New Patient Information Form

Welcome to Palm Coast OB GYN

Thank you for taking the time to complete this New Patient Information Form. It will become part of your medical record. Please fill in all fields that apply. If a field does not apply, Indicate "NA." Clearly **print** your answers.

Patient Information:

Name _____ DOB: _____

SS#: _____ (required to collect payment from insurance companies and verify your identity when it comes to looking up your health records)

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Email: _____ Marital Status: _____ Race: _____

Ethnicity: Hispanic Non-Hispanic Other _____ Preferred Language: English Spanish

---

Responsible Party—Only if NOT the Patient:

Name _____ DOB: _____

SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Email: _____ Marital Status: _____ Race: _____

No Show/Cancellation Policy:

We appreciate you trusting your medical care to our practice. We set aside enough time to provide you with the highest quality care possible. Any established patient who fails to show up or cancel an appointment and has not contacted our office with at **least 24 hours notice** will be considered a "no show" and charged a **$50.00 no show fee**. This fee is charged to the patient, not the insurance company, and must be paid in full before another appointment is scheduled.

_____ _____

Patient Signature Date

Patricia Modad MD PA
Palm Coast OB GYN
7 Boulder Rock Drive
Suite #4
Palm Coast, FL 32137

CONTACT AUTHORIZATION:

I, _____, with the date of birth of ____/____/____ authorize Patricia Modad, MD, PA, d.b.a. Palm Coast OB GYN to communicate medical Information with me in the following manner:

May we leave a detailed message on your phone? ☐ YES ☐ NO

Home Number: _____

Cell Number:_____

May we leave a detailed message on your email? ☐ YES ☐ NO

Email:_____

Whom may we contact if we are not able to communicate with you and/or in an emergency?

Name:_____

Relationship: ☐ SPOUSE ☐ CHILD ☐ PARENT ☐ GUARDIAN ☐ OTHER _____

Home Phone:_____

Cell Phone:_____

_____ _____

Patient Signature Date

Patricia Modad MD PA
Palm Coast OB GYN
7 Boulder Rock Drive
Suite #4
Palm Coast, FL 32137

History Intake

Welcome to our practice! Please help us meet all your healthcare needs by completing this form to the best of your knowledge. If you have any questions or need assistance, please ask us. We will be happy to help.

Reason for today's visit: _____

Today's Date: _____

Patient Name: _____ **Age:** _____ **Birthday:** _____

Primary Care Physician: _____

Imaging Center: _____

Pharmacy (Specify address): _____

_____

Current Medication (both over the counter and prescription):

_____

_____

_____

Drug Allergies: _____

_____

Gynecologic History (check all that apply):

☐ Frequent vaginal infection ☐ Urine loss or leakage ☐ Hot flashes/Night sweats ☐ Difficulty sleeping

☐ Vaginal dryness ☐ Decreased libido ☐ Frequent bladder infections ☐ Pain with intercourse

☐ Chronic itching ☐ Breast tenderness ☐ Genital sores ☐ Endometriosis ☐ Fibroids

Age of (menarche) start of menstruation: _____

Last menstrual cycle (start date): _____ If menopausal, what age? _____

Duration of cycle: _____ days

Days between cycles: : _____ days

Pain with cycles? YES / No

Current birth control (if any): _____

PAP/MAMMO/BONE DENSITY HISTORY:

Date of last Pap Smear: _____ Results: Normal/Abnormal

If Abnormal, result: _____

Date of last Bone Density Scan (if applicable): _____ Results: Normal/Abnormal

If Abnormal, result: _____

Date of last Mammogram: _____ Results: Normal/Abnormal

If Abnormal, result: _____

History of sexually transmitted diseases or infections (past and present)? YES / No

If yes, which one(s): _____

PAST PREGNANCY HISTORY:

Total #	Full term	Premature	Spont. Ab	Induced Ab	Ectopic	Multiples	Living
_____	_____	_____	_____	_____	_____	_____	_____

#	Month/Year	Birth Weight	# of Weeks	Delivery Type	Complications
				Vag/ C-Sect / V-Bac	
				Vag/ C-Sect / V-Bac	
				Vag/ C-Sect / V-Bac	
				Vag/ C-Sect / V-Bac	
				Vag/ C-Sect / V-Bac	
				Vag/ C-Sect / V-Bac	

FAMILY HISTORY:

Please list any family history of Breast, Ovarian, or Colon cancer (please specify maternal or paternal):

_____

_____

_____

List any other type of cancer/illness and specify family member (such as Mom, Dad, Sister, Brother, etc.):

_____

_____

_____

SOCIAL HISTORY:

_____Single _____Married _____Divorced _____Separated _____Widow

_____Smoke? If yes, how many packs a day? _____ If quit, what year? _____

_____Drink? If yes, how many drinks/wine/beer a week: _____

_____Prescription drug use/abuse? If yes, what drug(s)? _____

_____Illicit drug use/abuse (marijuana, cocaine, meth, PCP). If yes, what drug(s): _____

Exercise: ____ Occasional____ Low:____ Moderate:_____ High:_____

Sexually active? (circle): YES / NO Sexual orientation (circle): Heterosexual Homosexual/Bisexual

Would you accept a blood transfusion in an emergency? (circle): YES / NO

SURGICAL HISTORY:

List any surgeries or procedures and year they were done: _____

_____

_____

_____

MEDICAL HISTORY (check all that apply):

- ❒Anxiety Disorder
- ❒Breast Cancer
- ❒Cervical Cancer
- ❒Depression
- ❒Diabetes
- ❒Endometriosis
- ❒Heart Disease
- ❒Hepatitis
- ❒High Cholesterol
- ❒Hypertension
- ❒Infertility
- ❒Kidney Disease
- ❒Osteopenia
- ❒Osteoporosis
- ❒Ovarian Cancer
- ❒Thyroid problems (hypo or hyper)
- ❒Uterine Cancer
- ❒Abnormal MMGI
- ❒Abnormal Pap
- ❒Anemia
- ❒AIDS/HIV
- ❒Asthma
- ❒Bladder Infections
- ❒Blood in urine
- ❒Blood Transfusion
- ❒Blood clot in leg/lungs
- ❒Breast problems
- ❒In utero exposure to DES
- ❒Liver disease
- ❒Lupus
- ❒Rheumatoid Arthritis
- ❒Seizures
- ❒TB or exposure to TB

PATRICIA MODAD, MD, PA **PALM COAST OB GYN**

PATIENT: _____ DOB: _____ SS#: _____

PATIENT CONSENT AND AUTHORIZATIONS

CONSENT FOR TREATMENT: I, the undersigned patient, parent or legal guardian, knowing that I am (the patient is) suffering from a condition requiring medical care, do hereby present myself for treatment at **Patricia Modad, MD PA, Palm Coast OB GYN**, and voluntarily consent to the rendering of such care, including treatments, photographs for treatment evaluations, administration of anesthetics and performance of diagnostic and/or surgical procedures. In the event a medical device is implanted or explanted, I agree to the release of my Social Security number to the manufacturer/FDA for tracing of the device. I understand I am under the care and supervision of my attending physician and it is the responsibility of the office and its staff to carry out the instructions of such physician. I understand the physician furnishing services to me expects payment in full upon receipt of a bill and I will assist in billing the appropriate insurance companies if insurance or other benefits are involved. I am aware the practice of medicine is not an exact science and I acknowledge no guarantees have been made to me as to the result of treatments and/or examination in the office.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to **Patricia Modad, MD PA, Palm Coast OB GYN**, and the assignment of all medical benefits applicable and otherwise payable to me. I understand I am financially responsible to **Patricia Modad, MD PA, Palm Coast OB GYN** and for all charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

RELEASE OF MEDICAL INFORMATION: I, the undersigned patient, parent, or legal guardian, do hereby authorize **Patricia Modad, MD PA, Palm Coast OB GYN** or its employees to release to any third party any medical, psychiatric, alcohol or drug abuse, and/or HIV (AAIDS or AIDS-related complex) treatment information and records, in accordance with the policy of **Patricia Modad, MD PA, Palm Coast OB GYN**, any applicable State or Federal Statues, concerning diagnosis and treatment for the patient when requested by a third party payor for it's use in connection with determining a claim for payment for such treatment and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in the patient's care and treatment. I do hereby release **Patricia Modad, MD PA, Palm Coast OB GYN** from all liability that may arise from the information requested.

FLORIDA LAW: Section 817.234 Florida Statutes stipulates any person who knowingly and with intent to insure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

FOR MEDICARE PATIENTS ONLY—CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize a holder of medical or other information about me to release to the Social Security Administration or its intermediary/carriers, any information needed for this or a related Medicare claim. I request payment of authorized benefits be made on my behalf. I assign the benefits payable to **Patricia Modad, MD PA, Palm Coast OB GYN.** I understand I am responsible for any health insurance deductibles, copayments and coinsurance amounts.

_____ initial

MEDICARE BENEFICIARY NOTICE OF NON-COVERED SERVICES: Medicare does not cover some services, e.g., Medicare Part B covers a Pap smear, pelvic exam, and breast/chest exam once every 24 months. You may be eligible for these screenings every 12 months if you are at high risk for cervical or vaginal cancer or, you are of childbearing age and have had an abnormal Pap smear in the past 36 months

ACKNOWLEDGEMENT OF RECEIPT OF AN IMPORTANT MESSAGE FROM MEDICARE (FOR MEDICARE PATIENT ONLY): My signature only acknowledges my receipt of this message from **Patricia Modad, MD PA, Palm Coast OB GYN** as dated below and does not waive any of my right to request a review or make me liable for any payment.

I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENT TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE WITH PATRICIA MODAD, MD PA, PALM COAST OB GYN.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered, he/she individually hereby obligates them to pay the account of **Patricia Modad, MD PA, Palm Coast OB GYN** in accordance with the regular rates and terms of the physician. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

_____ Patient's signature

_____ Patient's Parent or Legal Guardian signature

_____ Witness

_____ Indicate relationship to Parent

Today's Date: _____

Patient unable to sign due to: _____

Patricia Modad MD PA
Palm Coast OB GYN
7 Boulder Rock Drive
Suite #4
Palm Coast, FL 32137

Acknowledgement of Receipt

HIPAA Notice of Patient Privacy Practices

By signing this Written Acknowledgement of Receipt for HIPAA Notice of Patient Privacy Practices ("Acknowledgement"), I hereby expressly acknowledge my receipt of HIPAA Notice of Patient Privacy Practices.

_____

Patient or Legal Representative Signature

_____

Printed Name of Patient or Legal Representative Signature

_____

Today's Date

Acknowledgement NOT obtained because:

_____ Patient or legal representative declined the Notice of Patient Privacy Practices

_____ Other (briefly describe) _____

_____ _____

Employee Signature Employee Printed Name

Patricia Modad MD PA
Palm Coast OB GYN
7 Boulder Rock Drive
Suite #4
Palm Coast, FL 32137

ATTENTION PATIENTS:

If you are having a pap smear, biopsy, or any other testing done today, we **DO NOT** collect money for these services. The collected fees are only for **SERVICES DONE IN OUR OFFICE.**

You will receive a bill from the lab your test was sent to if your insurance does not cover the test being performed. Rest assure, to the best of our ability, we send samples to the labs who offer quality service at the least expensive price.

Also, depending on your policy, you may be responsible for deductibles, coinsurance or copayments applicable to lab fees. Please be advised **Medicare** will not pay for HPV (Human Papilloma Virus) testing if you have having a pap smear. HPV testings for cell changes or abnormal cells in the cervix is a virus that can cause cervical cell changes and is part of the pap smear.

If you have any questions regarding these bills, please contact the lab directly as we are NOT responsible for any bills generated by the labs.

Thank you for your understanding.

_____ _____

Patient Signature Date

_____ _____

Employee Signature Date

Palm Coast OB GYN

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This is used for our office to request records from other providers and it allows us to release your records to others.

I, _____, hereby voluntarily authorize the disclosure of information

from my health record. My date of birth is: _____/_____/_____

II. The information is to be disclosed by: **And is to be provided to:**

PROVIDER:	PROVIDER
ADDRESS:	ADDRESS:
CITY/STATE:	CITY/STATE:
TELEPHONE: FAX:	TELEPHONE: FAX:

III: The purpose/need for this disclosure is:

- ☐ Further Medical Care ☐ Attorney ☐ School ☐ Research
- ☐ Personal Use ☐ Insurance ☐ Disability ☐ Other (specify)_____

IV: The information to be disclosed from my health record: (check all appropriate):

- ☐ Entire record
- ☐ Bone Density results ☐ Laboratory results ☐ Ultrasound results
- ☐ Only the period of events from: _____ to:_____
- ☐ Only information related to (specify):_____

If you would like any of the following sensitive information disclosed, check the applicable items below:

- ☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
- ☐ Sexually Transmitted Diseases ☐ Mental Health

V. I understand I may revoke this authorization in writing submitted at any time to the Health Information Management Department, expect to the extent the action has been taken in reliance on this authorization.

I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my revocation to the provider. I understand the revocation will not apply to information already released. I understand the revocation will not apply to my insurance company when the law provides an insurer with the right to contest a claim under my policy. I understand authorizing the discourse of this health information is voluntary. I can refuse to sign this authorization. I understand I may inspect/obtain a copy of the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

Patient Signature:_____ Date: _____

Authorized Representative/Parent: _____ Date: _____

Printed Name of Authorized Representative/Parent: _____

Relationship to Patient: _____

Address and Phone # of Authorized Representative/Parent: _____