Comprehensive OB/GYN, LLC

Modern Practice with Traditional Values

8880 Royal Palm Blvd., Suite 100 • Coral Springs, FL 33065
(954) 753-2411 • Fax (954) 753-1176

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.

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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) ☐ Caucasin ☐ American Indian ☐ Asian ☐ Africian 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

______________________________ ______________________________ ______________________________

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, ect.) 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 THESES 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 five 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:

____

____

____

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

THIS WILL AUTHORIZE:

Comprehensive OB/GYN, LLC

8880 Royal Palm Blvd., Suite #100

Coral Springs, FL 33065

TO RELEASE TO:

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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

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: ______________________ **Date of Birth:** ______________ **Age:** __________

Gender (M/F): ________ **Today's Date (MM/DD/YY):** ____________ **Health Care Provider:** ______________

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren.*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☒ Y ☐ N	*EXAMPLE: BREAST CANCER*	*45*	- - - - -	- - -	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐ Y ☐ N	BREAST CANCER							
☐ Y ☐ N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐ Y ☐ N	UTERINE/ENDOMETRIAL CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐ Y ☐ N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Your PERSONAL History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed at age 50 or younger
- ☐ Ovarian cancer at any age
- ☐ Two primary occurrences of breast cancer
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Pancreatic cancer with a breast or ovarian cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer*

Lynch Syndrome* - *(see cancer list below)*

- ☐ Colorectal cancer under age 50
- ☐ Endometrial/uterine cancer under age 50
- ☐ MSI High histology*** before age 60
- ☐ Abnormal MSI/IHC tumor test result *(colon/rectal/endometrial/uterine)*
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ YOU and one or more relatives with a Lynch syndrome cancer**

Your FAMILY History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Close relative with breast cancer less than age 50
- ☐ Close relative with ovarian cancer at any age
- ☐ Two or more breast cancer occurrences, in one relative or in two or more relatives on the same side of the family, one under age 50
- ☐ A male relative with breast cancer
- ☐ Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family
- ☐ Three or more relatives with breast cancer at any age
- ☐ A previously identified *BRCA1* or *BRCA2* mutation in the family

Lynch Syndrome** - *(see cancer list below)*

- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age
- ☐ A previously identified Lynch syndrome mutation in the family

*HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*

**Lynch syndrome cancer includes: *Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas*

***MSI High histology includes: *Mucinous, signet ring, tumor infiltrating lymphocytes, crohn's-like lymphocytic reaction histology, or medullary growth pattern*

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: ______________________________ Date: ____________

Health Care Provider's Signature: ______________________________ Date: ____________

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: __________