5800 S. Semoran Blvd. Suite: A Orlando, FL 32822
Phone#: 407-270-5925 | Fax#: 407-205-1494| www.obgynultrasoundllc.com

Registration Form

Patient Name: ____Nickname:____________________________________

Address: ____

City, State, Zip: ______________________________________Social Security #:___________________________________

Date of birth: _________________ Age: _______ Email: ____

Home#: _____________________Work#: ________________________Cell#: ________________________________

Marital Status:____________________PrimaryDoctor:_________________________Pharmacy:_______________________

Employer: _________________________________Occupation:____

Allergies: ____

Daily Medications: ____

Insurance Company: _______________________________________ Insurance I.D.________________________________

Insurance Card Holder (please check one):

SELF ( ) SPOUSE ( ) OTHER ( ):____

Primary Insured Name: ______________________________ DOB: ________________ SS#________________________

Spouse name: _______________________Occupation:______________________ Phone#: (_______)________________

Guardian / Parent Information If Patient is a Minor:

Name of parent(s): ____ Relationship: ________________________

Social Security#: _________________________________ Date of Birth: _____________________________________

Home#: (________)_______________________________Work#: (________) ____________________________________

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office bookkeeper. I request that payment of authorized insurance company benefits be made either to me or on my behalf to OB/GYN Ultrasound for any services furnished to me by that party who accepts assignments; I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party that accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (section 11288 of the Social Security Act and 31 U.S.C 3801-3812 provides penalties withholding this information).

SIGNATURE:____ **DATE:**___________________

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I wish to be contacted in the following manner (check all that apply):

( ) ***HOME TELEPHONE***

☐ LEAVE DETAILED MESSAGE

☐ LEAVE CALL BACK NUMBER ONLY

( ) ***WORK TELEPHONE***

☐ LEAVE DETAILED MESSAGE

☐ LEAVE CALL BACK NUMBER ONLY

( ) ***CELL PHONE***

☐ LEAVE DETAILED MESSAGE

☐ LEAVE CALL BACK NUMBER ONLY

( ) ***WRITTEN COMMUNICATION***

☐ MAIL TO HOME ADDRESS

☐ MAILTO WORK ADDRESS

( ) ***RELEASE TO IMMEDIATE FAMILY***

☐ MAIL TO HOME ADDRESS

☐ MAIL TO THIS ADDRESS:____________

____

( ) ***FAX THIS NUMBER:***________________

Emergency contact to leave call back information (if unable to reach you):

NAME: ____ RELATIONSHIP: ________________________

PRIMARY PHONE#:____________________________ ALTERNATE PHONE#.___________________

I UNDERSTAND THAT ALL PERSONAL RECORDS AND INFORMATION ARE KEPT CONFIDENTIALLY THROUGH OB/GYN ULTRASOUND. THE ABOVE INFORMATION IS APPROVED BY MY PERSON.

PATIENT SIGNATURE: ____ **DATE:** _________________

PRINT PATIENT NAME: ____ **DOB:** _________________

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Financial Policy

We are here to provide you the highest quality care. Your clear understanding of our professional fees is important. Please understand that as your health care providers, we are committed to you, not your insurance company.

Please review our policy:

- Patient responsibility: Payment is due at time of service, including co-payments and deductibles. Our policy states that as a courtesy to our patients, we submit their claims to their insurance companies as a way of helping them ensure the payments are sent for the service we render. We do not submit to secondary insurances. This is the patient's responsibility. We are not responsible for claims that are not filled in a timely matter for reasons such as (wrong insurance information was given; wrong id numbers or claims that are sent to the wrong insurance addresses). Ultimately, it is the patient's responsibility for payment of services that are rendered.
- Insurance: We accept most insurance, except for Medicare and Medicaid assignments. We are not contracted with workers compensation carriers. It is your responsibility to verify our participation with your health insurance plan. Please make sure your insurance plan covers the services provided by us. It is your responsibility to provide us with correct and complete insurance information. Your insurance card is needed at the time of check-in in order for us to provide you care. Please inform our office of any changes in your insurance.
- Payment Methods: We accept cash, checks, Visa, MasterCard, American Express and Discover.
- Insufficient funds: Our policy for non-sufficient funds (NFS) checks is as follows, we charge $45.00 return check fee. A letter is sent to the patient with a copy of the check that was returned to our office. This informs the patient that this check needs to be paid within a 15-day time period along with (NFS) fee of $45.00.
- No Show: Patients sign this agreement at the time a patient becomes part of this practice, so they understand how important it is for us to help all patients obtain an appointment. Failure to notify us at least 24 hours in advance of appointment cancellation will result in a $25.00 charge for first offense, $50.00 charge for second offense. Fee will be assessed to the patient acct automatically if the patient does not show up or call.
- Collection Process: We work diligently to resolve all claims with patient's insurance companies. We send patient statements/bills at the end of every month to each patient with an outstanding balance. This is done in a monthly basis along with a collection letter attached to the second and third request. At the end of 60 days, we call each patient to remind them that they have an outstanding balance for services rendered that has not been paid. If payment is not received within 90 days, we will send the account to an outside collection agency and a 35% fee will be added to the account, at which time the patient will be dismissed from our practices.
- Refund Policy: All refunds to insurance companies and patients are done at the end of the month.

I agree to the financial policy explained above.

Patient Signature: ___________________________ **Date:__________**

Witness Signature: ____________________________ **Date :__________**

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Notice

To: All Patients of OB/GYN Ultrasound

OB/GYN Ultrasound has decided not to carry medical malpractice insurance

Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. Your physician has decided not to carry medical malpractice insurance. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice.

This notice is provided pursuant to Florida law.

Patient Signature: ___________________________Date:___________

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Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

We are obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practice and abide by its terms. We reserve the right to change our privacy practices and apply revised privacy private practices to protected health information. This notice takes effect September 16, 2002 and will remain in effect until we replace it.
You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us at OB/GYN Ultrasound, LLC, 5800 S. Semoran Blvd. Suite A Orlando, FL 32822. Telephone: (407)-270-5925. Fax: (407)-205-1494.

USES AND DISCLOSURES OF MEDICAL INFORMATION

We use and disclose medical information about you for treatment, payment, and health care operations. This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMOs, and PPOs, managed care organizations, IPAs, CMS, or other governmental or third party payers, or any organizations contracting with any of the above entitles to perform such functions.
Copies of your medical information may be delivered to a primary care physician or any other physician who is directly or indirectly responsible for your medical care or the payment thereof.
We may use or disclose your medical information to notify a family member or another person responsible for your care based on our professional judgment and the circumstances. We may use your medical information to contact you to provide appointment reminders, and to attempt to call you to notify you that results are available. We may use your name and your location in our facility in our facilities directories.
We may use or disclose your medical information for purposes involving public health and safety issues and activities, death, certain requests from your employer, governmental personnel and programs, origins donation, judicial and administrative proceedings, law enforcement, abuse, neglect, or domestic violence issues and workers compensation issues.

INDIVIDUAL RIGHTS

This office will not use or disclose any medical or financial information for any purposes not stated above without your specific authorization. You may revoke your authorization at any time. You may request restrictions on certain uses and disclosures. This office is not required to agree to a request restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information from this office. We may charge a cost-based fee for copying records and for postage.

QUESTIONS AND COMPLAINTS

You may register a complaint with this office if you suspect that you privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

Patient Signature: ____ **Date:** __________________________

Printed Name: ____

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Ultrasound Instructions

You have been scheduled for an ultrasound on _________at________.
An ultrasound is a noninvasive procedure which enables your physician to visualize your internal anatomy without the risks associated with x-ray. Please ensure to follow the instructions below for your exam preparation.

Vaginal Ultrasound Examination: No special requirements are needed for this type of ultrasound examination.
Obstetrical Ultrasound Examination: below you will find preparation instructions for your upcoming scheduled ultrasound. Please note that the sex of your baby is best determined at 18 weeks of gestation.

- **Obstetrical Ultrasound:** For the examination, a full bladder is not required.
- **3D/4D Ultrasound Examination:** A full bladder for this examination is not required.
- **Pelvic Ultrasound:** For this examination a full bladder is required only if patient has never had sexual intercourse.

General Instructions

- Please be prompt. We regret that our busy schedule may not allow us to accommodate patients who are late for their appointments.
- The use of cell phones and other electronic devices are prohibited in the ultrasound room as they may interfere with the equipment.
- You may bring 3-4 persons for your ultrasound. We encourage you not to bring any children under the age of five. However if you must, please bring an additional adult to supervise.
- OB/GYN Ultrasound will provide a CD-R/DVD-R to each patient.
- If you need to cancel or reschedule your appointment or have any questions, please contact our office at least 24 hours prior to your appointment. Missed appointments will be charged a $25.00 no show fee for the first occurrence and $50.00 for any other occurrences.

NOTE: Please be aware a medical consultation is not included in this diagnostic procedure. Although the ultrasound might be performed and/or reviewed by a Physician, the ultrasound report will be sent to your Primary Care Physician for further evaluation and/or to follow the necessary treatment. If necessary OB/GYN Ultrasound will refer you to a physician that will better respond to your medical needs.

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CREDIT CARD AUTHORIZATION

This form is requested for all patients and required to be on file.

Our purpose here at OB/GYN Ultrasound, LLC, is to provide all of our patients the utmost care and tranquility during their procedures. Consequently, failing to be on-time/present (over 15 minutes) for scheduled appointments, as well as failing to cancel scheduled appointments within 24 hours before the appointment, results in our inability to use that time for another patient while also incurring in overhead costs. Therefore, our policy states that a $25 dollar fee will be charged for the first offense, which then doubles the fee to $50 for any other occurrences.

Due to the situations stated above, we request a credit card be kept on file. It is of great importance to our practice to ensure the protection and security of the personal information you provide.

Please provide the information below.

Credit Card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Card Number:_________________________ Expiration Date:____________ CVV*:_____________

Exact Name on Card:________________________ Billing Phone Number:(_____)______________

Billing Address:____ Suite or Apt.#:______________

City:_____________State:_______ Zip Code:__________ Home Phone:(______)______-_________

Email Address: ____

I, ________________, hereby authorize OB/GYN Ultrasound, LLC, to use my credit/debit card information provided above to process charges/fees assigned to me. Furthermore, I grant authorization for OB/GYN Ultrasound, LLC, to be compensated for missed appointments and/or failure to notify 24 hours prior to the time of my appointment. Missed appointments or appointments not cancelled within the time specified will be billed at the rate of $25 for the first time and $50 for any subsequent time.

Signature_______________________________________Date_____________________________

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