

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 _____
Home Phone (____) _____

Relationship _____ Sex _____
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 _____



FEMCARE OB-GYN, LLC
Geoffrey N. James, M.D.
Jason S. James, M.D.
Jila Senemar, M.D.
Karen Salazar Valdes, M.D.
Ingrid Paredes, M.D.

Snapper Creek Professional Center
7800 S.W. 87th Avenue, Suite A-120
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 _____



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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

"We Care Questionnaire"

Name: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____

Doctor: _____ Insurance Company: _____

1. Over the past month, have you leaked urine (even small drops) or wet yourself when you:
Cough, Sneeze, Change Position, Walk quickly or Exercise.....

2. Have a sudden strong urge to rush to the restroom or when you are undressing to go to the restroom.....

Not at all	1-2 times a Month	1 time a week	3-4 times a week	5-6 days a week	Every day	Your Score
0	1	2	3	4	5	STRESS
0	1	2	3	4	5	URGENCY

•How many times do you wake at night to empty your bladder? _____

•Would you be interested in learning more about a cure from leaking *WITHOUT* medicine or surgery? Yes No



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