Florida Gynecologic Oncology
Zoyla Almeida, M.D., F.A.C.O.G
4855 W. Hillsboro Blvd #B-13, Coconut Creek, FL 33073
P 954.420.9182 F 954.420.9184 www.floridagynonc.com

Primary Care Physician: _____

Phone Number: _____

City: _____

Referring Physician: _____

Phone Number: _____

City: _____

Pharmacy: _____

Phone Number: _____

City: _____

Email Address: _____

New Deductible Policy
01/02/2020

As of 01/02/2020, our practice has implemented a new policy regarding collections of patient insurance deductibles.

We have initiated a policy to collect unmet deductibles on all office procedures up front. All of these unmet deductibles will be collected on or before the time of service. This is in addition to your copay, which is also collected at the time of service.

The definition of procedure includes any office procedure such as a **colposcopy, colposcopy with biopsy, biopsy of any tissue, removal of foreign body, hysteroscopy**, and/or any other procedure performed in the office by our providers.

We will contact your insurance company to obtain your deductible amounts and contact you prior to your visit to inform you of your amount due.

The amount you are being asked to pay may not be exact, as there may be outstanding claims from another provider that your insurance has not applied to your deductible yet, and/or you may have an additional or different procedure in the office than what you may have been scheduled for. For an example: you may be scheduled for a colposcopy, but when the provider exams you finds something and decides it needs to be biopsied. She would then biopsy it at that time. Therefore, the price of the procedure is then different than what was expected because an additional procedure was performed. In these instances, you would be responsible for the remaining costs of the procedure, in addition to what you initially paid and will receive a bill for that.

All patients are responsible for their copays, deductible, and coinsurance amounts. Please be aware of your insurance policy and coverage as it is ultimately the patient's responsibility.

There are absolutely no exceptions to this policy.

Patient's signature: _____ Date: _____

Ultrasound Office Policy

Once you have agreed to schedule an ultrasound appointment with the office, you have agreed to a have a transvaginal and/or pelvic ultrasound in our office with our ultrasound technician.

If you need to cancel or reschedule your appointment, you must do so no later than the day before the scheduled appointment.

A fee of $50 will apply to all patients who do not show up for their ultrasound, and for those who reschedule or cancel the appointment on the same day of service. This fee is non-negotiable.

The ultrasound schedules fill up quickly, and to be able to provide a service to all our patients, we have to be able to provide them with openings in our schedules. If a patient does not appear for her appointment, or cancels and/or reschedules on the same day, we are left with openings in the schedule that we could have offered to another patient.

I understand the policy stated above:

Name: _____

Signature: _____

Date: _____

Patient Authorization for Use and Disclosure of Protected Health Information to Third Parties

Florida Gynecologic Oncology and Robotic Surgery

Section must be completed for all authorizations

I hereby authorize the use of disclosure of my individually protected health information. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

Persons/Organizations Receiving Information

NAME	**RELATIONSHIP & PHONE**

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ____/____/____. **Initial_____**

2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any effect on any actions they took before they received the revocation. **Initial_____**

_____ _____

Signature of patient or representative Date

(Form must be completed before signing)

Printed name of patient's representative: _____

Relationship to patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Patient HIPAA Authorization
PHI Release

Under the HIPAA law, Healthcare providers are able to leave limited or detailed messages on a phone voicemail, depending upon the patient's preference. Please indicate you preference below.

Según la ley HIPAA, los proveedores de atención médica pueden dejar mensajes limitados o detallados en el correo de voz de un teléfono, dependiendo de la preferencia del paciente. Por favor indique su preferencia a continuación.

☐ I **do not** want Florida Gynecologic Oncology and Robotic Surgery to leave any detailed messages on my voicemail, including test results. (No deseo que Florida Gynecologic & Robotic Surgery dejen mensajes detallados en mi correo de voz, incluyendo resultados de pruebas.)

☐ I **will allow** Florida Gynecologic Oncology and Robotic Surgery to leave detailed test result information on my voicemail, including test results. (Voy a permitir que Florida Gynecologic Oncology & Robotic Surgery deje información detallada sobre los resultados de las pruebas en mi correo de voz.)

☐ Por favor, deje los resultados en español en mi correo de voz.

Patient Signature: _____

Date: _____

Phone number to leave messages: _____

Zoyla Almeida, M.D., F.A.C.O.G. originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results; diagnoses, treatment, and my plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A toll for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I understand, and have been provided with a Notice of Privacy Practices that provides a more complete description of uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Zoyla Almeida, M.D., F.A.C.O.G. is not required to agree to the restrictions requested. I understand that I may revoke the consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking the consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Zoyla Almeida, M.D., F.A.C.O.G. reserves the right to change their notice and practices, and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Zoyla Almeida, M.D., F.A.C.O.G. change their notice, they will send a copy of any revised notice to the address I've provided by U.S. Mail.

I wish to have the following restrictions to the use or disclosure of my health information:

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 Signature Date

For Office Use Only

We have been unable to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices, despite an attempt on:

Date: _____ Attempt: _____ Name of Staff Member: _____

PAYMENT POLICIES AND CONSENT TO BILL INSURANCE COMPANY
Florida Gynecologic Oncology and Robotic Surgery

We accept two methods of payment: 1. Self-pay (out-of-pocket) 2. Insurance

Self-Pay: All clients who pay out-of-pocket are required to pay in full at the time of service. Payment can be made in the form of check or credit card. There is a $25 fee for any checks returned from the bank.

Insurance: We are a participating provider with some health insurance companies. It is the responsibility of the patient to check with her insurance to make sure we participate and are in-network. We will submit bills to the insurance company on your behalf if we participate with your insurance and plan. The patient is required to pay her co-pay, deductible, and/or coinsurance which is set by her insurance company. Copay is due at the time of service. Any deductibles and/or coinsurances will be billed to you after your insurance processes the claim and those fees are due at the time you receive your bill.

***Insurance Coverage Only*:** By using insurance you are granting permission for us to communicate confidential information to your insurance company. Please remember that we have no control of, or responsibility for how information is handled once it is released to third parties. Please note that many insurance companies require audits that request information about symptoms, diagnosis, and treatment. When information is requested by your insurance company, we will provide them with the information that they have requested on your behalf.

NOTICE OF INSURANCE COVERAGE AND NOTICE OF INSURANCE CHANGE: I, the undersigned, have provided a copy of my insurance card(s). If my insurance company does not cover for any reason, I agree that I am financially responsible for all charges. I also hereby authorize Florida Gynecologic Oncology & Robotic Surgery to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. Please remember to contact us immediately if your insurance changes for any reason. You are ultimately responsible for the bill. If your insurance changes and we do not accept that insurance, then you are responsible for the bills. My signature below indicates that I understand that I am responsible for notifying the office of any changes in my insurance. I am aware that I am fully responsible for any services provided to me or my family members in the event that my insurance is no longer valid.

Signature: _____ Date: _____

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Consent to Treatment

I hereby authorize evaluation and treatment to Dr. Zoyla Almeida and Lucy Trovato, ARNP at Florida Gynecologic Oncology & Robotic Surgery. The treatment provided by our office will include a medically indicated examination including but not limited to a pelvic exam.

I understand and agree that the signatures on this form will not expire without written notice.

_____ _____

Patient Name

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:
You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying Notice of Privacy Acknowledgement form.

Privacy Officer:
Danielle K. Fritz
4855 W. Hillsboro Blvd., #B-13
Coconut Creek, FL 33073
Office: (954) 420-9182 Fax: (954) 420-9184

Revised 01/02/2020

Please review it carefully

Getting your Lab Results

Please be advised that the results of any lab work or biopsies that are done during your appointment today will take approximately 7-10 days to be processed. If we receive your results sooner than expected we will call you once they have been reviewed by the doctor. Results cannot be given to the patient without the prior approval of Dr. Almeida. Due to her surgical schedule, a minimum of three days per week, Dr. Almeida will not be available to review your results immediately. We kindly request that you wait for our call with your results.

Our Financial Policy

Timely payment of your bills is considered part of your treatment, and all patients are expected to understand and comply with our financial policy. We accept checks, Visa, MasterCard, Amex and Discover. Our fees are based on the usual and customary professional fees for gynecology oncology in the South Florida area. Payment is expected at the time you check in for your appointment. Should your account become delinquent, you will be responsible for all costs of collection, including but not limited t: collection agency fees, court costs, interest and legal fees. All unpaid accounts are reported to the credit bureaus. The parent or guardian accompanying a minor is responsible for the payment of the bill. Patients under the age of 18 will need to be accompanied by a Parent/Guardian. Consent for examination must be signed by the Parent/Guardian.

For Insured Patients

All copays and deductibles are due at the time of your visit. ***Please verify that we are a participating provider of your insurance plan prior to scheduling your visit.*** It is not our responsibility to obtain your benefits and your plan coverage. We will bill your insurance company as a courtesy to you. If we have difficulty obtaining payment from your insurance company we may need your assistance in getting your claim paid. You will be responsible for payment of services not covered by your insurance plan. It is *your* responsibility to understand your plan's benefits and/or limitations. **HMOs that require a referral from your primary care physician prior to your visit are the sole responsibility of the patient.** Our office is not responsible to obtain the referral for patients that have MHO plans. If you arrive without a referral for your visit, and your insurance requires you to bring one, your appointment will be rescheduled.

For Our Self Pay Patients

In order to accommodate uninsured patients we have established self-pay rates. You are responsible for payment when you check in for your appointment. The fee for your office visit does not include the cost of additional procedures that may be required, or the cost of blood/urine testing. You will be billed separately for your lab work, which will be sent to a facility that offers the most economical alternative.