FemCare Ob-Gyn, LLC *Geoffrey N. James, MD, Jason S. James, MD, Jila Senemar, MD, Karen Salazar Valdes, MD, Ingrid Paredes, MD*

PATIENT INFORMATION

Social Security # _____
First Name _____
Last Name _____
Sex _____ Date of Birth _____
(Check One) ❒Employed ❒Retired ❒Full-Time Student
❒Other _____
Occupation _____
Employer _____
Marital Status: ❒Married ❒Single ❒Divorced ❒Widowed
Spouse's Name _____

Home Address _____ Apt _____
City _____ State _____ Zip _____
Email address _____
Home Phone (_____) _____
Cell Phone (_____) _____
Work Phone (_____) _____
Pharmacy Number (_____) _____
Primary Physician _____
Referred By _____
Primary Language _____

INSURANCE INFORMATION – *Please provide your insurance card and Driver's License to the receptionist*

Primary Insurance _____
Name of Subscriber _____
Policy # _____ Group # _____

Secondary Insurance _____
Name of Subscriber _____
Policy # _____ Group # _____

EMERGENCY CONTACT

Name _____ Relationship _____ Sex _____
Home Phone (_____) _____ Work Phone (_____) _____

I allow Doctor/Staff to leave messages/fax results at: ❒Home ❒Work ❒Cell ❒Fax ❒None

I authorize FemCare Ob-Gyn, LLC to disclose certain protected health information (PHI) about me to the parties listed below:

1._____ 2._____

Fees and Insurance Information

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency, I authorize said attorney to obtain my credit report and I understand that I will be liable for any charges incurred, including reasonable attorney's fees, court costs and collection expenses.

Malpractice Insurance Notification

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 provided pursuant to Florida Law.

Physician's Release and Assignment

I hereby authorize payment directly to FemCare Ob-Gyn, LLC ("Physician") of all benefits applicable and otherwise payable to me from my insurance carrier or other third party payor, for services rendered by the Physician. I understand that I am financially responsible to the Physician for any and all charges that the carrier declines to pay. I hereby authorize release of my medical records as deemed necessary for payment of benefits.

HIPAA Acknowledgement

By signing below, I acknowledge that I have read and understand the Notice of Privacy Practices of the Federal HIPAA Privacy Rule.

Consent to Treat

By signing below, I acknowledge that I consent to treatment by the physicians and other healthcare providers of FemCare Ob-Gyn, LLC, including performance of a medically necessary examination including, but not limited to, a pelvic examination.

Patient's/Guarantor's Signature _____ Date _____

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Snapper Creek Professional Center
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Miami, Florida 33173
Telephone (305) 412-6004
Fax (305) 412-3007
www.femcare-obgyn.com

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

This consent form is being requested pursuant to Florida law.

I understand the planned procedure and I consent to a medically indicated physical examination which may include, but may not be limited to the following:

- A female Gynecological Exam which may include a rectal exam and a pelvic examination
- An Ultrasound Exam which may include a probe placed in the vagina.
- Examination of external genitalia

This examination will be performed by any provider from FemCare Ob-Gyn, LLC.

The consent will remain active until I withdraw my consent in writing.

Name of Patient:

_____

Signature of Patient or Patient's Representative if under 18:

_____

Date _____

FEMCARE OB-GYN

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Dear Patient,

As Women's Health Physicians, our primary goal is to keep you healthy and prevent disease, especially cancer. At the same time, we want to minimize your discomfort and avoid performing unnecessary tests and procedure.

With that in mind, the American College of Obstetricians and Gynecologists (ACOG), the American Cancer Society (ACS), and the United States Preventive Services Task Force have updated their recommendations for cervical cancer screening in 2013. We will be implementing these recommendations in order to provide you with the most comprehensive and up to date care possible. The new recommendations are as follows:

- Start performing Pap smears at age 21
- Between the ages of 21-65, *in low risk individuals*, Pap smear and HPV testing **every 3 years**
- Stop performing Pap smears after age 65 or after hysterectomy except for patients with a history of cervical dysplasia/cancer

These guidelines apply **only** to cervical cancer screenings. The Pap smear is only a small part of your annual preventative screening visit. It is critical that you continue to be seen **every year** for a breast and pelvic exam to screen for cancers of the breast, vulva, and ovary, among other medical conditions. An annual exam is the ONLY way to ensure that various medical conditions are caught at an early and treatable stage.

Please also note that performing Pap smears outside of this recommended schedule may result in your insurance provider declining to cover its costs.

Please do not hesitate to ask your doctor or health provider if you have any questions. We are always available to help you make the best informed decisions about your health.

FemCare Ob-Gyn

Please acknowledge receipt of this notification:

Print name _____ Patient signature _____ Date _____

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Obstetric Call Schedule Acknowledgment

FemCare Ob-Gyn's physicians who preform deliveries are: Jason James MD, Jila Senemar MD, Karen Salazar Valdes MD, and Ingrid Paredes MD. These four physicians cover Baptist Hospital on a rotating basis throughout the week and weekends. Under most normal circumstances, deliveries will be performed by one of these four physicians. Two additional physicians provide occasional call coverage on some weekends and holidays: Cesar Vinueza MD and Wilfredo Alvarez MD. In addition, Baptist Hospital employs a group of emergency obstetricians who staff the hospital 24 hours a day and provide emergency coverage- this group is called OB Hospitalist Group and comprise multiple physicians who provide call to the hospital.

By signing below, I acknowledge that my obstetrical care may be provided by any of the above physicians depending on scheduling, availability and potential emergencies.

_____

Name (Print)

_____

Signature

_____

Date

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PHOTO RELEASE AUTHORIZATION FORM

At FemCare Ob-Gyn, we receive photographs of patient's, patient's families, and newborns in the forms of holiday photographs, photos taken at delivery and/or post-partum, and group pictures with the doctor/s, patients, families, and newborns. We display some of these photographs in the exam rooms, hallways, and other various locations in the practice and may include them in our website's (www.femcare-obgyn.com) picture gallery. As well as social media accounts as in Facebook and Instagram.

Please read and initial the option that applies:

_____ I herby give my consent to FemCare Ob-gyn to display the photographs in all locations as stated above.

_____ I hereby give my consent to photographs to be displayed in the office, **NOT** on the practice's website (www.femcare-obgyn.com) picture gallery, Facebook or Instagram.

_____ I only give consent to display the photographs in the practice's website (www.femcare-obgyn.com) picture gallery Facebook and Instagram, **NOT** in the office

_____ I **DO NOT** consent to the public display of the photographs that I have freely given to the practice.

I herby release FemCare Ob-gyn and any third parties from any rights I may have to the photographs. I understand that I will not be compensated for the use of my photographs .

I understand that I may terminate this Photo Release Authorization. To do so, I must notify this facility in writing regarding termination and effective date.

I know that I am entitled to receive a copy of this agreement.

Printed Name of Patient: _____

Signature of Patient or Legal Representative: _____

Printed Name of Legal Representative (if applicable): _____

Date: _____

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NOTICE TO OBSTETRIC PATIENT

(See Section 766.316, Florida Statutes)

I have been furnished information by Dr. Geoffrey N. James, Dr. Jason S. James, Dr. Jila Senemar, Dr. Karen Salazar Valdes, and/or Dr. Ingrid Paredes prepared by the Florida Birth-Related Neurological Injury Compensation Association (NICA), and have been advised that Dr. Jason S. James, Dr. Jila Senemar, Dr. Karen Salazar Valdes, and Dr. Ingrid Paredes are participating physicians in that program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor, delivery or resuscitation. For specifics on the program, I understand I can contact:

Florida Birth-Related Neurological Injury
Compensation Association
P.O. Box 14567
Tallahassee, Florida 32317-4567
1-800-398-2129.

I further acknowledge that I have received a copy of the brochure prepared by NICA.

In addition, I acknowledge that I have been advised and agree that occasionally I may be cared for by covering physicians who are also participating physicians in the NICA program and include, among others, Dr. Cesar Vinueza and Dr. Wilfredo Alvarez as well as Baptist Hospital employed physicians from OB Hospitalist Group.

DATED this _____ day of _____, 20___.

_____
Signature of Patient

_____
Printed Name of Patient

_____
Social Security Number

Witness:

_____
Signature

_____
Name

Date: _____

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Prenatal Genetic Screen

	YES	NO
1. Will you be 35 years or older when the baby is due?	____	____
2. Have you, the baby's father; or anyone in either if your families ever had any of the following disorders:		
Down Syndrome (mongolism)	____	____
Neural tube defect (spina bifida, meningomyelocele, Open spine, anencephaly)	____	____
Hemophilia	____	____
Muscular dystrophy	____	____
Cystic fibrosis	____	____
If yes, indicate the relationship of the affected person to you or the baby's father: _____		
3. Do you or the baby's father have a birth defect?	____	____
If yes, who has the defect and what is it? _____		
4. In any pervious marriages, have you or the baby's father has a child born dead or alive with a birth defect not listed in question 2?	____	____
5. Do you or the baby's father have any close relatives with mental retardation?	____	____
6. Do you, the baby's father, or close relative in either of your families have a birth defect, any familial disorder, or a chromosomal abnormality not listed above?	____	____
7. In any previous marriages, have you or the baby's father has a stillborn child or three or more first trimester spontaneous pregnancy losses (miscarriages)?	____	____
8. Are you or the baby's father of Jewish ancestry?	____	____
If yes, have you been tested for Tay Sach's disease?	____	____
9. Are you or the baby's father African American or African American descent?	____	____
If yes, have you been screened for sickle cell trait disease background?	____	____
If yes, have either of you been rested for B-Thalassemia?	____	____
10. Are you or the baby's father of Philippine or Southeast Asian ancestry?	____	____
11. Do you have any religious or personal reasons that would make you unwilling to accept blood transfusions in case of life- threatening emergency?	____	____
12. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period (including non-prescription or alternative medications)?	____	____
If yes, give name of medication and when taken:		
_____		
_____		

Name (Print): _____ Date: _____