Aventura OB-GYN Specialists
Dr. Lev Kandinov Dr. Alex Birman Dr. Arthur Schatz
2627 NE 203rd Street Suite 115, Aventura, FL 33180
phone: (305) 931-8844 fax: (305) 935-4113
web: www.aventuraobgyn.net

PATIENT REGISTRATION FORM

Today's date:			PCP:	
PATIENT INFORMATION				
Patient's Last Name: First:			Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid
Birth Date: ____ / ____ / _____	Age:	Social Security no.:		Cell Phone: (_____) _____
Street address:				Home Phone: (_____) _____
City:			State:	ZIP Code:
Occupation:	Employer:			Employer phone no.: (_____) _____
E-Mail Address:				
Pharmacy name, phone number:				

ALL FEES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED

INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				
Name of secondary insurance:	Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other				

IN CASE OF EMERGENCY		
Name of local friend or relative (not living at same address):	Relationship to patient:	Phone number:

_____ _____

Patient/Guardian signature *Date*

What is your main reason for coming to the doctor today?_____

_____

Menstrual History

Age at which periods started:____Number of days separating the beginning of each cycle: ___

# of days period lasts:_____

Date of last Pap smear: ____/____/____

Date of last period start: ____/____/____

If menopausal, age at which periods ended:_____Have you ever taken hormones? _____

What are you using for Birth control? _____

History of STD's (gonorrhea, chlamydia, HPV, trichomonas, HIV, herpes syphilis)? _____

_____

_____

Pregnancy History

# of pregnancies:_____# of therapeutic abortions:_____

# of miscarriages:_____# of children born alive:_____# of stillbirths: _____

Have you ever had any blood transfusions? _____

Have you ever taken a fertility drug of any kind?_____Which? _____

Have any of your children had birth defects of any kind? _____

_____

Summary of Previous Pregnancies:

Date	#Weeks	Birth Weight	Sex	Delivery Type	Anesthesia	Comment/ Complications	Location (city, state)

Date of Last: Mammogram _____

Bone Density _____

Have you ever had any of the following operations/procedures? Please check any that apply.

____Laparoscopy _____D & C _____Surgery for Endometriosis
____Appendectomy_____Tubal Pregnancy_____C-Section_____Tubal Ligation
____Gallbladder (open or Laparoscopy)
____Mastectomy (please specify which breast): _____
____Lumpectomy (please specify which breast): _____
____Bladder Repair _____LEEP or cervical conization
____Ovaries Removed: _____left_____right_____both
____Hysterectomy, type:___Vaginal___Abdominal___Laparoscopic___DaVinci (robotic)
Reason for hysterectomy_____

Please list any surgeries not listed above_____

Have you ever had any of the following? Please check all that apply.

____Stroke (CVA) ____Abnormal Pap smear
____Kidney Infection(s)
____Bladder Infections (frequent)
____Diabetes and Type 1___2___ _____Frequent Headaches/migraines
____Loss of urine when coughing or sneezing _____Urinary urgency with loss of urine
____High Blood Pressure
____Depression _____Anxiety
____DVT (blood clot in leg) _____PE (blood clot in lung)
____Any heart related problems- Please specify_____
____Cancer: What Type_____

Which of the following habits do you practice?

___Smoking ____Packs Per Day ____Drugs (which)

___Alcohol ____Drinks Per Day ____Drinks Per Week

Please list any medications you take regularly

Medication Name	Dosage	Reason for Medication

Please list any allergies you have: Reaction from taking this:

FAMILY HISTORY

	Mother	Father	Sister	Brother	Maternal GM	Maternal GF	Paternal GM	Paternal GF	Aunt	Uncle
High Blood Pressure										
Diabetes										
Breast Cancer										
Uterine Cancer										
Colon Cancer										
Ovarian Cancer										
Other Cancer type:										
Thyroid disease										
Kidney disease										
Heart Disease										
Anemia										
Birth Defects										

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CANCELLATION / NO-SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance, you will be charged a twenty-five dollar ($25) fee that is not covered by your insurance.

SCHEDULED APPOINTMENTS

We understand that delays can happen, however we must try to keep the other patients and doctors on time. If you are aware you will be running late, please contact our office prior to the appointment to let us know. If a patient is **30 minutes late** past their scheduled time without a call, most likely we will have to reschedule the appointment.

PRINT PATIENT NAME	SIGNATURE OF PATIENT/GARDIAN	____/____/20 DATE

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KNOW YOUR INSURANCE POLICY

Dear Patient,

We ask that you to please read and sign this form as it concerns you, the patient.

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. **Therefore, we urge you, the patient, to please check with your insurance company regarding your coverage.**

It is your responsibility to know your individual coverage and its limitations. Failure to obtain this information prior to your visit or procedure could result with you being responsible for all costs incurred. Please remember that your insurance policy is a contract between you and your insurance company.

To assist you in finding what coverage you have, please feel free to ask for assistance in finding phone numbers and addresses of the insurance company in question. Many insurance companies require referrals from your primary care physician (PCP). Some insurance plans state you cannot go "*out-of-network*". Changes are being implemented within insurance companies constantly. It is for your benefit that you ***KNOW YOUR INSURANCE POLICY.*** Utilize the insurance company's website as your primary resource.

Please advise us of any changes in your billing address, if you have changed your medical insurance carrier, or of any changes in your deductible policy. We will make every attempt to verify your benefits, but it is imperative that you know them as well.

We thank you for your help.

AVENTURA OB-GYN SPECIALISTS
DRS KANDINOV, BIRMAN, AND SCHATZ

_____ ____/____/ 20____
PRINT NAME DATE

_____
SIGNATURE

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List of Special Service Fees

***Copies of Medical Records**

Paper Chart = $1.00 per page

Printing of Electronic Health Records = 6.50

Returned Check/Credit Card Chargebacks

$25

Collection Fees

20%-40% of the amount turned over to the collection agency;

The fee charged by the collection agency

_____

Patient Name (print)

_____ _____

Patient Signature Date

These fees are subject to change without notice

Aventura OB-GYN Specialists

Многопрофильная Клиника Женского Здоровья
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The Aventura OB/GYN Specialists Center will securely maintain your credit card information to be used for payment of your co-pays, deductibles and co-insurance responsibilities. Payments will be processed after your claim has been successfully processed by your insurance.

If you choose to not utilize this payment option, you will be asked for payment at the time your services are performed, unless other arrangements have been made.

Credit Card Authorization

I authorize and agree to pay the amount charged to my credit card per the card issuer agreement (Merchant Agreement if credit voucher). I also authorize The Aventura OB/GYN Specialists to charge me credit card on file the balance that is owed after insurance and/or point-of-service (patient) payment for a specific date of service have been applied to my account. This authorization will expire when the associated credit card expires, or when, in writing, I cancel this authorization.

Patient Name (please print) _____

Authorized Signature: _____ Date: _____

Name of the card holder if not the patient: _____

Email address: _____

By signing the above, you give The Aventura OB/GYN Specialists permission to pay your portion of claims which are deemed your responsibility, with the credit card information you have provided to us. Should you dispute any charges with your credit card vendor, there **will be $25 chargeback** fee added to your account.

Internal use only: Recurring ID: _____ Masked ID (last 4): _____ Type of Card: _____ Initials: _____

Please check which card type you will be using: 1) American Express 2)Visa 3)MasterCard 4)Discover

Name as it appears on your credit card: _____

Credit Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date: _____ (Amex only has 15 numbers)

Card Holders Billing Address (street information only) _____ Zip Code: _____

Your credit card information will be destroyed once your card is established.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient name: _____ Date of birth: _____

Patient address: _____
Street

_____
City State Zip

Telephone number: _____ SS number: _____

TO: _____
Name of the doctor, office, clinic, or hospital from whom or which the records are being requested

Office address: _____

_____

Phone / Fax: _____

SPECIFIC INFORMATION TO BE RELEASED:

☐ Pap results ☐ Blood work results ☐ Imaging results ☐ Mammogram results ☐ DEXA results

☐ Operative reports ☐ H&P and progress notes ☐ Discharge summaries

☐ OTHER: _____

_____

THE PURPOSE OR NEED FOR THIS INFORMATION IS AND WILL BE USED FOR:

☐ Continuity of care ☐ Insurance ☐ Personal file

☐ OTHER _____

It is my intent that the information furnished is prohibited for any other purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I further direct that any information prior to the date of my signature below be honored; that his request be transmitted within 90 (ninety) days of my signature below; and that a photocopy of this authorization be granted the same authority as the original. Please fax the requested records to Aventura OB-GYN Specialists at **(305) 935-4113**.

Patient signature: _____ Date signed: _____

Witness: _____ Date signed: _____

Witness name:

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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Aventura OB-GYN Specialists' *Notice of Privacy Practices* effective 01/01/2010.

Name (please print): _____

Signature: _____ Date: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of Aventura OB-GYN Specialists' *Notice of Privacy Practices effective* 01/01/2010.

Name (please print): _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____

IF THE ACKNOWLEDGEMENT WAS NOT SIGNED BY THE PATIENT OR LEGAL GUARDIAN:

Notice of Privacy Practices effective 01/01/2010 given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing _____
☐ Email _____
☐ Other _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice took effect on January 1, 2010 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical Information private.
2. *Give* you this notice describing our legal duties, privacy practices, and your rights regarding your medical information
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use end disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of certain parts of your medical Information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you **50 cents** for each page, plus postage, if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the changes and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.