1447Medical Park Blvd., Suite 401
Wellington, FL 33414

Office 561-798-4100
Fax 561-798-4351

Isaac Halfon, M.D., F.A.C.O.G.

Obstetrics & Gynecology

WELCOME TO OUR PRACTICE!

Thank you for choosing the office of Isaac Halfon, M.D. We look forward to providing you with professional health care in a friendly and welcoming environment. This letter is designed to provide you with important information that most new patients find valuable. Please take a moment to read though this information.

YOUR FIRST VISIT

- Please arrive a few minutes prior to your scheduled appointment with the completed new patient paperwork attached.

WHAT TO BRING

- Completed New Patient Paperwork
- Your Insurance Card, if applicable
- Your Photo ID
- Referral from your Primary Care Physician, if applicable
- Method of Payment

APPOINTMENTS

- As a courtesy to other patients, please call the office as soon as possible if you are going to be late.
- If you are unable to keep your appointment, we ask that you provide notice of at least 24-hours in advance so we may offer that time to another patient.

We are looking forward to meeting you soon. Please visit our website for additional information (www.halfonmd.com).

Sincerely,

Isaac Halfon, M.D., F.A.C.O.G

IH/jm

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*

Race/Ethnicity ___
Raza/Etnia

(Check One) ☐ Employed ☐ Retired ☐ Full-Time Student
Marque Uno *Empleada* *Retirada* *Estudiante Tiempo Completo*

☐ Other ___
Otro

Employer ___
Empleador

Work Phone (___) ___
Telefono de Trabajo

Home Address ___
Direccion del Hogar

City ___ State ___ Zip ___
Ciudad *Estado* *Codigo Postal*

Email Address ___

Home Phone (___) ___ Cell Phone (___) ___
Telefono del Hogar *Telefono Cellular*

I was referred to: ___ by / *por*
Fui recomendado por

☐ Friend ___ ☐ Relative ___
Amigo *Familiar*

☐ Physician ___ ☐ Insurance ___
Médico *Seguro*

☐ Reputation of the LLC's Physicians ___
Reputación de los Médicos del LLC

☐ Existing Patient of the LLC ___
Paciente Existente de la LLC

☐ Other ___
Otro

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 ☐ Worker's Compensation ☐ 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 ☐ Worker's Compensation ☐ 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:*

Social Security # ___
Numero de Seguro Social

First Name ___ Middle ___
Primer Nombre *Segundo Nombre*

Last Name ___
Apellido

Sex ___
Sexo

Home Phone (___) ___
Telefono del Hogar

Work Phone (___) ___
Telefono del Trabajo

Pharmacy - *Farmacia*

Pharmacy ___
Farmacia

Pharmacy Phone ___
Numero de telefono de la farmacia

Pharmacy Address ___
Direccion de la farmacia

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 ___ / ___ / ___
Sexo *Fecha de Nacimiento*

Daytime Phone (___) ___
Teléfono durante el dia

Employer ___
Empleo

Address ___
Direccion

City ___ State ___ Zip ___
Ciudad *Estado* *Codigo Postal*

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 compañia 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 judgements 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 judgements 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 compañia de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico.

PATIENT'S / GUARANTOR'S SIGNATURE ____________________ DATE ____________

FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, American Express and Discover. We will be happy to help you process your insurance claim form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit. In special instances, we may accept assignment of insurance benefits.

There will be a $50.00 charge or 5% of the check amount, whichever is greater, added to your account balance for checks returned unpaid by your bank. In addition, interest will be accrued for balances over 30 days at 18% per annum and a 35% collection fee added to account balances over 90 days.

Charges may also be assessed to your account for missed appointments and appointments cancelled without 24-hours advance notice.

We will gladly discuss your proposed treatment and answer questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, or 80%) of "U.C.R." "U.C.R." is defined as usual, customary, and reasonable fees for this region. Thus, our fees are considered usual, customary, and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact the Office Manager promptly for assistance in the management of your account.

For our HMO patients: **Your insurance carrier requires you to have a referral for every visit to Dr. Halfon. (Some do allow one well woman check up per year without a referral.) It is <u>your</u> responsibility to obtain your referral prior to your visit with Dr. Halfon. If you do not have your referral, your visit will have to be rescheduled (delaying your treatment and care.)**

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

ASSIGNMENT OF BENEFITS

I hereby instruct and direct _____________________________ Insurance Company to pay by check made out and mailed to:

Isaac Halfon MD FACOG 1447 Medical Park Blvd, Suite 401, Wellington, FL 33414

or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Isaac Halfon MD FACOG 1447 Medical Park Blvd, Suite 401, Wellington, FL 33414

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

- A photocopy of this assignment shall be considered as effective and valid as the original.
- I authorize Isaac Halfon M.D., to deposit checks received on my account.
- I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
- I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

If appointments are NOT cancelled in advance, a $25.00 charge will be applied to your account.

Dated at Wellington, FL on _______/_______/20_______

____

Signature of Policyholder

____

Signature of Claimant if other than Policyholder

Notice of Privacy Acknowledgement

Isaac Halfon, M.D., LLC

I understand under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand this practice has the right to change its Notice of Privacy Practices and I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

______________________________ ____/____/20____

Patient Name of Legal Guardian (print) Date

____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:
Date: ____/____/20____ Attempt: ______________________________
Staff Name: ______________________________

MALPRACTICE INSURANCE NOTICE

Dear Patients,

By law, all physicians practicing in the state of Florida must notify their patients if they do NOT carry malpractice insurance. The malpractice insurance for Obstetricians and Gynecologist is not affordable and difficult to obtain. For this reason, myself and most other Obstetricians and Gynecologist in this state, have chosen NOT to carry malpractice insurance. I will provide you with the highest quality of medical care. Thank you for choosing our office for your medical needs.

Below is a copy of the official state statute S.458.320(5)(g)5 posted in the office:

"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 DOCTOR 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"

Thank you.

Isaac Halfon, M.D., F.A.C.O.G.

I, ________________________________ (print name) have read and understood the above Malpractice Insurance notice

________________________________(please sign your name and date)

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Authorization to Release Information to Family Members

Many of our patients allow family members, such as their spouse, significant other, parents or children to call and request results of test, procedures and financial information. Under the requirements for H.I.P.A.A., we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results, and/or financial information released to any family member, you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize the office of Isaac Halfon, M.D., to release my records and any information to the following individuals,

1. ______________________ Relation to Patient: __________

2. ______________________ Relation to Patient: __________

3. ______________________ Relation to Patient: __________

4. ______________________ Relation to Patient: __________

5. ______________________ Relation to Patient: __________

______________________ ______________________
Patient Name (Print) Patient Signature

_____/_____/20_____
Today's Date

Isaac Halfon, M.D., F.A.C.O.G.
Self Medical History

Today's Date: ____/_____/____

Last Name: ______________________ First Name: ________________ DOB: ____/_____/____ Age: _______

PAST MEDICAL HISTORY - Do you have any of the following? Check all that apply.

___ High Blood Pressure
___ Heart Disease
___ Blurred Vision
___ High Cholesterol
___ Dizzy Spells
___ Mononucleosis
___ Accidental Loss of Urine
___ Kidney/Bladder Disease
___ Gallbladder Disease
___Hepatitis/Liver Disease
___ Thyroid Disease
___ Varicose Veins
___Difficulty Breathing
___Migraines
___Severe Headaches
___ Other ____

___Epilepsy/Seizures
___ Wt Gain >10 lbs
___Wt Loss >10 lbs
___Nose Bleeds
___Skin Condition
___Breast Lumps
___Fevers or Hot Flushes
___Abnormal Pap Smears
___ Pelvic Infections
___ Uterine Fibroids
___Vaginal Itch
___Vaginal Discharge
___Pelvic Pain
___Genital Warts
___Gonorrhea

___Herpes
___Chlamydia
___Othr Sexually Transmitted Disease
___Cough
___Constipation
___Diarrhea
___Stroke
___Cancer
___Diabetes
___Blood Clots
___Anemia
___Depression
___Heartburn

SURGICAL HISTORY – Please list all surgeries you have had in your lifetime (including any cosmetic surgery)

____
____
____

FAMILY HISTORY – Please list family members and any illnesses

Father __ Alive __Deceased Illness______________
Mother __ Alive __Deceased Illness ______________
Sibling __ Alive __Deceased Illness ______________
Sibling __ Alive __Deceased Illness ______________
Sibling __ Alive __Deceased Illness ______________

Maternal Grandmthr __ Alive __Deceased Illness________
Maternal Grandfthr __ Alive __Deceased Illness________
Paternal Grandmthr __ Alive __Deceased Illness________
Paternal Grandfthr __ Alive __Deceased Illness________
Other ______________________________________

Have any member(s) of your family had uterine cancer, breast cancer or colon cancer? ____________________

OB/GYNECOLOGICAL HISTORY

Do you have children? ___ Yes ___ No How many biological children? ___________
Have you had any spontaneous abortions? ___ Yes ___ No How many? _____________
Have you had any abortions? ___ Yes ___ No How many? _____________

SOCIAL HISTORY

Are you ___Single ___Married ___Divorced ___Widowed
Alcohol Use ___None ___Daily ___Weekly ___Social/Holiday
Smoker? ___Yes ___ No
Drugs (Marijuana or Other) ___Yes ___No

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CONGRATULATIONS ON YOUR PREGNANCY!

I am very happy for you. I want to share some of the do and don'ts of pregnancy.

A healthy diet is very important. I suggest you eat 5 meals a day instead of the standard, breakfast, lunch, and dinner. This would mean eating a much smaller portion with each meal. The idea being that by eating more times a day you will always have food in your stomach and this should decrease the gastric acids which cause nausea and vomiting in pregnancy. I suggest snacks such as melba toast, dry toast, and saltine crackers. Every patient is different and thus will tolerate different foods. I encourage you to try a variety of snacks. Pregnancy is not a time to diet. We simply want you to eat a healthy diet. By eating the adequate amount of protein, starch, vegetable, and fruits in your diet, you will create a healthy environment for your baby and minimize your weight gain. The appropriate weight gain for a female with ideal body weight is 25-30 pounds.

Fish is a good source of DHA. But, you should not eat any raw fish or sushi. Some fish contain more mercury than others. Sword fish and bottom feeding fishes such as flounder are not recommended. You should not eat more than two cans of Tuna fish per week.

Deli Meat should not be eaten at any time during your pregnancy. This includes all processed and natural cut meats. Hot dogs and sausages should also not be eaten at all. There is a small risk of Listeria. If you had eaten any of these foods and experienced diarrhea, then you should be tested for Lysteria.

All foods should be thoroughly cooked and not red in the middle. You should not eat any raw meats.

Nausea and vomiting in the first trimester or the first twelve weeks of pregnancy is common. Ginger is a natural product that is safe during pregnancy and can reduce the nausea or vomiting. Ginger can be found has hard candy, gummies, pickled, or cooked. Any form of Ginger can combat nausea or vomiting. Ginger Ale is also helpful. It is important to always keep well hydrated. Drinking water is very important. Gatorade and natural coconut water is a good method of re hydrating. Please try to decrease fruit juices especially orange juice, cranberry juice, or apple juice. All-natural fruit juices contain a high amount of sugar and thus should be limited. All soft drinks should be illuminated from your diet.

Caffeine can be found in coffee, tea, and chocolates. The recommendation is not to have more than one cup of coffee per day. Or in other words, no more than one cup of caffeine per day.

Exercise is important, but should be limited. Early in pregnancy the exercise program should be less aggressive, and you not should get your heart rate above 100. Stairmaster, stationary bicycle, rowing, and swimming are excellent. As your pregnancy progresses, squatting and lifting weight become more dangerous.

Provide your Doctor with a list of all medications taken. Any medications given by another Physician should be approved by your Obstetrician. In general, Tylenol is safe in pregnancy. It is ok to take Tylenol for headaches.

Never take Motrin, Advil, or Ibuprofen products during pregnancy.

Prenatal vitamins are important and should contain DHA. Gummy pre-natal or other over the counter pre-natal vitamins do not contain sufficient minerals or iron. Prescription Pre-natal vitamins are recommended and should be taken daily. There are numerous name brands and if one does not settle well there are many other prescription pre-natal vitamins that can be sampled.

Sex is safe in pregnancy as long as there is no vaginal bleeding.

Jacuzzi tubs or hot tubs are not recommended at any time during pregnancy. This would also include hot baths. Showers are ok. Increased body temperature during pregnancy can cause mental retardation. Sun tanning is not recommended.

Hair dyes and nail polishes are also not recommended.

Fetal movements are very important. You will begin to feel flutters and then the fetal kicks are palpable after 26 weeks. If you feel the baby is not moving well, then lay on your right side and count the fetal movements in a one-hour period. The baby when being tested, should move at least 10 times in a one-hour period of time. If the baby does not move 10 times in one hour than come to the Labor and Delivery Department at the Hospital and the baby will be formally tested with a BPP and NST.

If you have any Emergencies after hours call 911 or go to the nearest Emergency room. You do not have to call your Doctor's office prior to going to the hospital. Immediately upon your arrival at the Emergency room or Labor and Delivery, your Doctor will be notified.

All pregnant patients are able to obtain a same day office appointment. As long as the Doctor is not in surgery, you are welcome to come into the office for evaluation. If you are having contractions, bleeding, or feel leakage of fluid, then we prefer you be checked at the hospital.

Occasional Contractions (Braxton-Hicks) are normal at 38 weeks of pregnancy. But, you should not have any contractions prior to 38 weeks. If contractions are persistent then come into Labor and Delivery for evaluation of Premature Labor. Bleeding is also not normal anytime during pregnancy. Always come into Labor and Delivery for evaluation of vaginal bleeding. Also, if you feel you are leaking vaginal fluid or may have broken your bag of water, then also come into Labor and delivery.

All your questions are important. I recommend they be written down prior to your appointment, so that all your questions can be answered.

I always try to be the attending Physician at the delivery, but no promises are ever made because one cannot predict the future. There is an in-house Hospitalist group which covers the practice when the Doctor is away at a Medical Conference or vacation. Always present to Labor and Delivery and give Dr. Halfon's name and he or the Doctor on call will be notified of your arrival.

I look forward to taking care of you during the next 10 months.

Isaac Halfon, M.D.