Acct #: Patient Name: Date of Birth:

What is your preferred **Pharmacy's Phone Number:** ( ) ______-__________ Pharmacy: ________________________________	**Who referred you to us? Please circle one:** **Friend Relative physician Existing Patient Insurance other (please specify)** ____

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

INSURANCE AUTHORIZATION AND ASSIGNMENT. I hereby authorize OB & GYN ASSOCIATES OF MIAMI, LLC to furnish information to my Insurance Carrier concerning illness and treatments and hereby assign OB & GYN ASSOCIATES OF KENDALL, LLC payments for medical services rendered myself or dependents**. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.**

Signature x ____ Date ________________________

Notice of Privacy Acknowledgement

- I acknowledge that the Notice of Privacy Practices is available.
  (If you would like to copy the Privacy Practices, please request one at the front desk)
- I acknowledge that due to the current HIPPA laws my doctor is required to obtain a written consent to disclose any Private Health Information in the presence of anyone other than myself.

Please check the corresponding line:

____ **I ALLOW** Obstetrics and Gynecology Associates of Miami, LLC to discuss details of my medical records / financial records with ____

Relation (of authorized person) to patient ____

_____ **I DO NOT ALLOW** Obstetrics and Gynecology Associates of Miami, LLC to discuss details of my medical records/ financial records with anyone else but me.

_____________________________________ ______________________________________

Patient's Signature Patient's Name

____

Date

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