Living Well OBGYN, LLC
Monica Daniel M.D., F.A.C.O.G.
Nancy Gavilanes A.P.R.N.
Obstetrics and Gynecology
17759 S. W. 2 Street Pembroke Pines, FL 33029
Phone: (954) 399-8875 Fax: (954) 505-4137

Patient Registration		
Patient name:	DOB:	Age:
Social Security #:	Marital Status:	
Home Address		
City:	State:	Zip code:
Cell Phone:	Email:	
Occupation:	Employer:	
Work phone:		
Primary language spoke:	Referred by:	
Emergency Contact:		
Cell Number:		
Primary Care Physician:	Phone #:	
Allergies to medications:		
Pharmacy name, address and phone number:		
INSURANCE INFORMATION		
Name of Primary Insurance:		
Provider Number/Customer Service number:		
Member ID:	Group number:	
Claims address (PO Box):		
Name of Subscriber:	DOB:	Relation to patient:
RELEASE OF INFORMATION/ENTREGA DE INFORMACION		
I authorize the release of any medical information necessary to process a claim.		
Signed:	Date:	
ASSIGNMENT OF BENEFITS		
I authorize payment of Medical benefits to myself or the name of the professional services rendered.		
Signed:	Date:	

Living Well OBGYN

Patient Name: _____ *Date:* _____

Have you been diagnosed with any medical problems, or worsening or existing problems? _____

_____

Have you had any surgeries, procedures, or pregnancies since your last visit? _____

Are you taking any new meds? _____

Is there anything new in your family history? _____

Review of Systems

Do you know or have any problems related to the following systems? Circle Yes or No

General		
Have you ever had fever, chills, or sweats	*Y*	*N*
Have you gained or lost weight recently	*Y*	*N*
How many Pounds? _____		
Other _____		
Eyes		
Blurred Vision	*Y*	*N*
Double Vision	*Y*	*N*
Have you ever lost vision	*Y*	*N*
Other _____		
Allergic/Immunologic		
Hay Fever	*Y*	*N*
Drug Allergy	*Y*	*N*
Infections	*Y*	*N*
Other _____		
Neurological		
Seizures	*Y*	*N*
Trouble Sleeping	*Y*	*N*
Headache	*Y*	*N*
Other _____		
Endocrine		
Excessive Thirst	*Y*	*N*
Too hot/cold	*Y*	*N*
Tired/Sluggish	*Y*	*N*
Other _____		
Gastrointestinal		
Abdominal Pain	*Y*	*N*
Nausea/Vomiting	*Y*	*N*
Diarrhea	*Y*	*N*
Other _____		
Cardiovascular		
Chest Pain	*Y*	*N*
Palpitations	*Y*	*N*
High Blood Pressure	*Y*	*N*
Other _____		

Ears/ Nose/ Mouth		
Ear Pain	*Y*	*N*
Sore throat/hoarse	*Y*	*N*
Sinus Problems	*Y*	*N*
Other _____		
Genitourinary		
Blood in Urine	*Y*	*N*
Painful/Frequent Urination	*Y*	*N*
Irregular Menstruation	*Y*	*N*
Vaginal discharge/itching	*Y*	*N*
Pain during/after sex	*Y*	*N*
Other _____		
Respiratory		
Asthma	*Y*	*N*
Frequent Cough	*Y*	*N*
Shortness of Breath	*Y*	*N*
Other _____		
Hematologic/Lymphatic		
Anemia	*Y*	*N*
Swollen Glands	*Y*	*N*
Blood clotting problem	*Y*	*N*
Other _____		
Psychiatric		
Are you unhappy with your life	*Y*	*N*
Do you feel severely depressed	*Y*	*N*
Have you considered suicide	*Y*	*N*
Other _____		
Musculoskeletal		
Joint Pain	*Y*	*N*
Swelling in your joints	*Y*	*N*
Arthritis	*Y*	*N*
Other _____		
Integumentary		
Skin Rash	*Y*	*N*
Nipple Discharge	*Y*	*N*
Persistent itch	*Y*	*N*
Other _____		

Sexually transmitted infections. It is recommended to test all women 25 and under for chlamydia and gonorrhea. Over the age of 25 we would recommend testing if you have any risk factors. Testing is done at the time of your pap smear. Most but not all insurances cover this important test. Like any other test if the laboratory received an insurance denial for these tests you are responsible for payment to the lab.

- ☐ *I request chlamydia and gonorrhea testing at this time.*
- ☐ *I decline chlamydia and gonorrhea testing at this time.*

Patient Signature _____ *Physician Signature* _____

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MEDICAL HISTORY

NAME: _____ AGE: _____ DATE: _____

REASON FOR TODAY'S VISIT: _____

MEDICAL HISTORY: Have you or members of your *immediate* family ever had:
(Please indicate relationship, ie. mother, father, sibling)

	You	Your Family		You	Your Family
Unusual headaches / migraines			Stomach, gallbladder, liver problems		
Convulsions or fainting spells			Diabetes		
Eye or ear problems		XXXX	Kidney or bladder disorders		
Thyroid disorder			Anemia or blood disorders		
Heart problems			Blood tranfusions		XXXX
Mitral Valve Prolapse			HIV or AIDS		
High blood pressure			Blood clots in legs or lungs		
Stroke			Eating disorders		XXXX
Benign breast disease			Nervous disorders		
Breast Cancer			Birth defects or inherited disorders		
Lung problems / asthma / TB			Other		

SURGERIES: _____

GYNECOLOGICAL HISTORY:
Age of first period: _____
Frequency between periods: _____
Duration of period: _____
Pain / Cramping: _____
Date of last period: _____
Last Pap: _____ Result: _____
Last Mammogram: _____ Result: _____

Have you had any history of ovarian cysts, uterine fibroids, abnormal Paps? _____
_____

Are you sexually active? _____
Type of birth control, if indicated: _____
Number of sexual partners in past year: _____
Do you have any history of any sexually transmitted infections, e.g. herpes, syphilis, gonorrhea, chlamydia, genital warts?
_____

If you are postmenopausal: _____
Have you had any vaginal bleeding since menopause? _____
Have you been on hormones? _____
Have you had a bone density? _____

OBSTETRICAL HISTORY (include stillborns):
Number of vaginal deliveries: _____
Number of Cesarean sections: _____
Complications: _____
_____
Miscarriages: _____
Terminations: _____
Tubal pregnancies: _____

Allergies: _____
_____
Current medications: _____
_____

Do you smoke? ❑ Yes ❑ No
# of packs per day _____

Do you drink alcohol? ❑ Yes ❑ No
# of drinks per day _____

_____
SIGNATURE

_____
DATE

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FLORIDA SENATE BILL 698
CONSENT FOR PELVIC EXAMINATION

Effective July 01, 2020 a written consent of the patient or the patient's legal representative or guardian is required prior to a pelvic examination.

A pelvic examination is defined by and includes an examination of the vulva, vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external genitalia, or pelvic organs using a combination of modalities, which may include, but not limited to, the healthcare provider's gloved hand or instrument.

I understand and consent to a **"MEDICALLY INDICATED EXAMINATION INCLUDING BUT NOT LIMITED TO A PELVIC EXAMINATION"**. This may be performed by the Doctor or Nurse Practitioner.

Patient name: _____ Date: _____

Patient Signature: _____

Signature of legal representative or guardian: _____
(If patient is under the age of 18)

Witness Signature: _____

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Notice of Privacy Practice Acknowledgement

Living Well OBGYN LLC

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 of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

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Nancy Gavilanes A.P.R.N.
Obstetrics and Gynecology

Laboratory Consent Form

Patient Name: _____ Date: _____

Most insurance companies have a "preferred laboratory" that you must use in order for your lab/culture/pathology work to be covered by your insurance company. We **DO NOT KNOW** the benefits of your individual personal policy nor can we be familiar with all policies in the insurance industry. Your insurance is the one contracted with the lab not with our office.

Monica Daniel M.D., L.L.C. and Nancy Gavilanes A.P.R.N. DO NOT TAKE RESPONSIBILITY FOR YOUR LAB BILLS.

We need to advise you that although you have a "preferred laboratory" there are occasions when your lab work/cultures/pathology would need to be sent to another lab due to more extensive testing that would be required.

I understand that all labs/cultures/pathology work ordered by my physician and sent to an in-network/out of network lab will be billed separately by that lab to my insurance company. I understand that I am responsible to pay for all lab charges, whether or not I have insurance and whether or not it is a covered benefit of my insurance. I understand that the laboratory will bill me separately for these lab charges.

Lab work includes, but is not limited to pap smears, vaginal cultures, urine cultures, blood test and biopsies/pathology.

Print Name: _____ Signature: _____
Date: _____

If a minor:
Print Guardian Name: _____ Relationship: _____
Signature: _____ Date: _____

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Financial Agreement Form

Dear Patient,

If we are a participating provider for your health insurance, we will file insurance claims to tour company. However, if a service performed by the doctor is denied, not a covered service, or you are found to have a deductible or co-insurance amount, you will be responsible for paying the balance.

These balances are generally determined by your insurance company. Occasionally you will have deductibles and co-insurance obligations unknown to us at the time of service. We will always try to inform you at the time of service if they may not be covered. However, sometimes that is not possible and the contract that you have with your insurance company will make the final determination of the amount you owe.

We are asking patients to complete the following information which will authorize payment for any balance, as determined by your insurance company only. We will send you a bill and explanation of any charger.

I authorize Living Well OBGYN, LLC to keep my signature on file and to charge my credit card for the patient responsibility portion of any balances incurred this year.

This may include: an insurance deductible not collected at the time of the visit, co-payments, patient responsibility portion, or services not covered by the insurance.

I understand that I am entitled to a refund should my insurance company later decide to pay for the service initially denied.

I understand this information will be kept complete secure and confidential.

CREDIT CARD ACCOUNT INFORMATION

NAMES ON CARD: _____

CREDIT CARD NUMBER _____ ***TYPE:*** *MC VISA AMX*

EXPIRATION DATE: _____ *CVV:* _____ ***BILLING ZIP CODE:*** _____

SIGNATURE : _____ ***DATE :*** _____

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MEDICAL APPOINTMENT CANCELLATION POLICY

Dear Patient,

We strive to provide excellent medical care to you, your family and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets asides ample time for a patient.

"No-shows", and late cancellations inconvenience those individuals who need access to medical care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented a Medical Appointment Cancellation Policy and it is effective immediately.

Our policy is as follows:

1. We request you give our office a **24- hour** notice in the event you need to reschedule your appointment. Our phone number is **954-399-8875.**

2. If you miss an appointment and do not contact us with at least a 24-hour prior notice, we will consider this a missed appointment and a **$25.00** no-show fee with be assessed to you. This applies to late cancellations and "no-shows."

3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.

4. Our office makes reminder calls for appointments. ***It is ultimately the patient's responsibility to remember their scheduled appointments.***

This fee will be billed to you directly and is not covered by your insurance. This balance must be paid prior to your next appointment. If you don't have a scheduled appointment, the balance is expected in a timely fashion and if not, will be subject to collections.

We thank you for trusting Monica Daniel M.D. and Nancy Gavilanes ARNP with your medical care.

I have read and understand the Medical Appointment Cancellation Policy and agree to the terms of this policy.

_____ _____

Signature Date

_____

Printed Name

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FINANCIAL POLICY

We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require for you to read and sign prior to any treatment.

ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT
WE ACCEPT: CASH, CHECK, MAJOR CREDIT CARDS: VISA, MASTERCARD

INSURANCE: *We will bill your insurance company for your visit as a courtesy to you. Due to difficulty of obtaining payment from your insurance plans, we may ask for your assistance in getting your claim paid. Please be advised that it is the patient's responsibility to verify that we are a participating provider of your insurance plan.*

HMO/REFERRALS: *It is your responsibility to obtain a referral from your primary care physician if your insurance carrier requires it for your visits. It is the patients' responsibility to know and understand the requirements of their insurance plan. Our office is not responsible to obtain referrals for patients on HMO plans. If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.*

MINOR PATIENTS: *The parent or guardian accompanying the minor is responsible for payment of the bill.*

RETURNED CHECKS: *Any check returned for any reason will be subject to any bank fees charged to us along with 5% of the face value of the check or $25 administrative fee (whichever is greater).*

COLLECTIONS: *Should your account become a collection problem, the patient/debtor assumes all costs of collection including but not limited to collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.*

NON-COVERED SERVICES: *You will be responsible for payment of services "not covered" by your insurance plan. It is your responsibility to understand your insurance plan's benefits and/or limitations.*

I HAVE READ AND FULLY UNDERSTAND the Financial Policy. I hereby agree to render payment in accordance with the terms and conditions set forth.

Patient/Responsible Party Signature: _____ *Date:* _____

Print Patient Name: _____