CELEBRATION OBSTETRICS AND GYNECOLOGY
A MEDICAL PRACTICE DEDICATED TO WOMEN'S HEALTH
410 Celebration Place, Suite 208, Celebration, FL 34747
2209 North Boulevard West, Suite C, Davenport, FL 33837
phone: 407-566-2229 fax: 407-566-2499

Patient Information:

First Name: _____ Last Name: _____ Middle Initial:_____

Street Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Age: _____Birth Date: _____– _____ – _____ Martial Status: Single Married Other

please circle one

Soc. Sec. : _____– _____ – _____ Home Phone:_____

Email Address: _____

Cellular Phone: _____ Patient's Occupation: _____

Employed By: _____ Phone: _____ Ext: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Spouse's First Name: _____ Last Name: _____ Birth Date: _____– _____ – _ _____

Spouse's Occupation: _____ Employed By: _____

In Case of Emergency? _____RELATIONSHIP:_____Phone :_____

Who May We Thank for Referring you to the Practice?_____

Primary Insurance Information:

Name of Person Responsible for Insurance: _____

Relationship to Patient: _____Birth Date: _____– _____ – _____ Soc. Sec.: _____– _____ – _____

Insurance Company Name: _____ Card ID #: _____

Assignment And Release

I, The Undersigned, (Or My Dependent) Has Insurance Coverage with _____

Name Of Insurance Company

and assign directly to Celebration Obstetrics and Gynecology all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. In case an action is instituted to collect this note or any portion thereof, the below named patient promises to pay all collection costs and additional sums as may be deemed responsible in said action, I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

_____ _____ _____

PATIENT OR GUARANTOR SIGNATURE RELATIONSHIP DATE

Celebration Obstetrics and Gynecology
Authorization To Release Or Use Information For Treatment, Payment or Health Care Operations

I _____(Patient's Full Name) , _____(Date of Birth), hereby authorize the release or use of my individually identifiable health information (PHI-"Protected Health Information") and medical record information by Celebration Obstetrics and Gynecology in order to carry out treatment, payment, or health care operations. You should review the Celebration Obstetrics and Gynecology's Notice of Privacy Practices for a more complete description of the potential release and use of such information. You have the right to review such Notice prior to signing this consent form.

We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the terms, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your PHI is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restriction; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my PHI and medical record information, confirm or change appointment times and speak to the office on my behalf with the following individuals who are my family members, legal representatives, guardians, healthcare surrogates, or have power of attorney:

Name	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____

Any additional individuals should be listed on the back of this form if needed.

I agree and have been given notice that the Practice may also disclose the following types of information contained in my medical record to the appropriate authorities as we are required by Florida State Law §384.25. (Please initial all categories below):

_____ HIV/Aids Information _____ Mental Health Information _____ Substance Abuse Information

_____ Sexually Transmitted Disease Information _____ If Patient is under the age of eighteen (18), Pregnancy Information

I understand that if the practice needs to contact me, it will be via the primary phone number listed in my file. I agree to keep this number updated at all times and understand that my demographics are my responsibility. I acknowledge that I can update my demographics through several sources. I can update them in the office directly, through a call to the phone center, or through my patient portal Should the Practice need to communicate with me and my phone is unavailable, after 3 attempts a certified letter will be sent through the mail. I elect for correspondence to be directed to me in the optional form of:

email or fax (Please Circle one) fax number or email to be used: _____

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign this consent form. If you (or an authorized representative) sign this consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the patient or the authorized party to act on the behalf of the Patient to sign this document verifying consent to the above terms.

Date: _____ Time: _____ AM/PM

X_____

Signature of Patient or Authorized Representative

If you are not the Patient, please describe your relationship to the Patient and include a description of the Representative's authority to act on the behalf of the Patient: _____

_____

CELEBRATION OBSTETRICS AND GYNECOLOGY

BILLING AND FINANCIAL POLICY

Please initial in the space provided and sign your name acknowledging your consent and agreement.

If you have insurance, we will provide insurance claim filing for your primary insurance plan with which we participate; however, if we do not accept your insurance plan or if a **claim is denied or a balance is due, you are responsible for payment of the balanced owed and we expect payment within 30 days from the date we notify you of such determination. It is our policy that we do not take secondary insurance and do not file claims to secondary insurance. It is your responsibility to pay any co-pay, deductible, co-insurance or any other balance not paid for by the insurance or third party payer within 30 days**. **Please note all claims must be finalized before any refunds will be submitted for processing. Refund processing can take up to 30 days to issue. For Obstetrical patients all claims including delivery must be finalized.**

It is the responsibility of the patient/guardian to provide us with current insurance plan information prior to services rendered in order for accurate billing of services to be filed. You are also responsible for contacting your insurance company to make sure we are in network with your particular plan. It is important that you are familiar with the guidelines of your plan requirements regarding authorizations, deductibles, co-payments and other vital requirements.

It is the responsibility of the patient/guardian to obtain any referrals that may be required by the insurance company PRIOR to the scheduled visit. Failure to do so will result in the need to reschedule your appointment and a potential $25.00 late notice rescheduling fee may apply.

In consideration of services rendered, you agree to transfer and assign to Celebration Obstetrics and Gynecology all rights, title and interest in any payment due to you or otherwise payable to you for services rendered.

Insurance: _____(initial)

In consideration of the services rendered, you agree to pay Celebration Obstetrics and Gynecology in accordance with the regular rates and terms of service/costs for Celebration Obstetrics and Gynecology. Unless prior arrangements have been made, payment is due in full at the time services are rendered. You affirm that you are duly authorized as the patient or as patient's guardian/agent to execute this document and accept its terms.

Self-Pay: _____(initial)

Patient's certification authorization to release information and payment request. You certify the information given to Celebration Obstetrics and Gynecology in applying for payment under Title XVIII/XIX of the Social security act is correct. You authorize any holder of medical or other information about you to release to Social Security Administration/Division of Family services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. You further certify all insurance proceeds pertaining to treatment or services provided shall be assigned to Celebration Obstetrics and Gynecology.

Medicare/Medicaid: _____(initial)

We collect and send specimens to a laboratory for processing. We are NOT responsible for laboratory charges. If you have any questions regarding the laboratory charges, you must call the laboratory listed on the bill.

Laboratory Charges: _____(initial)

OB Contract: Any OB contract signed by the patient must be paid by the 28th week of pregnancy. Non-payment of the contracted amount may result in discharge from the practice for non-compliance with our financial policy.

Credit Cards: For your convenience, we will keep your credit card information on file to be used for balances on your account that are your responsibility (co-insurances, co-pays, deductibles), not to exceed $150.00.

FMLA: There is a **$25.00 fee** for FMLA paperwork This fee is due **PRIOR** to any paperwork being faxed or picked up. There is a **$50.00 fee** for expedited FMLA paperwork.

Returned Check Fee: A **$25.00 fee** will be assessed to your account for any returned checks

Cancellation/No Show Policy/Late: A **$25.00 fee** will be assessment to your account for "NO SHOW" if you fail to cancel or reschedule an appointment with at least **24-hour notice**. A **$200.00 fee** will be charged for surgeries cancelled less than **72 hours** prior to the surgery date. Patients who arrive late for their appointment will be rescheduled.

Office Charges/Policy: _____(initial)

You understand and agree that all accounts must be brought current within 30 days of the service that was rendered. After 30 days a late fee charge of $25.00 per month will be assessed. After 60 days the account will be turned over to our attorney for collection.

Should this account be referred to an attorney for collection, you will be responsible for reasonable attorney's fees, court costs, recording fees and collection expenses. You further agree that exclusive venue for any collection action shall be in Osceola County, Florida.

You authorize Celebration Obstetrics and Gynecology and hereby give all of its affiliated entities, employees, agents and Independent Contractors permission to call you through the use of dialing equipment artificial voice or similar technology, even if you are charged for the call. You expressly agree that such automated calls may be made by Celebration Obstetrics and Gynecology and all of its affiliates, contractors and agents. With such consent, you specifically waive any claim you may have against Celebration Obstetrics and Gynecology, its affiliates, contractors and/or agents for making such calls, including any claim under the Telephone Consumer Protection Act. You also expressly agree that this provision applies to the use of text messaging. You authorize Celebration Obstetrics and Gynecology, its affiliates, contractors and/or agents to use any cell phone or other telephone number to contact you for any purpose, including collection of an outstanding invoice at the number set forth below. If you have a change in address or telephone number, it is your responsibility to provide Celebration Obstetrics and Gynecology with your updated contact information.

Collection: _____(initial)

I have read, understand and agree to Celebration Obstetrics and Gynecology's Billing and Financial Policy:

_____ _____

Patient Name **Patient Date of Birth**

_____ _____

Patient/Guardian Printed Name **Date**

_____

Patient/Guardian Signature

Celebration Obstetrics and Gynecology

HIPPA

Health Insurance Privacy & Portability Act

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 your care and services you receive at our organization. We need this record to provide you 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 your legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

l. Change our privacy practices and the terms of this notice at any time, providing 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:

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

Celebration Obstetrics and Gynecology

A medical practice dedicated to women's health

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Celebration, Florida 34747
Telephone 407-566-2229
Fax 407-566-2499

www.celebrationobgyn.com

2209 North Boulevard West Ste C
Davenport, Florida 33837
Telephone 863-424-4321
Fax 407-566-2499

Acknowledgement Form

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Patient Name: _____

Patient Signature: _____

Date: _____

Witness: _____