Island ObGyn

Joseph F. Lang, MD

Patient Name: _____

Billing Address: _____

City: _____ ST: _____ Zip:_____

Other Address: _____

City: _____ *ST:* _____ *Zip:*_____

Date of Birth: _____ **Social Security Number:** _____

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:**_____

Email Address: _____

Pharmacy: _____ **Phone #:**_____

Laboratory of Choice: ☐ **Quest Diagnostics** ☐ **Lab Corp / Gynecor**

PLEASE HAVE YOUR INSURANCE CARD AND ONE FORM OF ID AVAILABLE AT OUR FRONT DESK

Primary Insurance: _____

Insurance ID Number: _____ **Group Number:** _____

Insured Party Name: _____

Insured's Date of Birth: _____ **( ) Female ( ) Male**

Secondary Insurance: _____

EMPLOYER INFORMATION

Employer: _____

Employer Phone Number: _____

Employer Address: _____

Employer City, State, Zip: _____

I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name & Phone #: _____ **Relationship** _____

Name & Phone #: _____ **Relationship** _____

Name & Phone #: _____ **Relationship** _____

PLEASE READ AND SIGN BELOW

The patient understands that he/she or responsible party is financially responsible for all fees not paid by insurance or third party coverage. In addition, the patient authorizes his/her insurance company to pay Joseph F. Lang, MD dba Island ObGyn directly for services rendered. In the event that an outside collections agency is necessary to enforce payment of the account, the patient agrees to pay for all collection fees deemed reasonable. This form will also give authorization to Joseph F. Lang, MD to release any medical information necessary to process any insurance claims.

_____ _____

Date **Signature of Patient or Responsible Party**

Please fill out the following information; feel free to skip any sections or questions that are not relevant to you or if you would prefer not to answer.

NAME: _____ AGE: _____
Reason For Visit:

_____

ALLERGIES _____
_____
_____

MEDICATIONS: ***(if you have a list please feel free to just present that to the doctor)*** ☐ **SEE LIST**

	Name	***Dose***	***How often***
1.			
2.			
3.			
4.			
5.			

FAMILY HISTORY ***(medical problems)***

Mother _____ Father _____
Sister(s) _____ Brother(s) _____
Aunt(s) _____ Uncle(s) _____
Other _____

PREGNANCY

Number _____ Premature _____ Abortions _____ Miscarriage _____ Ectopic _____
Twins _____ Living Children _____
Complications _____
_____

Gynecological History

Last Menstrual Period: _____
Menstruation: duration (days): _____ Flow: _____ heavy _____ moderate ____ light
Frequency: _____ Age of First Menses: _____
Any STDs _____
Menopausal Symptoms _____
Incontinence Issues _____ yes _____ no

Sexual Issues
Concerns _____
Questions _____

Current Contraception _____ Past Contraception _____
Comments _____
_____

MEDICAL CONDITIONS: ***(check if yes and please describe)***

Anemia _____ Arthritis _____ Asthma _____ Back Pain _____ Blood Transfusion _____
Breast Disease _____ Broken Bones _____ Cancer _____ Cardiovascular _____ Diabetes _____
Endometriosis _____ Gastrointestinal Problems _____ Hearing Problems _____
Visual Problems _____ High Blood Pressure _____ Musculoskeletal _____ Neurologic _____
Psychiatric _____ Skin Problems _____

Comments_____
_____

Please indicate the date (if known) of the most recent:

PAP: _____; Normal: ____ yes ____ no; describe: _____
Mammogram: _____; Normal: ____ yes ____ no; describe: _____
GYN Exam: _____; Normal: ____ yes ____ no; describe: _____

Chest X Ray: _____EKG: _____Colonoscopy: _____

Immunizations:
Hepatitis A _____ Hepatitis B _____ Influenza _____
Pneumococcal _____ Tetanus _____

Surgery:
Procedure/Date

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

If you have had a hysterectomy, were your ovaries removed as well? Yes No

SOCIAL ISSUES

Marital Status: _____single _____married _____divorced _____widowed _____living with

Alcohol Use: _____yes _____no _____ how much/day
Smoking: _____yes _____no _____ how much/day

Exercise: _____yes _____no _____ daily/weekly

REVIEW OF SYSTEMS:
(Please describe any problems with the following; if none leave blank)

Skin ____ Eyes ____ Ears ____ Nose ____ Throat ____ Teeth ____ Neck ____ Breast ____
Lungs ____ Heart ____ Digestive ____ Musculoskeletal ____

Comments _____
_____

Island ObGyn

Consent for Purpose of Treatment, Payment or Health Care Operations

I consent to the use or disclosure of my protected health information by Island ObGyn for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Island ObGyn's practice.

I understand that diagnosis or treatment of me by Island ObGyn may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment of health care operations. Island ObGyn is not required to agree to restrictions that I may request. However, if Island ObGyn agrees to a restriction that I request, the restriction is binding on Island ObGyn's practice.

I have the right to revoke this Consent, in writing, at any time, except to the extent that Island ObGyn's practice has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and indentifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Island ObGyn Notice of Privacy Practices prior to signing this document. Island ObGyn's Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices for Island ObGyn's practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performances of Island ObGyn's health care operations.

A summary of the Notice of Privacy Practices for Island ObGyn is also posted in the waiting room.

Notice of Privacy Practices also describes my rights and the duties of Island ObGyn's practice with respect to my protected health information.

Island ObGyn reserves the right to change the privacy practices that are described in the Notice of Privacy Practice.

_____ _____

Name of Patient (please print) **Signature of Patient or Representative**

_____ _____

Name of Patient or Representative (please print) **Date**

Please be advised that many insurance companies do not cover annual exams, infertility testing, weight control counseling and screening tests etc.

Island ObGyn participates with many insurance plans, and it is impossible for us to know what type of plan you or your company has purchased. It is your responsibility to know what type of coverage, benefits, deductibles and co-payments you have with your insurance plan.

If your visit is for an exam or screening test that is not covered under your plan, you will be billed directly. We cannot change our coding of visits to accommodate your coverage. Incorrect coding is considered fraud and can result in large fines for our office and yourself.

In the event that an outside collections agency is necessary to enforce payment of the account, the patient agrees to pay for all collection fees deemed reasonable.

By signing this document, I am aware that it is my responsibility to know what type of coverage, benefits, deductibles and co-payments my insurance requires and allows. I am aware that I will be billed directly for uncovered services

_____ _____

Patient signature **Date**

Island Ob/Gyn
For A Woman's Best Health

Cancellation & No-Show Policy Agreement

As your appointment time is reserved specifically for you, Island OB/GYN has a cancellation/no-show policy. Out of consideration for Dr. Joseph F. Lang and staff, we ask that you notify us *24 hours in advance* should you need to cancel or reschedule your appointment.

Island OB/GYN will charge a $50.00 cancellation fee for missed appointments and late cancellations without 24 hour advance notification.

We do understand that unanticipated events happen occasionally; emergency cancellations are handled on an individual basis.

As a courtesy, Island OB/GYN will make an effort to confirm with you at least 1 to 2 days before your appointment; however, it does remain the patient's ultimate responsibility to keep track of their appointments.

I have read and understand Island OB/GYN's cancellation policy. I consent to these terms.

Patient Signature: _____

Patient Name (Printed): _____ Date: _____

983 North Collier Blvd Marco Island, FL 34145
T 239.389.LITE (5483)
F 239.389.5260

Joseph F. Lang, MD
www.islandobgyn.com

MyQuest by Care360

Island Ob/Gyn
For A Woman's Best Health

Patient Portal

Because who cares more about the future of your health than you?

View Test Results and PAP Smears with the CLICK of a Button!

☐ I am interested in getting set up for the Patient Portal

- ☐ Print Directions
- ☐ Email Me Directions: _____

☐ I am NOT interested in getting set up for the Patient Portal

Patient Name: _____ DOB: _____

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CONSENT TO LEAVE MESSAGE

Island Ob/Gyn Clinical staff will often contact you by phone with information such as test results, medication needs, treatment plans, appointment needs or instructions from your doctor. We can leave detailed medical information on your voicemail with your consent.

By signing this "Consent to Leave Message" you consent to Island OB/GYN, allowing the clinical staff to leave a message containing detailed medical information on the phone number(s) listed below. This information can include but not be limited to medical information (diagnosis, medications, test results, etc.) financial information (billing questions, cost of procedures) and the name of the hospital, department within a hospital or physician practice where you received services.

Which phone number(s) may we leave messages that contain the above referenced medical information?

❒ Cell_____ ❒ Home_____ ❒ Work _____

May we leave detailed messages that contain medical information with a family member or representative of your choice? If so, please identify them below:

Name_____Relationship _____

Name_____Relationship _____

I understand that the Island OB/GYN cannot require me to sign this consent form in order to receive treatment.

I understand I have the right to revoke this consent at any time by signing a written request to the Office. My decision to revoke this consent does not apply to any information disclosed in a voicemail prior to the date of my revocation of this consent.

Patient Name _____

Patient Signature_____Date _____

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