Perinatal Centers of Florida

Patient Information Form

Primary Care Doctor________________________ Primary Car Doc. Phone #___________________ Fax #_________________
Name____________________________________ Sex M__ F___ Email____
Social Security #___________________________ Birthdate____________ Marital Status: S____M___ W___ D___
Religion_________________________ Age_____ Home Phone #___________________ Cell Phone #__________________
Street Address____ Apt #_________
City ____ State_____ Zip______________
Driver's License #___________________________________ Driver's License State____________________________
Employer/School___________________________________ Title_________________________Phone #__________________
Street Address_____________________________________ City_________________________ St._________ Zip___________
Spouse____ Age__________ Birthdate__________________________________
Spouse Employer___________________________________ Title______________________ Phone #______________________
Street Address_____________________________________ City________________________ St._________ Zip___________
Translator Needed? ___Yes ___No Primary Language Spoke___________________ Referred By______________________

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY, OTHER THAN SOMEONE LIVING WITH YOU:

Name______________________________ Phone____________________________ Relationship_________________________
Address_____________________________ City______________________________ State_________________ Zip________

PRIMARY Insurance Information

Insurance Co_____________________________________
Address____
City/State/Zip_____________________________________
Phone #____
I.D. #____
Group Name or #__________________________________
Is this an employer plan?__________________________
Insured's full name_______________________________
Insured's social sec. #____________________________
Insured D.O.B. ___________________________________
Relationship to Insured___________________________
(Self – Husband – Wife – Child – Other)

SECONDARY Insurance Information

Insurance Co_____________________________________
Address____
City/State/Zip_____________________________________
Phone #____
I.D. #____
Group Name or #__________________________________
Is this an employer plan?__________________________
Insured's full name_______________________________
Insured's social sec. #____________________________
Insured D.O.B. ___________________________________
Relationship to Insured___________________________
(Self – Husband – Wife – Child – Other)

Guarantee of Payment

I fully understand that I am directly responsible for payment to the Physicians in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the even it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

Authorization to release information

I hereby authorize to Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.

Assignment of Insurance Benefits

If insurance claims are filed by this office on my behalf, I hereby authorize direct payment of any benefits to the Physicians in this office for medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of the authorization to be used in place of the original.

Signature____ Date________________________________
(Patient's Parent, if minor)

Authorization to Discuss Protected Health Information*

I, ________________________________, authorize Perinatal Centers of Florida to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named persons**:

1.________________________________ 2.________________________________

3.________________________________ 4.________________________________

➡ *Please be advised that any person not referred to on this list will not be given any information related to your care, including billing information. You may change, restrict or expand this listing at any time.

➡ ** You are not required to list any names if you choose not to do so. (Not required)

Please list phone numbers you would like us to contact you:

- Results – labs, ultrasounds, etc.
- Reminder notices
- Changes on scheduled appointments

1.________________________

2.________________________

Pharmacy Information:

Name:________________________________

Phone number:________________________

Address:______________________________

City:_________________________________

Patient's name: ________________________________

Date of Birth: __________________________________

Date: ____

I hereby authorize the use of and/or disclosures of any telephone number, provided by me or my behalf, that is assigned to a residential line, cellular telephone service, paging service, facsimile machine, computer, or any other service or device for which the called party is charged for the call for the purpose of billing and collecting payment for medical services rendered to me. This consent applies to any call made using an automatic telephone dialing system or an artificial or prerecorded voice.

Signature____ Date_________________________

Perinatal Centers of Florida- Maternal Fetal Medicine

Patient Name: ____

RELATIONSHIP BETWEEN PERINATAL CENTERS OF FLORIDA AND PERINATAL DIAGNOSTIC IMAGING:

Perinatal Centers of Florida (PCF) is an MFM practice that provides MFM consultations and obstetrical ultrasounds, in addition to some other services. *Perinatal Diagnostic Imaging (PDI)* is a center for obstetrical ultrasound which provides diagnostic services only. No Maternal Fetal Medicine (MFM) consultations are provided at PDI. You will follow-up with your physician for the results of your tests and additional management of your pregnancy. Your physician may request that PDI arrange follow-up for you for another ultrasound or with an MFM physician in certain situations. PDI and PCF have a contractual relationship whereby they provide certain services to each other. PCF will provide MFM consultations for patients for patients who have been seen at PDI, if this has been requested by your physician. By signing below, I am stating that I understand that PCF and PDI are 2 separate legal entities, and neither is responsible for the actions or omissions of the other entity.

Signature____ Date_________________________

SONOGRAM CONSENT: I have read the SONOGRAM CONSENT. I understand the limitations of sonography to diagnosed abnormalities of my baby, whether performed at PDI, PCF or at any other medical imaging office.

Signature____ Date_________________________

CONSENT FOR TREATMENT: By signing this consent, I am authorizing the PDI and/or PCF physician(s) to perform and/or order person associated with PDI and/or PCF to perform all exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to PDI and/or PCF unless revoked by me by giving written notice to PDI and PCF.

Signature____ Date_________________________

CONSENT TO OBTAIN RECORDS: Recognizing the importance of accurate information and follow up in maintaining quality care, I hereby authorize PDI and/or PCF to obtain medical information pertinent to my medical condition including, but not limited to the diagnosis, treatment and care offered or rendered to me for this pregnancy or previous pregnancies, including records pertaining to my labor and delivery and newborn infant's outcome (e.g. hospital records this pregnancy newborn discharge summary). This information will be treated as part of the medical record of PDI and/or PCF. I plan to deliver at ______________________________ (hospital). This consent remains in effect until revoked by me in writing to PDI and PCF.

Signature____ Date_________________________

NOTICE OF PRIVACY (Summary): I have read the information of NOTICE of Privacy Practices (Summary) and agree to the use and disclosure of my Private Healthcare Information as described.

Signature____ Date_________________________

PHYSICIANS RELEASE AND ASSIGNMENT: I hereby assign payment directly to PDI and/or PCF of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by PDI and/ or PCF. I understand that I am financially responsible to PDI and/or PCF for any and all charges that the carrier declines to pay (including but not limited to those considered to be an uncovered benefit, not preauthorized or disallowed by plan for any reason). I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el page directamente a Perinatal Diagnostic Imaging 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 por todos los cargos no cubiertos bajo miseguro medico.

Signature____ Date_________________________

Perinatal Centers of Florida

Maternal-Fetal Medicine

Office Philosophy

We think it is very important to spend as much time as necessary with each patient to fully address your medical problems. This enables us to explain our suggestions and recommendations in depth and answer any questions you may have during your visit. Our staff schedules patients accordingly and we try to be as efficient as possible in order to expedite your entrance and departure from this office. Please be reassure that we value your time. However, given the unpredictable nature of our work, it is not uncommon to have a prolonged waiting period. On many occasions, we are delayed for such matters as patients' medical problems which require immediate attention, hospital calls, physician calls, and/or emergencies. These issues are unforeseen and need to be addressed appropriately. We do not leave this office until all patients are seen and all their medical problems are addressed, regardless of whatever time is necessary.

After you are seen, a full report is sent to the referring physician in a timely fashion. Our well-trained staff members will assist you with any difficulties that may arise before, during or after your visit.

We encourage your comments and suggestions.

Thank you,
Laurie Scott, M.D., F.A.C.O.G., Medical Director
Elvire Jacques, M.D., F.A.C.O.G.
Jeanine Carbone, M.D., F.A.C.O.G.
Jose Hernandez, M.D.

I acknowledge and understand the above-stated Office Philosophy

Name: ____ D.O.B.:_____________________________

Date: ____

Important Information Regarding Ultrasound Examination

What is an ultrasound?
Ultrasound uses the same principle as sonar. Sound eaves from the ultrasound probe (far beyond the range of human hearing) bounce off of the uterus, placenta and baby, making echoes which a computer converts into detailed images. In essence, an ultrasound exam is a series of pictures of the baby and organs in the mother's pelvis.

Are ultrasounds safe?
There has been extensive evaluation of the safety of diagnostic ultrasound. There is no documented evidence that diagnostic ultrasound causes harm to either that mother or the baby when ordinary power and frequency is used. Ultrasound exams done in our facility are done using the lowest power level that can reasonably achieve a meaningful image.

Does a normal ultrasound prove that my baby will have no abnormalities?
Ultrasound examination can detect many abnormalities, but some abnormalities are not detectable by ultrasound. The exam gives information about the size and shape of the baby and the baby's organs but does not give complete information about the function of the baby's organs or tell us that the baby is completely "healthy". Abnormalities of brain function such as mental retardation cannot be detected by ultrasound. Additionally, there are many conditions that evolve over time, appearing normal at the time of the ultrasound exam but become apparent later in the pregnancy.

You should realize that even with a complete ultrasound exam, we may be unable to find existing fetal abnormalities or those abnormalities that can appear later in the pregnancy or after birth. Thus, although ultrasound examination is a very helpful diagnostic tool, it should not be considered absolute proof that the baby is normal

Can an ultrasound determine if there are chromosomal abnormalities?
Findings on ultrasound exam can be an indicator of potential chromosomal abnormalities but are not definitive. Currently, the only way to assess the baby's chromosomes with certainty is to actually obtain a sample of the baby's cell by amniocentesis, chronic villus sampling or fetal blood sampling. Some pregnancies are at increased risk for fetal chromosome abnormalities, either because of the mother's age, because of results of blood screening test, or because of findings on the ultrasound exam. It is important to realize that an ultrasound exam cannot tell for certain whether the baby's chromosome count is normal or abnormal. A normal ultrasound examination does not guarantee that the chromosomes are normal.

If you have any questions concerning ultrasounds, please do not hesitate to ask the ultrasound technologist, perinatologist or your doctor. You are requested to sign this document before your ultrasound examination to acknowledge that you have read and understood the information on this form and have had the opportunity to ask questions.

____ ____________________
Signature Date

____ ____________________
Printed Name Date of Birth

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices for the company and its subsidiaries and affiliates. I understand that copies of the Notice of Privacy Practices are available on the company's website and paper copies are out and available in the office and that I can take on of these copies with me. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as it has been amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 and any implementing regulations.

Effective Date of Notice: September 23, 2013

Patient: ____ Date: __________________________
(Print Name)

Patient Signature: _______________________________________

Or

Patient's representative: ___________________________________ Date:__________________________

Relationship to patient: ___________________________________