PATIENT INFORMATION

WELCOME TO OUR OFFICE

Today's Date:_____

Primary Doctor:_____

IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION. ALL INFORMATION IS STRICTLY CONFIDENTIAL. PLEASE PRINT CLEARLY.

AGE: _____

PATIENT'S NAME_____ D.O.B.:_____

SOCIAL SECURITY #:_____ MARITAL STATUS: S M W D

ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____

TELEPHONE: HOME: ( )_____ CELL: ( )_____ WORK: ( )_____

EMAIL ADDRESS:_____@_____

DO YOU PREFER MESSAGES BE LEFT ON: CELL ( ) HOME ( )

EMERGENCY CONTACT NAME: _____ PHONE ( )_ _____

RELATIONSHIP:_____

FREQUENTLY USED PHARMACY: NAME:_____ PHONE:_____

CROSS STREETS:_____ CITY:_____

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*Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the actual charges. It is your responsibility to pay any deductible amounts, co-insurance and any balance which is not covered by your insurance carrier.

*It is the policy of Women's Surgical Specialists of Ft. Lauderdale, LLC that charges for the office visits be paid at the conclusion of each visit in order to control billing costs.

*I understand that I am financially responsible for all charges incurred on my behalf including any balance remaining after insurance benefits, and/or cost of attorney's fees in collecting delinquent payment and or collection agency fees (if applicable).

*I also authorize the release of any medical information necessary and permitted by law to process this claim and hereby assign insurance benefits directly to Women's Surgical Specialists of Ft. Lauderdale, LLC.

SIGN:_____ DATE:_____

PATIENT, OR PARENT IF MINOR

THANK YOU FOR CHOOSING OUR OFFICE

Women's Surgical Specialists of Ft. Lauderdale, LLC

E. Jason Gates, M.D.
Gail Ehlin, ARNP

OFFICE PROCEDURE SCHEDULING POLICY

We provide a number of procedure base services in our office.

This service allows for greater convenience for you and often results in lower costs than performing the same procedure/test in the hospital.

To keep the office running as close to on time as possible, these procedures are set up prior to your arrival. That means that we have dedicated time and supplies to your procedure prior to your arrival.

As a result of these expenses we will charge a **"NO SHOW"** fee when you do not give our office 24 hours' notice of a cancellation or if you fail to show for your scheduled procedure.

By signing below you acknowledge the receipt of the above policy and understand that you will be charged personally and this fee will **NOT** be sent to your insurance company for reimbursement.

_____ _____/_____/_____

PATIENT'S SIGNATURE DATE

Notice of Privacy Acknowledgement

Women's Surgical Specialists of Fort Lauderdale, LLC

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

_____ _____

Patient Name or 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: _____ Attempt: _____

Staff Name: _____