



Comprehensive Ob-Gyn, LLC

A Modern Practice with Traditional Values

954-753-2411

Thank you for choosing Comprehensive OB/GYN, LLC. We have enclosed a patient information sheets for you to complete prior to your appointment. Please bring them with you to your appointment. You may print these forms and bring them with you to your appointment or you may email your information to info@compobgyn.com

Please bring all your insurance cards and driver's license with you for us to scan into our computer system. If you do not have your card at the time of your visit, it will be your responsibility to contact the insurance carrier for verification of insurance coverage and to provide us with all applicable policy, group, ID numbers and effective dates.

Co-payments and deductibles are due at the time of your visit. If you do not have insurance to cover your office visit, payment will be due at the time of your visit. We accept Visa, MasterCard, American Express, Discover and Care Credit.

NO CHILDREN POLICY

Please be advised no children are allowed in the office under the age of 12. If you need to bring your child, they must be accompanied by another adult to watch them in the **Waiting Room Only.** If your child is under the age of 2, they must remain in a stroller or carrier at all times. If you do bring your child and do not follow the office policy, you will be asked to reschedule your appointment.

This policy will be strictly enforced.

We look forward to seeing you. If you have any questions, please feel free to contact our office.

Sincerely,

The Physicians and Staff of
Comprehensive OB/GYN, LLC.



Thank you for selecting our healthcare team! We will strive to provide you with the best possible health care. To help us meet all your healthcare needs, **PLEASE FILL OUT THE FORM LEGIBLY AND COMPLETELY.**

Personal Information

Name _____ Birthdate _____
First Middle Last

Address _____ Apt# _____

City _____ State _____ Zip _____

Home Phone (____) _____ Cell phone (____) _____ Other: (____) _____

Email _____

Social Security # _____ Language best served _____

Marital Status (circle) Married Single Divorced Separated Widow

Race (check one) [] Caucasian [] American Indian [] Asian [] African American [] Hispanic [] Unlisted

Employer Name _____ City _____

Work (____) _____

Primary Physician _____ Phone# _____

Emergency Contact _____ Phone# _____

How did you hear about us? [] Friend [] Physician [] Internet [] Newspaper [] Other _____

Insurance Information

Name of Insurance Company _____ Please provide actual Card Please provide actual Card

Name of Insured (Policy Holder): _____ Date of Birth of Insured: _____

Was this visit related to: (Check one) [] Work injury [] Auto accident [] Other accident [] No accident

Authorization and Release

Signature of patient or parent if minor

Date



Notice of Privacy Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy.

Print Patient Name or Legal Guardian

Signature of Patient or Legal Guardian

Date

FMLA/Disability Form Notification

(Any form that must be completed by the physician that requires the physician's signature)

I acknowledge that there is a **\$25.00** fee for any disability, FMLA, or any other paperwork that needs to be completed by your physician. As a patient, you are required to provide the paperwork from your employer, and complete our request for completion of any disability form(s). This fee is not paid by your insurance company, nor is it included in your visit. Please allow 7-10 business days for your paperwork to be completed.

Print Patient Name or Legal Guardian

Signature of Patient or Legal Guardian

Date

Protected Health Information Disclosure List Request

I authorize the below named person/s to request, review or obtain my medical records and history from Comprehensive OB/GYN, LLC.

Name

Relationship

Phone #

DOB

Name

Relationship

Phone #

DOB

Print Patient Name or Legal Guardian

Signature of Patient or Legal Guardian

Date

EMAIL CONSENT

I understand that under the under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Email Consent. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy.

Print Patient Name or Legal Guardian

Signature of Patient or Legal Guardian

Date



Financial Policy

Thank you for choosing our practice. We want to make sure every experience you have with us is a positive one. We have developed a set of guidelines regarding financial responsibility. If you have any questions, please speak with the insurance office staff.

- **You must present your insurance card prior to or at the time of your visit.** If we do not receive your insurance card before you see the doctor, that visit becomes a fee for services, and full payment is expected at that time or arrangements need to be made.
- **Co-Payment, Deductibles and Co-Insurance.** A co-payment is a set dollar amount you owe for each office visit. Some insurance plans are subject to a deductible and co-insurance. **You will be asked to pay your co-payment, deductible and/or co-insurance amount at the time of service if your deductible has not been met.** Co-insurance is the amount required by some plans over and above the deductible amount.
- **Laboratory / Pathology Fees.** If any tissue is removed for a pathology examination or if a laboratory test (blood work, cultures, pap smear, etc..) is done in our office to confirm a diagnosis/determine a course of treatment, the actual test is usually carried out by a laboratory vendor. **THIS MEANS IF A PAYMENT IS DUE, YOU WILL RECEIVE A SEPARATE BILL FROM ANOTHER DOCTOR /PATHOLOGIST OR LAB COMPANY FOR THESE TEST.** Some plans do not specify a lab to use; if your insurance does, please let us know. Therefore, you are ultimately responsible for any bill you may receive from the laboratory/pathology service used. If you receive a bill from a lab, please contact that lab directly to resolve any billing concerns.
- **Forms of Payment.** For your convenience, we accept cash, personal checks, MasterCard, Visa, Discover, Care Credit and American Express.
- **Estimation of Services.** We will be happy to give you an estimate of fees when this is possible. Please remember that we can only assure you of the cost of a procedure on the day when the doctor has determined the actual code being used. The estimate of our charges will NOT include work done by an outside lab or pathology service.
- **Collection Efforts.** We will make every effort to work with you to make payment arrangements should your bill become outstanding. If all efforts do not bring about a resolution of the account after several attempts, the account balance will be turned over to an outside collection agency.

I understand that I am financially responsible to pay Comprehensive OB/GYN, LLC its usual charges for all services received through the office including any balances such as co-pays, deductibles, non-covered services, co-insurances and items considered not medically necessary from my insurance company. I hereby assign all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier to Comprehensive OB/GYN, LLC and direct that payment be made directly to the office. I authorize the release of any medical information necessary to process these claims. Should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court cost.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to S.458.320 (5) (g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida law.

Print Patient Name

Signature of Patient

Date



AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's name _____

Address _____

Birth Date _____

THIS WILL AUTHORIZE:

THIS WILL AUTHORIZE:

Comprehensive OB/GYN, LLC
8880 Royal Palm Blvd., Suite #100
Coral Springs, FL 33065
Main: 954-753-2411

TO RELEASE TO:

Comprehensive OB/GYN, LLC
8880 Royal Palm Blvd., Suite #100
Coral Springs, FL 33065
Main (954) 753-2411
Fax (954) 753-1176

TO RELEASE TO:

****FOR THE PURPOSE OF TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATION****

PLEASE INCLUDE: ___ ALL MEDICAL RECORDS

___ HIV/AIDS

___ X-RAY/SONOGRAMS

___ LAB REPORTS

___ PAP REPORTS

___ MAMMOGRAM REPORTS

___ BONE DENSITY REPORTS

___ PRENATAL RECORDS

OTHER: _____

This consent will remain valid for the duration of the patient treatment at this facility and will expire only with written instruction from the patient, **termination of the patient/provider relationship by either party or when 36 months has elapsed without documentation of patient care.** There is the potential for personal healthcare information to be re-disclosed by the recipient and therefore no longer protected under federal confidentiality laws.

SIGNATURE

DATE



Please answer the following questions, so your physician can better address your needs and concerns.

Cancer Screening

1. Any family History of Cancer? **YES OR NO** If so, what type of Cancer? _____

IF YOU ANSWERED YES, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. At what age was family member diagnosed with Cancer? _____

2. Is there more than one family member with the same type of Cancer? **YES OR NO**

Pelvic Health Survey

1. Do you lose urine involuntary or accidentally? **YES OR NO**

IF YOU ANSWERED YES, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. When coughing or sneezing? _____

2. Do you have a sudden urge to urinate? **YES OR NO**

3. Do you lose stool infrequently, accidentally or involuntary? **YES OR NO**

4. Do you feel a bulging sensation in the vagina? **YES OR NO**