Dear Patient,

Our practice is honored that you have chosen Orange Blossom Women's Group. We strive to perform well above other offices you may have visited in the past, and we hope you will notice the many ways in which we are different. We work to always smile for our patients, while we request the same from them. Everything we do is intended to efficiently deliver to you the best care possible, in a legal and ethical manner. Please ask if you have questions regarding any of our policies or procedures.

Because we make every effort for your appointment to be at the scheduled time, it is very important that we receive all forms one week prior to your visit. If they are not returned complete before your appointment, it is possible that you will have to reschedule. Please fill in ALL blanks, whether or not they apply to you. We prefer that you fax the completed forms to 1-877-260-1182, or you can mail to or drop off at our office.

Please pay special attention to all policies listed, as you are agreeing to adhere to them.

Initial_____ Missed Appointments: There may be a $25 charge for a missed appointment unless you advise us one business day prior to your appointment. Being more than 15 minutes late is considered a late cancellation, and is subject to the same fee.

Initial_____ Completing Forms and Copying Charts: There is a $25 charge for each disability, FMLA, or other medical form to be completed. Please allow 7 days to for the forms to be completed. Copying costs are $1 for the first 25 pages and $.25 each page after.

Initial_____ Payment: Payment is due at the time services are rendered. We accept cash, credit cards, and checks. Per our contracts with the insurance companies we must collect all co-pays prior to your office visit, or your visit may need to be rescheduled. If we are a contracted provider with your insurance company and are able to verify and confirm coverage, you will only be responsible for your co-pay and deductible at the time of your visit. Please note: You will be considered responsible for all visits, labs, and procedures not covered by your insurance. Benefits quoted are an estimation and are not a guarantee of payment, as such you are ultimately responsible to know your policy's terms and conditions.

Initial_____ Percentages due (co-insurance): If your insurance policy only pays a percentage of your visit or surgery an estimate of your amount owed must paid the day of your visit or prior to your surgery. The percentage is based upon the allowed amount. If there is an over payment we will refund the difference to you upon request or it may be applied to future visits.

Initial_____ Returned Check Policy: Non-sufficient funds checks returned to us will require complete payment in cash or certified funds for the amount of the check PLUS any fees allowed by Florida law.

Initial _____ I do give permission for photographs and other audiovisual and graphic materials to be used by the Orange Blossom Women's Group for marketing, education and promotional purposes. Although the photographs or accompanying material will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos.

Initial _____ I do not consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities).

I understand and agree to all the policies above.

_____	_____	_____
Patient Name	Patient/Representative Signature	Date

General Consent to Treat/Patient Authorization/Acknowledgement of Benefits Release/e-Prescribing/Medication

The following are the conditions for services provided by Orange Blossom Women's Group, for the patient whose name appears at the bottom of this page.

Consent for Medical Treatment: I/we voluntarily consent to medical treatment and diagnostic procedures provided by Orange Blossom Women's Group, and its associated physicians, clinicians and other personnel. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

Authorization for Release of Information: The practice and physicians are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning and further medical treatment, to disclose to my employer (if seen for work related exam or injury) insurance and/or any third party payer all medical information, test results and findings made during the course of this examination and/or treatment. To include information referring to psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV for services provided during this visit. I/we also agree to the release of medical or other information about me to government federal or state regulatory agencies as required by law.

Assignment of Insurance Benefits: I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and Orange Blossom Women's Group. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of. I/we understand that Orange Blossom Women's Group, can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected, I/we shall pay all collections fees and cost, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

Acknowledgement of Receipt of Notice of Privacy Practices: I/we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice maybe changed at any time.

I authorize discussion of my general medical condition and diagnosis (including treatment, payment, and health care options) with: ☐ Spouse Children ☐ No One ☐ Other _____

Can we leave a message on your answering machine or voice mail concerning normal lab results, appointment reminders, or other questions? I (the patient) understand that answering machines and cell phones are not secure lines. ☐ Yes ☐ No

I understand that Orange Blossom Women's Group may send postcards or leave voice mail messages for appointment reminders.

I certify that I am the patient or the patient's duly authorized representative and that the information given by me to Provider in applying for payment under Medicare and/or Medicaid programs, insurance plans, or other protection is correct and complete. I understand, acknowledge and agree to the terms set forth above.

Signature: _____ Date: _____ Printed Name _____

e-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan. - Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events. - Fill status notification – allows the prescriber to receive an electronic notice from the pharmacy telling them if patient's prescription has been picked up, not picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Orange Blossom Women's Group can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Orange Blossom Women's Group to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Signature: _____ Date: _____

First Name:_____ MI:_____ Last Name: _____ Date of Birth: _____

Race: Black/African American ___Other Race __Pacific Islander __Patient declined information __White or Caucasian

Ethnic Group: __Hispanic/Latino __Not Hispanic/Latino __Patient declined information

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell Phone: _____

Would you like to receive text and email notifications from the practice? Yes___ No___ Email: _____

Emergency Contact: _____Relationship: _____ Phone: _____

ONLY IF PATIENT IS A MINOR – RESPONSIBLE PARTY INFORMATION

Please fill in ALL blanks

First Name:_____ MI:___ Last Name: _____ Sex: __ M __ F Date of Birth: _____
Phone: _____ Address: _____City: _____ State:____ Zip :_____

INSURANCE INFORMATION – Please fill in ALL blanks

Insurance Company: _____ Claims Address: _____

Insurance telephone number: _____ Group/Policy #: _____ Subscriber/ID #: _____

Policy Holder's Name: _____ Date of Birth: _____

Primary Physician: _____ Preferred Pharmacy (with cross streets:_____

Mail Order Pharmacy: _____ Address: _____ Phone_____

Check, circle, or fill in ALL answers that apply (you may mark more then one choice). Please mark 'none' if it does not pertain to you.

ALLERGIES

Medication	Type of Reaction

CURRENT MEDICATION

Current Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		

First Name:_____ MI:_____ Last Name: _____ Date of Birth: _____

FAMILY MEDICAL HISTORY

Please include ANY family members with the following medical condition

Breast Cancer ☐Yes ☐No Which relative:	Birth Defects ☐Yes ☐No Which relative:
Ovarian cancer ☐Yes ☐No Which relative:	High blood pressure ☐Yes ☐No Which relative:
Uterine cancer ☐Yes ☐No Which relative:	Heart disease ☐Yes ☐No Which relative:
Osteoporosis ☐Yes ☐No Which relative:	Diabetes ☐Yes ☐No Which relative:
Colon cancer ☐Yes ☐No Which relative:	Psychiatric disorder ☐Yes ☐No Which relative:

MEDICAL HISTORY

Do you currently have (or have had) any of the following?

☐None ☐Asthma ☐Atrial fibrillation ☐Adult onset diabetes ☐Anxiety ☐Arthritis

☐Breast cancer ☐ BV ☐Bipolar ☐Bronchitis ☐Cancer (type)_____

☐Chicken pox ☐COPD ☐Compulsive disorder ☐Colon ☐CMV ☐Depression ☐DVT

☐High cholesterol ☐GERD ☐Glaucoma ☐Heart attack ☐Hypertension ☐ Hepatitis

☐HIV/AIDS ☐Hypothyroid ☐Heart disease ☐Infertility ☐Migraines ☐Melanoma

☐Kidney stones ☐Seizures ☐Measles ☐Recurrent UTI ☐Liver disease ☐PMS/PMDD

☐Insomnia ☐Yeast infections ☐Suicide attempt

GYNECOLOGICAL HISTORY

First day of last menstrual period ___/___/___

Regularity of periods

☐Irregular ☐Not sure ☐Every 28 days ☐30-42 day cycle

☐Longer the 42 day ☐Every 14 days ☐Menopausal

First Name:_____ MI:_____ Last Name: _____ Date of Birth: _____

Current Contraception

☐ Oral birth control pills ☐IUD (type) _____ ☐Depo Provera ☐Nuvaring

☐Pull out method ☐Nexplanon (Implant) ☐Permanent sterilization

Which brand of birth control pills are you currently taking?_____ Will you need a refill today ☐Yes ☐No

Menopause

Age of onset of menopause _____

Do you have any menopausal symptoms?

☐None ☐Hot flashes ☐Night sweats ☐Vaginal dryness ☐Mood changes

☐Memory loss ☐Insomnia ☐Weight gain

Sexual concerns

☐None ☐Painful sex ☐Decreased libido ☐No orgasm ☐Burning ☐Vaginal dryness

Date of last mammogram_____☐ Normal ☐Abnormal

Date of last bone density scan_____☐ Normal ☐Abnormal

Date of last colonoscopy_____ ☐ Normal☐Abnormal

Date of last pap smear_____ ☐ Normal ☐Abnormal

History of Abnormal Pap Smear

☐None ☐ASCUS ☐LGSIL ☐HGSIL ☐No treatment ☐Conization ☐Colposcopy ☐LEEP

Follow up pap smears: ☐Normal ☐Abnormal

OBSTETRIC HISTORY

Past pregnancies:

Total # of pregnancies	Total # of miscarriages
Total # of Full term births	Total # of Ectopic/tubal pregnancies
Total # of Preterm births (<36 weeks)	Total # of Multiple births (twins)
Total # of Induced abortions	Total # of Living children

First Name:_____ MI:_____ Last Name: _____ Date of Birth: _____

For each child, please list the following:

	Child 1	Child 2	Child 3	Child 4
Date of birth				
Birth weight				
Type of delivery				
Anesthesia				
Complications				

SOCIAL HISTORY

Tobacco Use: ☐Never ☐Former smoker ☐Current smoker_____

Alcohol Use: ☐NONE Type of Alcohol_____ ☐Occasional ☐Moderate ☐Heavy

Sexual or Physical Abuse ☐NONE ☐Raped ☐Abuse as a child
☐Incest ☐Physical abuse in past ☐Physical abuse currently

SEXUAL HISTORY

Are you currently sexually active ☐Yes ☐No Age of first sexual encounter_____

☐Heterosexual ☐Homosexual ☐Bisexual

Total lifetime sexual partners _____

History of STD

☐None ☐Chlamydia ☐Gonorrhea ☐HPV ☐Warts ☐HIV ☐PID
☐Syphilis ☐Trichomonas ☐HSV (herpes)

Drug Use: ☐NONE ☐Marijuana ☐Cocaine ☐Heroin ☐LSD ☐Methadone
☐Prescription drug abuse

Abuse/Domestic violence: ☐NONE ☐History of rape ☐Abuse as a child ☐Physical abuse

Current abuse _____

SURGICAL HISTORY

☐NONE ☐Appendix ☐Tonsils ☐Gallbladder ☐Tubal ligation ☐Laparoscopy

☐Bladder surgery ☐Orthopedic ☐Hysterectomy ☐Lumpectomy ☐Mastectomy

☐Abortion ☐Other_____

Orange Blossom WOMEN'S GROUP

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____ Last Four of SS# Only: _____

Please send the requested information below:

Entire Medical Record: ☐ Office Notes: ☐ Test Results: ☐ Radiology Reports: ☐

Referrals: ☐ Consults: ☐

Reason for the request: Transfer of Care: ☐ Healthcare: ☐ Personal: ☐

I authorize Orange Blossom Women's Group to obtain records from:

Provider Name: _____

Address: _____

City, State, Zip: _____

Phone number: _____

Fax number: _____

I authorize Orange Blossom Women's Group to send records to:

Provider Name: _____

Address: _____

City, State, Zip: _____

Phone number: _____

Fax number: _____

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 12 months following the date of my signature shown below. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature:_____ Date: _____

Office Use Only

Received Date:_____ Date Faxed: _____

Orange Blossom Women's Group 2043 Little Road Trinity, Fl 34655
Phone (727) 846 - 7000 Fax: (877) 260-1182

CONSENT FOR PELVIC EXAMINATION

Florida Statute Section 456.51 (Consent for Pelvic Exam) requires the written consent of a patient or the patient's legal representative before a healthcare practitioner may perform a pelvic examination on a patient. By signing below, the patient (or patient's legal representative) acknowledges that she has been given the opportunity to ask questions about the pelvic examination before signing this Consent for Pelvic examination. And that the patient (or the patient legal representative) has voluntarily agreed to the pelvic examination by a healthcare practitioner. If the patient lacks the capacity to sign this Consent for Pelvic Examination, this form will be signed by the person authorized to consent for the patient.

___ I **DO NOT CONSENT** to a pelvic examination by a healthcare practitioner.

___ I **CONSENT** to a pelvic examination by a healthcare practitioner.

I have ready and fully understand the above statement and the explanations. The consent was given freely and voluntarily.

_____
Name of Patient

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed name of Patient or Legal Representative

_____
If Legal Representative, Relationship to Patient

_____ _____
Signature of Witness Date

_____ _____
Printed Name of Witness