the restrictions on our use and disclosure of your health information, you have the following specific rights regarding the use and disclosure of your health information:

Restrictions of Use and Disclosures. You may request that West Kendall OBGYN restrict the use and disclosure of your health information for various reasons such as restricting that certain health information not be disclosed to a specific family member, for example. Although there are numerous reasons why you may want West Kendall OBGYN to restrict the use and disclosure of your health information, West Kendall OBGYN is not required to agree to a requested restriction except requests to restrict disclosure of your protected health information to a health plan if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (b) the protected health information pertains solely to a health care item or service for which you, or person other than the health plan on behalf of you, has paid West Kendall OBGYN in full.

While West Kendall OBGYN is generally not required to agree to any requested restriction, if West Kendall OBGYN agrees to a restriction, West Kendall OBGYN is bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. West Kendall OBGYN will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right to Request Confidential Communications. You may request in writing, and West Kendall OBGYN must accommodate reasonable requests by you, to receive communications of protected health information from West Kendall OBGYN by alternative means or at alternative locations. West Kendall OBGYN may condition the provision of reasonable accommodation on (a) when appropriate, information as to how payment, if any, will be handled; and (b) specification of an alternative address or other method of contact. West Kendall OBGYN may not require an explanation from you as the basis for the request as a condition of providing communications on a confidential basis.

Access to Health Information. You have the right to look at or get copies of your health information, with limited exceptions. You may request that West Kendall OBGYN provide copies in a format other than photocopies such as a PDF format via electronic mail. West Kendall OBGYN will use the format you request unless we cannot practicably do so. However, providing copies of your health information in any format other than paper copies, such as electronically, comes at a risk that your information may be stolen or obtained by others. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice.

Amending Health Information and Records. You have the right to request that your health information or a specific record be amended provided you do so in writing to the person designated at the end of this Notice and you provide reasons why such health information or record should be amended. Although you have a right to request that your health information or records be amended, West Kendall OBGYN may deny your request under certain circumstances such as when the information requesting to be amended was not created by West Kendall OBGYN or the information is accurate and complete.

Accounting of Disclosures of Protected Health Information. Excluding certain disclosures, for example by way of illustration and not limitation, West Kendall OBGYN's disclosures for treatment, payment and health care operations and pursuant to an authorization as provided in the Federal regulations, you have a right to receive an accounting of disclosures of protected health information made by West Kendall OBGYN up to the six years prior to the date on which the accounting is requested. If you want an accounting of our use and disclosure of your health information, then please do so in writing to the person designated at the end of this Notice. We will respond in writing to your request.

Right to Obtain Paper Copy of Privacy Notice. You have the right to request a paper copy of this Notice upon request even if you agreed to receive it electronically.

PART 4 - How You May Ask for Help or Complain

If you need to request information from West Kendall OBGYN regarding your health information or need to request an amendment to and! or restriction on the use and disclose of your health information you may do so by writing to one of West Kendall OBGYN's Office Management Staff. If you feel that your rights have been violated, you may file a complaint with one of West Kendall OBGYN's Office Management Staff, and the Secretary of the Department of Health and Human Services (DHHS), the Office for Civil Rights, at the contact information below in this Part 4. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

West Kendall OBGYN
Office Management Staff
8200 SW 117th Ave, Suite 410, Miami, FL, 33183
Phone: 305·226-5651
Online: www.wkobgyn.com

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW, HHH Building
Room 509H Washington D.C., 20201
Phone: 866-627-7748 TTY: 886-788-4989
Online: www.hhs.gov/ocr

PART 5 - Amendments To This Notice of Privacy Practices

West Kendall OBGYN reserves the right to revise or amend this Notice at any time. These revisions or amendments may be made effective for all personal health information West Kendall OBGYN maintains even if created or received prior to the effective date of the revision or amendment. West Kendall OBGYN will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by posting on its website the most recent version of this Notice, and upon written request, West Kendall OBGYN will mail or electronically send to you the most recent version of this Notice.

PART 6 - On-Going Access To This Notice of Privacy Practices

West Kendall OBGYN posts the most recent version of this Notice on its website at: sirvenmds.com. Also, upon written request to any at West Kendall OBGYN's privacy officers, West Kendall OBGYN will send you by mail or electronically a copy of the most recent version of its Notice. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact West Kendall OBGYN's privacy officers at the following address or telephone number:

West Kendall OBGYN'
Office Management Staff
8200 SW 117th Ave, Suite 410, Miami, FL, 33183
Phone: 305·226-5651
Online: www.wkobgyn.com

FINANCIAL POLICY

The following is a statement of our financial policy which we require that you read and sign prior to any treatment. Please understand that payment of your bill is considered a part of your treatment, **and our policy requires payment of co-payments and deductibles at the time of service.** As a courtesy, we will file your claim to the insurance carrier for you. If there is any balance owed after all insurance companies have made their payment, we will bill you for the remaining balance. In the event that your insurance coverage changes to a plan in which we are not participating providers, or in the event there are any services considered "non-covered," we will require payment in full at the time of service. Although we will assist you in submitting your claim to your carrier, you are ultimately responsible for the services you receive. Payment to our office is not contingent or dependent upon your insurance carrier, and we require that you keep a credit card on file.

Please note that this office always verifies benefits prior to a patient being seen by our Providers as a courtesy to our patients and that, ultimately, it is your responsibility to know and verify your health benefits with your insurance plan. *Verification of benefits is not a guarantee of payment for medical services to your physician by your insurance company*.

Prior Authorizations:

If you have an insurance carrier that requires prior authorization for your visits, it is your responsibility to obtain any referrals or authorizations from your primary care physician. Failure to provide authorization may result in your appointment being rescheduled or higher out of pocket expenses.

Credit Card On File:

It is our policy to store an active credit card on file as a convenience to our patients in an attempt to easily resolve any outstanding patient balances that exists after the insurance company has paid. Your credit card will NOT be automatically charged at the onset of the balance. You will receive notification of a pending payment at which point you will have the opportunity to change payment methods if necessary. If your credit card becomes inactive within the duration of this agreement, it is your responsibility to alert our office and update us with new information. Failure to do this may cause your balance to be sent to collections.

Medical Records:

Copies of records will be provided at the request of patients for a fee of $1.00 per page for the first 25 pages and $0.25 for each additional page.

Collections:

Any past due balances over 90 days will be submitted to a collection agency, unless other arrangements have been made. If your account is placed with a collection agency, the patient/debtor assumes all costs of collections including but not limited to collection agency fees ($25.00 fee), court costs, interest and legal fees. Timely payment will ensure your credit rating remains unaffected.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY. I HEREBY AGREE TO RENDER PAYMENT IN ACCORDANCE WITH THE TERMS AND CONDITION SET FORTH.

_____

(SIGNATURE OF PATIENT OF RESPONSIBLE PARTY)

_____

(DATE)

_____

(PRINT PATIENT NAME)

IMPORTANT NOTICE TO **ALL** PATIENTS

The following services are offered in our office at an **extra charge** as follows:

Blood services → $20
Injections → $25
Makena Multiple Injections → $10 each
Disability Forms → $20
FMLA Forms → $15
WIC Forms → $15

Medical Records → $1 per page for the first 25 pages & $.25 cents thereafter. (For mailing records there will be a $20 charge for processing fee & postage.)

IMPORTANT NOTICE TO **ALL** PATIENTS

Nuestra oficina ofrece los siguientes servicios con **un costo adicional**:

Servicios de laboratorios → $20
Inyecciones → $25
Inyecciones Makena → $10 c/u
Formas de Incapacidad → $20
Formas de FMLA → $15
Formas de WIC → $15

Records Médicos → $1 por página por las primeras 25 páginas y $.25 centavos por página adicional. (Si los records requieren ser mandados por correo será un costo adicional de $20 para el manejo y envió.)

Patient Name (PRINT) / Nombre del Paciente (Letra de Molde) _____

Patient's Signature / Firma del Paciente _____

Date / Fecha _____

WEST KENDALL OBGYN
Obstetrics & Gynecology

CONSENT FOR PELVIC EXAMINATION

According to The American College of Obstetricians and Gynecologists, the pelvic examination is part of the evaluation of women presenting with many common conditions, including pelvic pain, abnormal bleeding, vaginal discharge, and sexual problems. Pelvic exams—both in the office and while under anesthesia— are also an important part of evaluation for gynecologic procedures to ensure safe completion of the planned procedure. Often, a pelvic examination is performed for women without symptoms while looking for gynecologic cancer, infection, and pelvic inflammatory disease.

A pelvic examination is an assessment of the external genitalia; internal speculum examination of the vagina and cervix; bimanual palpation of the adnexa, uterus, and bladder; and sometimes rectovaginal examination.

Reasons for a pelvic exam can include (but are not limited to) health screening, abnormal bleeding, pelvic pain, sexual problems, vaginal bulge, urinary issues, or inability to insert a tampon. Other indications include patients undergoing a pelvic procedure (e.g., endometrial biopsy or intrauterine device placement). Also, pelvic examination is indicated in women with current or a history of abnormal pap results, gynecologic cancers, or toxic exposures.

The potential benefits of a pelvic examination include the detection of vulvar, vaginal, cervical, uterine and ovarian cancers and precancers, yeast and bacterial vaginosis, trichomoniasis, and genital herpes, early detection of treatable gynecologic conditions before symptoms begin occurring (e.g. vulvar or vaginal cancer), as well as incidental findings such as dermatologic changes and foreign bodies. Additionally, screening pelvic examinations in the context of a well woman visit may allow gynecologists to explain a patient's anatomy, reassure her of normalcy, and answer your specific questions.

The potential risks of a pelvic exam may include (but are not limited to) fear, anxiety, embarrassment (reports ranged from 10% to 80% of women) or pain and discomfort (from 11% to 60%).

There are few alternatives to pelvic examination, the alternatives are not as effective for providing diagnostic or evaluative information and carry their own set of potential risks. If you have concerns, you should discuss with your healthcare provider.

I _____ understand that this Patient Consent Form is required by law. I understand that I need to sign this form to show that I am making an informed decision to have pelvic examinations and I have read and understand the above.

The provider or their delegate has explained to me the nature, purpose, and possible consequences of each procedure as well as risks involved, possible complications, and possible alternative methods of treatment. I also know that the information given to me does not list every possible risk and that other, less likely problems could occur. I was not given any guarantee from anyone about the final results of this procedure.

_____ _____ / _____ / _____
Signature Date

I understand that my provider is involved in educating tomorrow's medical professionals and that familiarizing students with the female anatomy and instilling a physician workforce with confidence in pelvic examination skills is essential. I consent to pelvic examination by the medical professional student under the supervision of my medical provider.

_____ _____ / _____ / _____
Signature Date

CONSENTIMIENTO PARA EL EXAMEN PELVICO

Según el Colegio Estadounidense de Obstetras y Ginecólogos, el examen pélvico es parte de la evaluación de las mujeres que presentan muchas enfermedades comunes como dolor pélvico, sangrado anormal, flujo vaginal y problemas sexuales. Los exámenes pélvicos, tanto en el consultorio como bajo anestesia, también son una parte importante de la evaluación de los procedimientos ginecológicos para garantizar que se complete de forma segura el procedimiento planificado. A menudo, se realiza un examen pélvico para mujeres que no tienen síntomas mientras se busca cáncer ginecológico, infecciones y enfermedades inflamatorias pélvicas.

Un examen pélvico es una evaluación de los genitales externos; examen interno con espéculo de la vagina y del cuello uterino; palpación bimanual de las partes adjuntas –el útero y la vejiga– y a veces el examen rectovaginal.

Las razones para un examen pélvico pueden incluir (pero no se limitan a) exámenes de salud, sangrado anormal, dolor pélvico, problemas sexuales, abultamiento vaginal, problemas urinarios o incapacidad para introducir un tampón. Otras indicaciones incluyen a pacientes sometidas a un procedimiento pélvico (p. ej., biopsia endometrial o la colocación de un dispositivo intrauterino). Además, el examen pélvico está indicado en mujeres con antecedentes actuales o historial de resultados anormales de papanicolaou, cánceres ginecológicos o exposiciones a productos tóxicos.

Los beneficios potenciales de un examen pélvico incluyen la detección de cánceres y precánceres vulvares, vaginales, cervicales, uterinos y ováricos, vaginosis bacteriana y por hongos, tricomoniasis y herpes genital, detección temprana de condiciones ginecológicas tratables antes de que los síntomas comiencen a aparecer (por ejemplo, cáncer de la vulva o vaginal), al igual que hallazgos incidentales como cambios dermatológicos y cuerpos extraños. Además, la detección de los exámenes pélvicos en el contexto de una visita de mujer sana puede permitir a los ginecólogos explicar la anatomía de una paciente, asegurar la normalidad y responder sus preguntas específicas.

Los riesgos potenciales de un examen pélvico pueden incluir (pero no se limitan a) miedo, ansiedad, vergüenza (los informes variaron del 10% al 80% de las mujeres) o dolor e incomodidad (del 11% al 60%).

Hay pocas alternativas al examen pélvico; las alternativas no son tan efectivas para proporcionar información de diagnóstico o evaluación y conllevan su propio conjunto de riesgos potenciales. Si tiene inquietudes, debe hablar con su proveedor de atención médica.

Entiendo que este formulario de consentimiento del paciente es requerido por ley. Entiendo que necesito firmar este formulario para demostrar que estoy tomando una decisión informada para hacerme exámenes pélvicos y que he leído y comprendido lo anterior.

El proveedor o su delegado me ha explicado la naturaleza, el propósito y las posibles consecuencias de cada procedimiento, así como los riesgos involucrados, las posibles complicaciones y los posibles métodos alternativos de tratamiento. También sé que la información que se me brinda no enumera todos los riesgos posibles y que podrían ocurrir otros problemas menos probables. Nadie me dio ninguna garantía sobre los resultados finales de este procedimiento.

_____ _____ / _____ / _____
Firma Fecha

Entiendo que mi proveedor está involucrado en la educación de los profesionales médicos del mañana y que es esencial familiarizar a los estudiantes con la anatomía femenina e inculcar una fuerza laboral médica con confianza en las habilidades del examen pélvico. Doy mi consentimiento para que el estudiante profesional de medicina realice un examen pélvico bajo la supervisión de mi proveedor médico.

_____ _____ / _____ / _____
Firma Fecha