PATIENT INFORMATION RECORD

PATIENT'S NAME: _____

LOCAL MAILING ADDRESS: _____

CITY STATE ZIP CODE

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ AGE: _____

MARITAL STATUS: (S,M,D,W): _____ RELIGION: _____ RACE: _____

EMAIL ADDRESS: _____ CELL PHONE#: _____

PATIENT'S PHONE #: _____ WORK PHONE #: _____

PLACE OF EMPLOYMENT: _____ Primary Insurance Co: _____

If your insurance is under someone else's name, please provide the following:

Subscriber's Name: _____ DOB: _____ SS# _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

CIRCLE LAB we are to use for your specimens: ***QUEST*** ***LABCORP*** ***CFHA/LRMC***

Local Pharmacy Name: _____ *Phone #:* _____

Mail Order Pharmacy Name: _____ *Phone #:* _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid by my insurance or third payer within a reasonable period of time not to exceed 60 days. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

I authorize, request and assign payment directly to Lake OB-GYN Associates of Mid-Florida, LLC by all insurance carriers with whom I have coverage or from whom benefits are or may become payable to me including settlements or judgments flowing from incidents for which I may receive treatment. This assignment shall remain in effect until revoked by me in writing.

I authorize Lake OB-GYN Associates of Mid-Florida, LLC to release information or copies of all medical records, including those that may contain information related to **HIV/AIDS, sexually transmitted diseases, mental health (excluding psychotherapy notes maintained separately from my medical record), alcohol or substance abuse, and genetic testing**, which are contained in my patient file to any third party payor or their representatives for the purpose of obtaining payment for the services rendered by Lake OB-GYN Associates of Mid-Florida, LLC, or, at my request, to another medical provider for the purpose of continued care.

FOR MEDICARE PATIENTS: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Lake OB-GYN Associates of Mid-Florida, LLC for any services furnished me by Lake OB-GYN Associates of Mid-Florida, LLC. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I agree to execute such forms and documents as may be necessary to apply for and obtain payment.

I hereby acknowledge that I have received a copy of the Lake OB-GYN Associates of Mid-Florida, LLC Notice of Privacy Practices as required by Federal Law.

I hereby consent to services, treatment and diagnostic procedures, including but not limited to medications, lab tests and/or a medically indicated physical examination. This may include, but is not limited to: a gynecological exam, which may include a rectal exam and/or a pelvic exam; an ultrasound exam, which may include a probe placed in the vagina; a rectal exam; examination of external genitalia. This will be performed by one of the Lake OB-GYN Associates Physicians or Nurse Practitioners. This consent will remain active until I withdraw my consent in writing.

_____ _____ _____

Date Patient's Signature or Personal Representative Description of Personal Representative's Authority

Lake OB-GYN ASSOCIATES of Mid-Florida, LLC

601 East Dixie Avenue, Medical Plaza #401, Leesburg, FL 34748
1400 US Hwy. 441 N., Bldg. #950, Suite #952, The Villages, FL 32159

PATIENT NAME:_____ SS#:_____ Date:_____

Birthdate:___/___/___ Age:____ Marital Status - M S D W

Primary Care Physician:_____ Referring Physician:_____

CHIEF COMPLAINT: _____

PAST MEDICAL HISTORY AND FAMILY HISTORY: Please respond by placing a check mark (*T*) beside any illnesses you or your immediate family have experienced. If you do not understand the questions, leave it blank.

	Self	Family		Self	Family
Diabetes	____	____	Heart Disease	____	____
Thyroid Disease	____	____	Stroke	____	____
Cancer of the Ovary	____	____	Varicose Veins	____	____
Cancer of the Breast	____	____	Phlebitis	____	____
Cancer of the Lungs	____	____	Hypertension	____	____
Cancer of the Colon	____	____	Slow / Irregular pulse	____	____
Arthritis Bursitis	____	____	Migraines	____	____
Back pain or Sciatica	____	____	Hepatitis or Cirrhosis	____	____
Anemia	____	____	Gallstones	____	____
Tuberculosis	____	____	Colitis	____	____
Asthma/Sinus Allergies	____	____	Diverticulitis	____	____
Cholesterol	____	____	Polyps in bowel	____	____
Emphysema	____	____	Hemorrhoids	____	____
Kidney Stones	____	____	Breast Disease	____	____
Bladder Infections	____	____	Epilepsy	____	____
Glaucoma	____	____			

SOCIAL HISTORY:

Tobacco Use: __No __Yes Alcohol/Drugs Use: __No __Yes Caffeine Use: __No __Yes
Seat Belt Use: __No __Yes Domestic Violence: __No __ Yes Reg. Exercise: __No __Yes
Other:_____

First day of last menstrual cycle: ___/___/___
Menstrual cycles began at age:____
Every ____ days; Lasting ____ days

No. Of Pregnancies (ALL):_____ C-Sections?_____
Miscarriages or Abortions?_____
Birth Control Pills?_____
Menopause at what age or year?_____
If YES, when?_____

Have you had a hysterectomy? YES / NO

PATIENT NAME:_____ DOB:_____

REVIEW OF SYSTEMS: Do you have any of the following symptoms currently? Please respond by placing a check mark beside the symptom. If you do not understand the question, please respond with a question mark.

	YES		YES
Headaches	___	Depression/Crying	___
Dizziness	___	Night Sweats/Hot Flashes	___
Loss of Consciousness	___	Water Retention/Swelling feet	___
Mood Swings	___	Breast Mass/Soreness	___
Fatigue	___	Nipple Discharge or Bleeding	___
Muscle Weakness	___	Gas	___
Difficulty swallowing	___	Coughing up Blood	___
Indigestion/Heartburn	___	Wheezing	___
Nausea or Vomiting	___	Trouble Walking	___
Poor Appetite/Weight Loss	___	Glasses/Contacts	___
Diarrhea	___	Painful Intercourse	___
Constipation	___	Shortness of Breath	___
Blood in Bowel Movement	___	Chest Pain	___
Urinary Problems	___	Skin Rash or Itching	___
Painful Urination	___	Jaundice (Yellow Skin)	___
Blood in Urine	___	Incontinence	___

Any other problems not mentioned above:_____

**Do you have to routinely take antibiotics before visiting the dentist? YES / NO

LIST MEDICATIONS YOU USE REGULARLY:

1._____
2._____
3._____
4._____

ALLERGIES

1._____
2._____
3._____
4._____

LIST SURGERIES YOU HAD:

1._____
2._____
3._____
4._____
5._____
6._____

Patient's Signature:_____ Date:_____

NAME:_____ DATE:_____

Last *First* *Middle*

Total Pregnancies:___ Abortions:___ Twins:___ Living Children:___ Date of Last Period:_____ Monthly Periods: YES / NO Birth Control at conception: YES / NO

PAST PREGNANCIES (Last Five):

DOB	Gestation Weeks	Length of labor	Birth Weight	Sex M / F	Type of delivery	Anesthesia	Place of Delivery	Preterm Labor Yes/No

GENETIC SCREENING/TERATOLOGY COUNSELING (Includes Patient, Baby's Father, or anyone in EITHER family with:

	YES	NO		YES	NO
1. Patient's age 35 years or older as of estimated date of delivery			12. Huntington's Chorea		
2. Thalassemia (Italian, Greek, Mediterranean, or Asian background): MCV less than 80			13. Mental retardiation/Autism		
3. Neural tube defect (Meningomyclocele, Spina Bifida, or Anencephaly)			If Yes, was person tested for Fragile x?		
4. Congenital Heart Defect			14. Other inherited genetic or chromosomal disorder		
5. Downs Syndrome			15. Maternal metabolic disorder (eg, Type 1 diabetes, PKU)		
6. Tay-Saclis (Ashkenazi Jewish, Cajun, French canadian)			16. Patient or baby's father had a child with birth defects not listed above		
7. Canavan Disease (Ashkenazi Jewish)			17. Recurrent pregnancy loss, or a stillbirth		
8. Familial Dysautonomia (Ashkenazi Jewish)			18. Medication (including supplements, vitamins, herbs or OTC drugs) illicit/recreational drugs/alcohol since last menstrual period)		
9. Sickle Cell disease or Trait (African)			19. Muscular Dystrophy		
10. Hemophilia or other blood disorders			20. Any other?		
11. Cystic Fibrosis					

INFECTION HISTORY:

	YES	NO		YES	NO
Live with someone with TB or exposed to TB?			Hepatitis B, C?		
Patient or partner has history of genital herpes?			History of STD, Gnorrhea, Chlamydia, HPV, HIV, Syphilis?		
Rash or viral illness since last menstrual period?			If Yes, list which ones?		

COMMENTS:_____

Lake OB-GYN ASSOCIATES

Douglas H. Moffett, MD, FACOG / Mitra Mossaddad, MD, FACOG
Amanda Quinn, APRN / Tara Poston, APRN

601 E. Dixie Ave. / Medical Plaza #401 / Leesburg, FL 34748 / (352) 787-1535 / Fax (352) 787-5310
1400 US Hwy. 441, N. / Bldg. #950 / The Villages, FL 32159 / (352) 259-5649 / Fax (352) 259-9187

Advance Beneficiary Notice (ABN) *Non-Medicare*

Patient Name:_____ **DOB:**_____

It is possible that your insurance company **may not pay** for the item(s) or service(s) that your are having and are described below. Your Insurance Company does not always pay for all of your healthcare costs.

Procedure(s) that may not be covered:	**Approximate Cost:**
Initial New Patient OB Visit	$650.00
Initial Established Patient OB Visit	$485.00
Global Obstetrical Care (OB visits, Delivery and Post-Partum visits)	$5,500.00-$6,500.00

Why your insurance company MAY NOT pay for these services is because the services may be considered a "non-covered" service/procedure by your insurance company or may be applicable to your deductible or co-insurance/co-pay.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options; you should read this entire notice carefully. Ask us to explain, if you do not understand why your Insurance Company may not pay.

PLEASE CHOOSE ONE OPTION:

☐ **Option 1: Yes, I want to receive these items or services**. Please submit my claim(s) to my insurance company. If my insurance company pays for these services, you will refund me any payments I made to you, once my insurance company sends payment. If my Insurance Company denies payment, I agree to be personally and fully responsible for payment of these services/procedures.

☐ **Option 2: No, I have decided not to receive these items or services.**

_____ _____

SIGNATURE of patient or person acting on patient's behalf Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurance company. Your insurance company will keep your health information confidential.

OBSTETRIC FEES for Lake OB-GYN ASSOCIATES of Mid-Florida,LLC

Normal Vaginal Delivery (with insurance) - **approx. $5,500.00**
(Physician fee only. ALL other bills are separate.)

Caesarean Section Delivery (with insurance) -**approx. $6,500.00**
(Physician fee only. ALL other bills are separate.)
Assistant Surgeon for C-Section - -**approx. $1,500.00**

INCLUDED in the above fees:

Routine OB visits:	Once a month until the 7th month (28 weeks)
	Twice during 7th & 8th months (28-36 weeks)
	Weekly until delivery (36 - 40 weeks)
Hematocrits:	Finger sticks to check blood iron.
Urinanalysis:	Urine dipstick to check for sugar, protein and blood in urine.
Post-Partum:	Two and Six week post-partum visits

Procedures performed that ARE NOT included in our "Global OB Fee":

Initial OB Visit - First visit to establish obstetrical care. This is approximately $650. and may be subject to your deductible and co-insurance, which you are responsible to pay once insurance has responded in addition to your regularly scheduled OB payments.

Non-Pregnancy Office Visits - If you need to be seen for something other than a routine obstetrical visit, (i.e., cold, sore throat, ear ache, Rhogam injection, etc.), this is an office visit charge and subject to a co-pay. It is NOT included in our obstetrical fees.

Laboratory tests - You will receive a bill from your laboratory for drawing and reading your prenatal labs and will be charged from the lab for them.

Hospital Stay - You will receive a bill from UF Health-Leesburg Hospital for your hospital stay. It is NOT included in our fee..

Epidural - If you have an epidural, you will receive a bill from the anesthesiologist for this. It is NOT included in our fee.

Circumcision- Performed by our physician's and billed separately to your insurance company. It is NOT included in our fee. The deposit for this is $350.00. This deposit is payable prior to the procedure being done.

NST- Non-Stress Tests performed in our office are billed separately to your insurance company and are NOT included in our fee. You are responsible for your co-pay for this test.

*****PLEASE NOTE...In order for our staff to provide you with the most prompt and efficient medical attention, we ask that you make arrangements for the care of your children during your appointments.***

_____ _____
Patient's Signature Date

_____
Witness

(OBFees.lst)

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NEW OB PATIENT INFORMATION CHECKLIST

I have been given a copy of the Lake OB-GYN Associates "OB Policy".

I have been advised of fees and have signed a monthly installment contract, if needed.

I have been advised to contact the hospital (UF Health-Leesburg Hospital) at 352-323-5090 to inquire if my insurance is covered at their facility.

I have been advised of the cost for "extra" office visits during the pregnancy. (This includes any visit related to sickness, injections and the Post-Partum Depression Screening visit, Growth U/S Scans and NST's.)

I have been advised that if I have a C-Section, the fee will be approximately $6,500.00, AND that I will also be charged for an assistant surgeon (approx. 25% of surgeon).

I have been advised that the first "New OB" visit, is a separate charge. The approximate charge for this visit is $650. for New patients and $485. for established patients. If this first visit is subject to my deductible and/or percentage that insurance does not cover, I understand that I am responsible for this amount, in addition to my monthly payment.

During your 7th or 8th month, I have been advised to call my insurance company to notify them of my approximate due date for pre-certification authorization, as well as Pre-registering at LRMC.

I have been advised to call my insurance company within 24-48 hours of delivery to add the baby to my policy.

I have received the Florida Birth-Related Neurological Injury Compensation Association booklet, signed the notification, and will share this information with the baby's father.

Circumcision - The deposit for a circumcision is $350. This is payable prior to the procedure. This procedure is performed in our office within 10 days of delivery. Please call our office once you have delivered to schedule this appointment.

If you have insurance, in the event your insurance is cancelled due to non-payment, you are responsible for any balance on your account.

IF YOUR INSURANCE CHANGES AT ANY TIME DURING YOUR PREGNANCY, IT IS YOUR RESPONSIBILITY TO ADVISE OUR OFFICE. FAILURE TO DO SO COULD RESULT IN YOU BEING RESPONSIBLE FOR THE ENTIRE BILL OF APPROXIMATELY $6,500.00 PAYABLE AT YOUR SIX WEEK POST-PARTUM VISIT.

_____ _____

Patient Signature Date

_____ _____

Witness Date

PRENATAL CARE AND POLICIES

Welcome and Congratulations! We are happy to be involved during this exciting and interesting time in your life. We are available to answer your questions and encourage you to ask them so that you may better understand and enjoy your pregnancy.

During your pregnancy the physicians will alternate seeing you during your prenatal appointments. This will enable them to be familiar with you and your pregnancy in the event one is out of town during your delivery, the others will be available and familiar to you.

Your prenatal appointments will be arranged at approximately four-week intervals for the first seven months, twice a month during your seventh and eighth months and then weekly until you deliver. You are urged to keep your appointments. It is an established fact that good prenatal care contributes to a healthy mother and infant.

FEE AND PAYMENTS:

Our fee for a normal vaginal delivery is approximately $5,500.-$6,000.. You will receive a copy of your payment schedule, if one has been arranged.

FEE INCLUDES:

- All pregnancy related office visits during your pregnancy
- Complete care of the mother at the time of the delivery
- Your six-week postpartum checkup

THERE ARE ADDITIONAL FEES FOR THE FOLLOWING:

- Prenatal Profile (Hematocrits, CBC, VDRL, Blood Type, RH Factor, Rubella antigen, GC Culture, Hepatitis B)
- Other laboratory tests (i.e., Alpha Fetoprotein, Glucose Screening at 26 weeks, Amniocentesis, Genetic Counseling, Sickle Cell Prep and pap Smear at six week postpartum check-up.)
- Injections (i.e., RhoGam Injection at 28 weeks, if RH Negative)
- Cesarean Section
- Assistant Surgeon's fee for Cesarean Section
- Other Surgery (i.e., Tubal Ligation - $800)
- Circumcision of male infant ($350 - Consent form must be signed.)
- Non-routine care (i.e., Hospitalization)
- Non-stress test in hospital)

Charges made by the hospital, anesthetist or anesthesiologist (if utilized), newborn care and procedures not usually performed by me such as amniocentesis, are charged separately, (by those directly involved).

HOSPITAL CHARGES:

We deliver all of our obstetric patients at UF Health-Leesburg Hospital. For information on hospital charges, please contact the hospital directly. We advise you to pre-register with the hospital during your 7th or 8th month so they will have all of the pertinent personal information on you prior to the day of delivery.

GENERAL RECOMMENDATIONS:

Ideal weight gain in pregnancy is about 25-30 pounds from your pre-pregnancy weight. Pregnancy is not a time to diet and yet it is also not a time to go "wild" with eating. Try to eat a balanced diet and stay away from "junk food". Try to avoid any caffeine (drink caffeine-free sodas, coffee and tea - diet drinks with NutraSweet are OK). Bare in mind that most of the weight gain is during the second half of the pregnancy. A balanced diet helps prevent complications during the pregnancy and will help control some swelling you may have. Also, NO DRINKING ALCOHOL during the pregnancy. It has been shown to have unwanted effects on the fetus. NO ASPIRIN or any medications that contain it. TYLENOL is OK to take for minor pain, headaches or fever. Maalox and Mylanta are OK to take for heartburn or indigestion. Please contact us regarding taking any other mediation. If you smoke, PLEASE STOP, as this adversely affects your baby's growth and well-being. Exercise is OK during pregnancy as long as it is not too strenuous. We do not recommend aerobics, bicycle riding or horse-back riding. Swimming, floor exercises and walking are excellent forms of exercise but please remember to take frequent breaks and avoid excessive fatigue. Sexual intercourse if OK during pregnancy as long as you are not having any complications. (I.e., vaginal bleeding, cramping, infections). If you have questions regarding this, please consult us. Douching is not recommended at all. If you find you are getting too constipated, you may cut the iron back to one tablet every other day or if you are still too constipated, stop the iron for a period of time, then gradually restart it. We do not advise flying after about the 32nd week of your pregnancy.

Please read the brochure on AFP testing. This test is best done between 16-20 weeks of the pregnancy. Also, you will be screened at approximately 26 weeks for Diabetes with a special blood test. If you are Rh negative, you will undergo some extra tests and receive an injection of RhoGam at about 28 weeks of pregnancy, if indicated.

A WORD ABOUT CATS

Cats are a potential source of an infection known as Toxoplasmosis. Pregnant women can avoid infection by having someone else dispose of the daily cat litter and by carefully hand washing after handling cats. This infection can also be acquired by eating raw or poorly cooked meat.

LABOR

Please telephone our office, (352-787-1535, available 24 hours a day, 7 days a week) if you believe that you are in labor (strong regular contractions) or if your bag of water breaks, even if you are not having any contractions with it. Call if you think your "water" is leaking. Call if you are in doubt. If labor is starting, DO NOT EAT OR DRINK ANYTHING!!

Please make arrangements before delivery for your Pediatrician or Family Physician to examine your newborn baby. If you need help in making this decision, we will be happy to discuss it with you.

AFTER THE HOSPITAL

Your obstetric fee includes a six-week postpartum examination. It is important that you have regular annual examinations when you are not pregnant. This should include a cancer screening test referred to as a Pap smear.

Our ultimate goal in providing you obstetric care, is your continued good health and the delivery of a healthy, robust newborn. If you have further questions, please feel free to discuss them with us.

Again, Congratulations!!

Douglas H. Moffett, MD Mitra Mossaddad, MD