Osceola Gynecology, LLC

INFORMACIÓN DE REGISTRO

Proveedor de Referencia: _____ **Médico Primario:** _____

Primer Nombre: _____ Apellido: _____

Número de Seguro Social: _____-_____-_____ Fecha de Nacimiento: ___/___/___ Edad: _____

Dirección Postal: _____

Cuidad: _____ Estado: _____ Código Postal: _____

Estado Civil: ○ Soltera ○ Casada ○ Divorciada ○ Viuda ○ Separada

Teléfono de la Casa: ( )-_____-_____ Teléfono Celular: ( )-_____-_____

Teléfono del Trabajo: ( )-_____-_____

Mejor número para comunicarnos con usted:

Día: ○ Casa ○ Celular ○ Trabajo

Noche: ○ Casa ○ Celular ○ Trabajo

Empleador: _____

Contacto de Emergencia: _____ Relación: _____

Teléfono: ( )-_____-_____

Correo Electrónico: _____

Información del Asegurado Responsable - Favor de llenar todos los espacios en blanco

Si usted (el paciente) es el asegurado responsable (la persona que tiene la póliza de seguro), marque "sí mismo" y siga a la "Información de Seguros." Si su cónyuge o padres tienen la póliza de seguro, marque la casilla correspondiente y continúe.

Relación del paciente al asegurado responsable: ○ Si Mismo ○ Cónyuge ○ Dependiente

Primer Nombre: _____ Apellido: _____

Número de Seguro Social: _____-_____-_____ Fecha de Nacimiento: ___/___/___ Edad: ____

Dirección Postal: _____

Cuidad: _____ Estado: _____ Código Postal: _____

Empleador: _____ Teléfono de Trabajo: ( )-_____-_____

Información de Seguro – Favor de llenar todos los espacios en blanco

Compañía de Seguro: _____
Número de Teléfono: _____
ID del Suscriptor: _____
Número de Grupo: _____

CONSENTIMIENTO PARA TRATAMIENTO: Autorizo Osceola Gynecology para realizarlos tratamientos o procedimientos aprobados por mi médico. Reconozco que no hay garantías, ya sean expresadas o implícitas, con respecto al resultado de mis tratamientos y/o procedimientos. Entiendo que la naturaleza y la finalidad del procedimiento, los posibles métodos alternativos de tratamiento y los riesgos involucrados y las posibilidades de complicaciones serán explicados a mí antes de cualquier procedimiento y/o tratamientos.

_____ _____

Firma del Paciente Fecha

Responsabilidades del Consumidor

Declaración de las Responsabilidades

En un sistema de salud que protege los derechos del consumidor, es razonable esperar y alentar a los consumidores a asumir responsabilidades razonables. Una mayor participación individual de los consumidores en su cuidado aumenta la probabilidad de lograr los mejores resultados y ayuda a apoyar una mejora de la calidad, en un medio ambiente consciente de los costos. Dichas responsabilidades incluyen:

- Asumir la responsabilidad de maximizar los hábitos saludables, como hacer ejercicio, no fumar y comer una dieta saludable.
- Involucrarse en decisiones específicas de atención de la salud.
- Trabajar en colaboración con el médico en el desarrollo y la ejecución de los planes de tratamiento acordados.
- Revelar la información relevante y comunicar con claridad los deseos y necesidades.
- Utilizar procesos de queja y apelación interno del plan médico para orientar las preocupaciones que puedan surgir.
- Evitar la propagación de enfermedades a sabiendas.
- Reconocer la realidad de los riesgos y los límites de la ciencia de la atención médica y la falibilidad humana del profesional de la salud.
- Sea consciente de la obligación de los médicos a ser razonablemente eficiente y equitativo en la atención de otros pacientes y la comunidad.
- Conocer acerca de sus opciones de planes de cobertura de salud y planes de salud (cuando esté disponible) incluyendo todos los beneficios cubiertos, limitaciones y exclusiones, las normas relacionadas con el uso de proveedores de la red, las reglas de cobertura y de remisión , los procesos apropiados para asegurar la información adicional, y el proceso de apelar las decisiones.
- Mostrar respeto por otros pacientes y trabajadores de la salud.
- Hacer un esfuerzo de buena fe para cumplir con las obligaciones financieras.
- Cumplir con los procedimientos administrativos y operativos de los planes de salud, médicos y programas de beneficios de salud del gobierno.
- Informar acerca de delitos y fraudes a los recursos o/a las autoridades legales.

Patient Rights/Derechos del Paciente

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you also respect the health care provider's or facility's right to expect certain behavior from you. You may request a copy of the full text of this law from your nurse. We have provided for you a summary of your rights and responsibilities from this law, and those provided to you through additional hospital policy, regulatory and accrediting requirements.

Respect and Dignity: You have the right to participate in decisions regarding your medical care, and to be treated with courtesy and respect, with appreciation of your dignity, and protection of your need for privacy. You have the right to a prompt and reasonable response to your questions and requests. You have the right to know what rules and regulations apply to your conduct. You have the right to get information about your care in your language, and to know what patient support services are available, including whether an interpreter is available if you do not speak English. You also have a right to communication in a manner that meets your needs, including assistance with vision, speech, hearing, or cognitive impairments.

You have the right to be informed about the care you will receive, and to know when something goes wrong with your care. You have the right to ask questions and to be listened to. You may refuse at any time recordings or other images made for purposes other than your care. You have the right to be from neglect, exploitation, and any type of abuse. You also have the right to resolve conflicts that may arise regarding your care; see the section titled Conflicts Concerning Care of the Patient in this brochure.

You have the right to express grievances regarding any violation of your rights, as stated in Florida law, through the Hospital's grievance procedure and to other agencies, including the Florida Department of Health and The Joint Commission. We are committed to continually improving our services and would appreciate and request the opportunity to first hear your grievance and provide you with a resolution. Please ask to speak with the nursing director of your patient care area, or the Hospital's risk manager. Voicing a complaint does not in any way jeopardize your care.

If you prefer not to bring your concern to our attention, you may also file a grievance with the following:

1. Florida Department of Health Consumer Services Unit at 4052 Bald Cypress Way, Bin C75, Tallahassee, Florida 32399-3275, or by telephone at (888) 419-3456.

2. Joint Commission at Office of Quality Monitoring, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181, or by telephone at (630) 792-5636.

Access to Care: You have the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment. You have the right to treatment for any emergency medical condition that will deteriorate if treatment is not provided. You have the right to know who is providing you medical services and who is responsible for your care. You also have the right to be given, by your physician, information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis. You have a right to pain management. You may refuse any treatment, except as otherwise provided by law. If you refuse treatment or care that is the sole basis for hospitalization, or would result in care below known professional standards of care, you may be requested to leave, be transferred to another facility, or we may be required to report your refusal to other state agencies.

Access to Information: You have the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for your care. If you are eligible for Medicare, you have the right to know, upon request and in advance of treatment, whether your health care provider or the Hospital accepts the Medicare assignment rate. You have the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care. You are entitled to receive a copy of a reasonably clear and understandable, itemized bill and, if you request, to have the charges explained.

We must tell you if medical treatment is for purposes of experimental research and you must be given the opportunity to give your consent or refusal to participate in such experimental research. You have the right to access, request amendment to, and obtain information on disclosures of your health information, in accordance with law and regulation.

Your Responsibilities: You are an integral member of the health care team. Your health and safety is enhanced by your willing participation in your recovery. You are responsible for providing your physician and our staff, to the best of your knowledge, accurate and complete information about your present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.

You are responsible for reporting unexpected changes in your condition and for communicating promptly whether or not you comprehend a contemplated course of action and/or what is expected of you. You are also responsible for following the treatment plan recommended by your doctor which includes instructions provided by nurses and other allied health providers. You are responsible for communicating any concerns you have about your treatment, care, environment, or other issues that may impact your care, hospitalization or recovery.

You are responsible for your actions if you refuse treatment or do not follow the physician's instructions. You are responsible for following the Hospital's rules and regulations affecting patient care, respecting hospital property and your conduct as well as the conduct of those who visit you. This includes, but is not limited to, following instructions related to visitors, treating your caregivers with respect, requests related to security issues, dietary restrictions, not smoking, maintaining a quiet environment for others, and refraining from consuming substances, medication and/or foods from outside sources.

You are responsible for keeping appointments and, when you are unable to do so for any reason, for notifying us or your physician. You are responsible for assuring that the financial obligations of your health care are fulfilled as promptly as possible.

Privacy and Confidentiality: You have the right, within the law, to personal and informational privacy. You have the right to:

- Refuse to talk with or see anyone not officially connected with the hospital, including visitors, or persons officially connected with the hospital but not directly involved in your care.
- Be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy. This includes the right to have a person of your same sex present during certain parts of a physical examination, treatment, or procedure performed by a health professional of the opposite sex and the right not to remain disrobed any longer than is required for accomplishing the medical purpose for which you were asked to disrobe.
- Expect that any discussion or consultation involving your case will be conducted discreetly and that individuals not directly involved in your care will not be present without your permission.
- Have your medical record read only by individuals directly involved in your treatment or in the monitoring of its quality and by other individuals only on your written authorization or that of your legally authorized representative.
- Expect all communications and other records pertaining to your care, including the source of payment for treatment, to be treated as confidential.
- Request a transfer to another room if another patient or a visitor in the room is unreasonably disturbing you by his/her actions.
- Be placed in protective privacy when considered necessary for personal safety.

Personal Safety/Restraints: You have the right to receive care in a safe setting, and to be free from mental, physical, social, and verbal abuse, neglect and exploitation. You have the right to access protective or advocacy services. You have the right to be free of restraints (or seclusion) of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.

Identity: You have the right to know the identity, function, and qualifications of individuals providing service to you and to know which physician or other practitioner is primarily responsible for your care. You may request such information from your provider or the Hospital. This includes the your right to know of the existence of any professional relationship among individuals who are treating you, as well as the relationship to any other health care or educational institution involved in your care. You have a right to refuse to allow students in clinical training programs to participate in your care.

Communication: You have the right to access communication with others outside the hospital by means of visitors and by verbal and written communication. If you need assistance with communicating with family or your health care provider(s), please let your nurse or physician know so that we can provide you with assistance.

Plan of Care: You have the right to participate in the development and implementation of your plan of care prior to and during the course of your treatment. You have the right to refuse a recommended treatment or plan of care to the extent permitted by law and to be informed of the medical consequences of this action. If you refuse treatment, you are entitled to other appropriate care and services that the hospital provides or transfer to another hospital. We will notify you of any policy that might affect patient choice within the hospital. You have the right to exclude any or all family members from participating in your health care decisions. You may at any time request additional consultation with a specialist.

Consent : You have the right to participate in informed decision-making regarding your health care. To the degree possible, this should be based on a clear, concise explanation of your condition and of all proposed technical procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation and probability of success. Your physician is responsible for providing you with this information. You should not be subjected to any procedure without your voluntary, competent and understanding consent. You should be informed when medically significant alternatives for care or treatment exist.

You have the right to know who is responsible for authorizing and performing the procedures or treatment. Your consent is required for recording or filming made for purposes other than the identification, diagnosis, or treatment. You may request cessation of recording or filming and you may rescind consent for use up until a reasonable time before the recording or film is used. You and others you authorize have the right to be informed about the outcomes of care, including unanticipated outcomes. Your physician is responsible for explaining the outcome of treatments or procedures you authorize whenever the outcome differs significantly from the anticipated outcome.

Transfer and Continuity of Care: You may not be transferred to another facility unless you have received a complete explanation of the need for transfer and of the alternatives to such a transfer, following all EMTALA and other applicable laws for transfers between health care facilities. You have the right to be informed by the practitioner responsible for your care, or his/her delegate, of any continuing health care requirements following discharge from the hospital.

Hospital Charges: Regardless of the source of payment for your care, you have the right to request and receive an itemized and detailed explanation of your total bill for services rendered in the hospital. You also have the right to timely notice prior to termination of your eligibility for reimbursement by any third-party payer for the cost of your care.

Pain Management : You have the right to an initial assessment and regular reassessment of your pain. You have the right to expect that all relevant care providers have been educated in pain assessment and pain management. You and those you authorize have the right, when appropriate, to receive education regarding their roles in managing pain as well as the potential limitations and side effects of pain treatments. You have the right to know, after taking into account your cultural, spiritual, and/or ethical beliefs, that pain management is an important part of your care.

Conflicts Concerning Care of the Patient : Occasionally, a conflict will develop between the patient (and/or a parent or guardian, in the case of minors) and the hospital staff or physician concerning your care. Should this occur, it is the responsibility of the patient (or guardian, if appropriate) to inform the Department Director of the conflict. The Department Director will attempt to resolve the matter. If s/he cannot, s/he will refer the matter to the Chief Nursing Officer, or his/her designee, who will review the matter with the patient (or guardian). Presentation of a complaint does not in itself serve to compromise a patient's future access to care. An Ethics Committee consultation is always available as a non-judgmental forum for the resolution of bio-ethical issues and conflicts regarding patient care.

Osceola Gynecology, LLC

SU COMPAÑÍA DE SEGUROS REQUIERE QUE SE COLECTE SU CO - PAGO EN EL MOMENTO DEL SERVICIO.

Usted es responsable de TODOS los pagos de co-seguro y deducible después de que su seguro procesa su reclamo.

Si usted tiene un deducible será recogido un mínimo de$ 50 en el momento del servicio.

ACEPTAMOS EFECTIVO, CHEQUES Y TARJETAS DE CRÉDITO/DÉBITO.

Por favor haga los cheques a nombre de:
Osceola Gynecology
Gracias por su cooperación.

Al inicial aquí _____, yo reconozco que soy consciente y entiendo que los servicios no cubiertos por mi compañía de seguros son mi responsabilidad financiera y de acuerdo al respecto se me cobrará y se me facturará [por correo.

OSCEOLA GYNECOLOGY

Reconocimiento de Recibo
Del
Avisode Prácticasde Privacidad

He recibidouna copia del AvisodePrácticas de Privacidad deestaoficina.

_____
Imprima Su Nombre

X_____
Firma

_____
Fecha

Por favor escribalos nombres decualquier persona queelpersonal de la oficinapuede divulgarinformaciónen su nombre. Si no estánen esta lista,nose dará informaciónrespecto a su cuidadoo condición.

Nombre y Relación	Teléfono
_____	_____
_____	_____

Solo para uso de Oficina:

Intentamos obtenerconfirmaciónpor escrito del Reconocimiento dela Notificaciónde prácticas de privacidad, pero no se pudoobtener la confirmación porque:

_____ Individuose negó aaceptar la notificación

_____ Individuo se negóa firmarel reconocimiento

_____ Individualno pudo firmar

_____ Una situación de emergencianosimpidió obtener la confirmación.

_____ Otro:

_____

X_____
Firma De Empleado(a) Fecha

Póliza de Cancelaciones y de No Presentarse

Nuestro objetivoes proporcionaratención médica de calidaden el momento oportuno. Con el fin dehacerlo posible hemos tenido queimplementar una póliza deCancelacionesde Citasy de No Presentarse. Esta pólizanos permiteutilizar mejorlas citasdisponiblespara nuestrospacientesque necesitan atenciónmédica.

Por favor,secortés yllame a nuestra oficinasi ustedno puede asistir auna cita. Si esnecesario que ustedcancele sucita, por favorpóngase en contacto connuestras oficinasa másde veinticuatrohoras (24 horas) de anticipación.Sucancelación anticipada le dará a otrapersonala posibilidad de teneracceso a la atenciónmédica oportuna.

Cada vez que unpaciente pierdeuna citasin darnotificación (No Presentarse),otro pacienteseve impedido de recibiratención. El hecho de noestar presenteen el momento desu cita programadaserá registradoen la historia clínica, yse accederá aunacuota administrativa de $25.00 ala cuenta.Una cartaserá generada yenviada por correo aladirección registradapara avisar alpacientede queno han podidopresentarse auna cita. Si un individuo tienetres (3) citas de No Presentarse en unperiodo de un año, pueden ser dados de alta dela práctica.

Si bien entendemos quepueden surgirsituaciones que previenen que los pacienteslleguena sucitaa tiempo,si el pacientese tarda más de(15) minutos asucitasin notificar ala oficina, lacita podrá sercancelada o reprogramada. Si tiene algunapregunta sobre esta póliza, por favorconsulte con nuestro personaly estaremosencantados deaclarar cualquierduda que pueda tener.

Al firmar este documento, usted reconoce que usted ha sidopresentadoconla póliza anterior.

Imprima su Nombre_____ Firma_____

Fecha_____

Osceola Gynecology, LLC

Anthony Gyang, M.D.

St. Cloud Office

3004 17th Street

St. Cloud, FL 34769

Phone: 407-556-3973

Fax: 321-805-4718

Kissimmee Office

505 West Oak Street

Kissimmee, FL 34741

Phone: 407-483-7777

Fax: 407-483-7778

Orlando Office

2877 Delaney Ave

Orlando, FL 32806

Phone: 407-483-7777

Fax: 407-483-7778

AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Social Security:

Medical Records to be released from:

_____

_____

Authorization For Release To:

I hereby authorize you to release a copy of my medical records to the name listed below:

_____

_____

I understand this medical record may contain information about drug abuse, alcohol abuse, venereal disease, abortions, AIDS/HIV testing and/ or mental health treatment.

I understand that I may revoke this consent at any time, except where information is already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

Print Name_____

Sign name_____ Date_____

Osceola Gynecology, LLC

Fecha de hoy: ___/___/___
Nombre: _____ Fecha de Nacimiento: ___/___/___
Razón de su visita: _____
Número de Embarazos: Vaginal: _____ Cesárea: _____ Aborto Involuntario/Aborto: ___
Ultimo ciclo Menstrual: ___/___/___ Es Usted sexualmente activa? SI o NO
ALERGIAS: _____

Lista de Medicamentos:	**Dosis:**

Nombre de Farmacia: _____**Teléfono:** _____

Condiciones Médicas: _____

Historial de Cirugías: _____

Favor de marcar con un círculo que corresponda a su historial médico familiar:

Cáncer de Seno Cáncer del Ovario Cáncer Uterino Cáncer Cervical

Cáncer del Colon Melanoma

Ultimo Papanicolaou:	Antecedentes de Papanicolaou anormal?
Ultima Mamografía:	Antecedentes de Mamografía anormal?
Ultima Colonoscopía:	Antecedentes de Colonoscopía anormal?

Bebe usted alcohol? **Si/No**
Usted fuma? **Si/No**
Alguna vez has sido víctima de abuso sexual? **Si/No**

Historial de Cirugias :

Liste las cirugias:	**AÑO/FECHA:**
1.	
2.	
3.	
4.	
5.	

Condiciones Medicas:

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10**

Historial medico de la familia: Breast Cancer Ovarian Cancer Uterine Cancer Cervical Cancer Colon Cancer Melanoma

Acerca de su vida social: Fuma Si/No Toma Alcohol: Si/No Historial de abuso sexual: Si/No

Lista de Medicamentos:

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10**

Nombre de la Farmacia preferida: _____

Localidad/Tel#: _____

Print name: _____

Signature: _____ Date:_____

Osceola Gynecology, PLLC

Self-Pay Specimen Agreement

At the time of your visit, Dr. Gyang might require or recommend laboratory work. As a self-pay patient, it will be your responsibility to pay or be billed by the provider testing the samples collected at the office or at their location.

For additional information, please speak to one of our staff before seeing the Dr. Gyang.

Signature_____ Date_____

Osceola Gynecology, PLLC

Yearly Well-Woman Exam

The Yearly woman exam includes:

- Pap Smear
- Breast Exam

Any other exams and/or procedures such as Ultrasounds, Lab work, etc. are NOT PART of the Yearly Woman Exam and will NOT be covered by your insurance company. You may incur or be liable for some fees/costs if other exams are perform.

For additional information, please speak to one of our staff before seeing the Dr. Gyang.

Signature_____ Date_____