Date _____
Fecha

Patient Registration
Registración del Paciente

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

Patient Information - *Información del Paciente*

Social Security # _____
Numero de Seguro Social
First Name _____ Middle _____
Primer Nombre *Segundo Nombre*
Last Name _____
Apellido
Sex _____ Date of Birth ____/____/____
Sexo *Fecha de Nacimiento*
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Estado Civil *Casada* *Soltera* *Divorciada* *Viuda*

(Check One) ☐ Employed ☐ Retired ☐ Full-Time Student
Marque Uno *Empleada* *Retirada* *Estudiante Tiempo Completo*
☐ Other _____
Otro
Employer _____
Empleador

Home Address _____
Direccion del Hogar
_____
City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*
Email Address _____
Home Phone (_____) _____
Telefono del Hogar
Work Phone (_____) _____
Telefono del Trabajo
Cell Phone (_____) _____
Telefono Cellular
Referring Physician _____
Referida Por el Dr:
How did you hear of us? _____
Como usted supo de nosotros?

Insurance Information - *Información del Seguro*

Please provide your insurance card to the receptionist - *Por favor entregue su tarjeta de seguro a la recepcionista*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other _____

Insurance company _____
Compañia de Seguro
Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado *Relación*
Policy # _____ Group # _____ Phone ( ) _____
Numero de Poliza *Numero de Grupo* *Telefono*

Secondary Insurance Information - *Información del Seguro Secundario*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other _____

Insurance company _____
Compañia de Seguro
Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado *Relación*
Policy # _____ Group # _____ Phone ( ) _____
Numero de Poliza *Numero de Grupo* *Telefono*

Emergency Contact - *En Emergencias, contactar a:*

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*
Last Name _____
Apellido

Home Phone (_____) _____
Telefono del Hogar
Work Phone (_____) _____
Telefono del Trabajo

Spouse / Guarantor / Responsible Party - *Esposo / Persona Responsable*

Social Security # _____
Numero de Seguro Social
Relationship _____
Relación
First Name _____ Middle _____
Primer Nombre *Segundo Nombre*
Last Name _____
Apellido
Address _____
Direccion
City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*

Sex _____ Date of Birth ____/____/____
Sex *Fecha de Nacimiento*
DAYTIME PHONE (_____) _____
Teléfono durante el dia
EMPLOYER _____
Empleo
ADDRESS _____
Direccion
CITY _____ STATE _____ ZIP _____
Ciudad *Estado* *Codigo Postal*

Signature Required Please See Reverse Side
Firma Requerida. Por Favor mire al Dorso

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos ciertas tarjetas de credito. Su seguro medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsable de los gastos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to S.458.320 (5)(g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida law.

Hemos elegido no llevar seguro de negligencia medica o no demostrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (la ley 5) (g). Florida impone penas contra los medicos de los no-asegurado que no pueden satisfacer los juicios adversos que se presentan de demandas de la negligencia medica. Este aviso esta conforme a la ley de la Florida.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by the physician. I understand that I am financially responsible to the physician for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a el medico todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Yo entiendo que soy responsible por todos los cargos no cubiertos bajo mi seguro medico.

_____ _____

PATIENT'S / GUARANTOR'S SIGNATURE DATE

Todd Goldberg, D.O. FACOOG Douglas Smith, D.O. FACOOG Suzette Rodriguez, M.D. FACOG
603 N. Flamingo Road/Suite 361, Pembroke Pines, Florida 33028 – Phone #954-432-7900/Fax: 954-433-4903
2300 N. Commerce Pky/Suite 205, Weston, Florida 33326 – Phone #954-389-3855

Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Gemini OB/GYN, LLC to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Gemini OB/GYN, LLC.

I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am financially responsible for all charges including costs of collection and litigation if necessary.

Date_____ Signature_____
(patient, parent, or guardian)

Physician Financial Responsibility

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non insured physicians who fail to satisfy adverse judgment arising from claims of medical malpractice. This notice is pursuant to Florida law.

Date_____ Signature_____
(patient, parent, or guardian)

Medical Malpractice Agreement

Further, I understand that I am entering into a contractual relationship with Gemini OB/GYN, LLC for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Gemini OB/GYN, LLC, I (the patient) and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Gemini OB/GYN, LLC.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use ABMS board-certified expert medical witness(es) in the same or similar specialty as Gemini OB/GYN, LLC. Furthermore, I agree that these expert witness(es) will adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case. In further consideration for this, Gemini OB/GYN, LLC, agree to the same stipulations.

_____ _____
Date Patient