WELCOME TO OUR OFFICE

We would like to take this opportunity to thank you for choosing Dr. Jessica White-Videa as your OB/GYN. We look forward to providing you with quality care and demonstrating why this is the IDEAL place for all of your obstetrical and gynecological needs. Please complete the attached forms prior to your visit. In addition to these forms, we will need your insurance card and photo ID. If you did not provide your insurance information in detail when making your appointment, please call our office prior to your visit. Providing this information in advance will allow us to verify your benefits before you arrive and decrease your wait time. Lastly, after your visit, you may receive a survey about your experience in our office. We appreciate and value your input.

The Office of Dr. Jessica White-Videa
2855 N. University Drive, Suite 300
Coral Springs, FL 33065
Telephone (954)317-0772*Fax (954)317-0787

Registration Form

Name: ____Today's Date_______________
Last First Middle initial

Date of Birth: ____________________ Age: ________ Social Security #______-_______-_______

Mailing Address:

____
Street City State Zip Code

Cell Phone: _________-_________-_________. Home Phone: ________-_______-___________

Employer: _____________________________________Employer Phone: _______-_________-_______

Primary Care Physician: __________________________Physician Phone: ______-______-________

Marital Status ( ) Single (_) Married (_) Divorced (_) Widowed

Referred by: (_) Physician (_) Family/Friend (_) Insurance (_) Google search (__) social media

PRIMARY INSURANCE

Ins. Co Name: _____________________________________ Phone: ______-_______-________

Address____

ID No________________________________Group#____

ARE YOU A DEPENDENT ON THIS PLAN?
(_) YES- If yes, who is the PRIMARY INSURED?

The Office of Dr. Jessica White-Videa
2855 N. University Drive, Suite 300
Coral Springs, FL 33065
Telephone (954)317-0772*Fax (954)317-0787

(_) NO

NAME OF PRIMARY POLICY HOLDER/SUBSCRIBER ____

Relationship to Patient _________________________Policy Holder Date of Birth ___-___-____

(_) Check here if the subscriber has the same billing address as you

Address ____

SECONDARY INSURANCE (_) NOT APPLICABLE

Ins. Co Name: ____________________________________ Phone: _______-_________-________

Address: ____

ID No: _______________________________ Group No_______________________________

ARE YOU A DEPENDENT ON THIS PLAN?

- (_) YES- If yes, who is the PRIMARY INSURED?
- (_) No

PRIMARY POLICY HOLDER/SUBSCRIBER ____

Relationship to Patient _________________________Policy Holder Date of Birth ___-___-____
(_) Check here if the subscriber has the same billing address as you

Address: ____

PHARMACY: INFORMATION

(_) CVS (_) TARGET (_) WALGREENS (_) WALMART (_) PUBLIX (_) OTHER

Streets/Address: ____

Phone Number _______-________-_____________

The Office of Dr. Jessica White-Videa
2855 N. University Drive, Suite 300
Coral Springs, FL 33065
Telephone (954)317-0772*Fax (954)317-0787

EMERGENCY CONTACT

Who Should We Contact? ___________________________________

Relationship: ___________________

Phone: _______-________-________

Signature_____________________________________**Date**_________________

Patient's rights of disclosures

How would you like to be contacted by us?

In general, the HIPAA privacy rule gives the individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communications of health information be made by alternative means.

I______________________________, wish to be contacted in the following manner:

HOME
____Ok to leave a detailed message
____Leave message with callback number only

CELL PHONE
____ Ok to leave a detailed message
____ Leave message with callback number only
_____Ok to send text messages

WORK

____OK to leave detailed message
____Leave message with callback number only

WRITTEN COMMUNICATION

____OK to mail to home

The Office of Dr. Jessica White-Videa
2855 N. University Drive, Suite 300
Coral Springs, FL 33065
Telephone (954)317-0772*Fax (954)317-0787

List all persons in your household with whom we may speak to regarding your medical information.

NAME____Relationship______________________

Patient Signature: _____________________________________ Date: ___________________

Notice of Privacy Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). 1 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 IDEAL WOMEN'S HEALTH CARE, LLC has the right to change its Notice of Privacy practices and that I may contact the practice at any time to obtain and current copy of the NPP.

___________________________ _______________________________________

PATIENT LEGAL NAME(PRINT) SIGNATURE DATE

OFFICE USE:

WE HAVE MADE THE FOLLOWING ATTEMPT TO OBTAIN THE PATIENT'S SIGNATURE ACKNOWLEDGING RECEIPT OR NOTICE OF PRIVACY PRACTICES

____

ATTEMPT MADE BY DATE

The Office of Dr. Jessica White-Videa
2855 N. University Drive, Suite 300
Coral Springs, FL 33065
Telephone (954)317-0772*Fax (954)317-0787

FMLA/DISABILITY Form Notification

I acknowledge that there is a $25.00 fee for any disability, FMLA or any other paperwork that needs to be completed by the physician. As a patient, I am required to provide the paperwork from my employer (and/or disability company) and complete the patient portion(s). This fee is not paid by the insurance company nor is it included in the visit. Please allow 3-5 business days for your paperwork to be completed.

____

PATIENT NAME (PRINT) **SIGNATURE** **DATE**

The Office of Dr. Jessica White-Videa
2855 N. University Drive, Suite 300
Coral Springs, FL 33065
Telephone (954)317-0772*Fax (954)317-0787

FINANCIAL POLICY

We have developed a set of guidelines regarding financial responsibility. If you have any questions, please speak with the office manager.

You must present your insurance card (and your ID card) at the time of your visit. If we do not receive your insurance card before you see the doctor, that visit becomes a SELF PAY, and payment is expected.

For your convenience, we accept cash, check, MC, Visa, Discover and American Express. Any bounced checks will result in a $35 returned check fee.

We will make every effort to collect payments from the patient's or guarantor's insurance company through courtesy filing of insurance claims and other required documentation.

Since most carriers have time limits for filing correct information it is imperative that we receive complete and correct insurance information. Although assistance will be provided, it is the patient's responsibility to make sure his/her insurance carrier pays his/her claim.

Patients, or their guarantors, are responsible for payment in full of financial obligations whether or not their insurer makes a payment.

The Office of Dr. Jessica White-Videa
2855 N. University Drive, Suite 300
Coral Springs, FL 33065
Telephone (954)317-0772*Fax (954)317-0787

Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment of all charges is the patient's responsibility and should it be necessary for this account to be turned over to a collection agency, I understand that I will be liable for any charges incurred, including collection agency's fee, attorney's fee and court costs.

Co-pay, Deductible, and Co-insurance. A copay is a set dollar amount you owe for each office visit. Some insurance plans are subject to a deductible and coinsurance. Our office staff will attempt to contact you prior to your visit, to advise you of your responsibility. You will be expected to make payment before services are rendered.

Estimation of Services, whenever possible, our office staff verifies your benefits with the insurance company and will provide you with the approximate cost of the service. The final cost may change based on what is actually done on the day of your visit. Additionally, the estimate of our charges will not include any outside lab or pathology service.

Lab/Pathology Fees, if any laboratory testing is collected (blood work, cultures, biopsy, PAP smear, etc.) in our office to confirm a diagnosis or to determine a course of treatment, the laboratory will perform the actual testing of the sample. THIS MEANS YOU MAY RECEIVE A SEPARATE BILL FROM THE LAB/PATHOLOGIST- we do not verify your lab benefits.

- ☐ **Physician's Release and Assignment: I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carries /HMO/TPP for services rendered by the physician. I understand that I am financially responsible to the physician for any and all co-insurance, deductibles, copays and/or non-covered service charges that the carrier declines to pay. I hereby authorize the release of my medical records to my insurance provider as deemed necessary for payment of insurance benefits.**

____

PRINT NAME **SIGNATURE** **DATE**

The Office of Dr. Jessica White-Videa
2855 N. University Drive, Suite 300
Coral Springs, FL 33065
Telephone (954)317-0772*Fax (954)317-0787

CONSENT FOR PELVIC EXAMINATION

Written consent of the patient or the patient's legal representative or guardian is required prior to a gynecological examination. The examination may include but is not limited to a breast examination as well as a pelvic examination including rectal examination,

A pelvic examination is defined by and includes an examination of the vulva, vagina cervix, uterus, fallopian tubes, ovaries, uterus, rectum, or external genitalia, or pelvic organs using a combination of modalities, which may include, but not be limited to, the healthcare provider's gloved hand or instrumentation.

I understand and consent to a "MEDICALLY INDICATED GYN EXAMINATION INCLUDING BUT NOT LIMITED TO A PELVIC EXAMINATION AND/OR RECTAL EXAMINATION".

Patient Name: ___________________________________ Date: ______________________

Patient Signature: ____

Signature of Legal Representative or Guardian: _____________________________________
(If patient under the age of 18)

Witness Signature: ____

The Office of Dr. Jessica White-Videa
2855 N. University Drive, Suite 300
Coral Springs, FL 33065
Telephone (954)317-0772*Fax (954)317-0787

PATIENT PORTAL

The Patient Portal enables our patients to communicate with the doctor or staff members securely via the Internet.

Participating patients are given secure User IDs and passwords, enabling them to access the portal to view their personal and private documents, including lab and diagnostic test results, educational information, billing statements, and other health information.

Through the Patient Portal, you are able to:

- Ask questions/send messages directly to the doctor or staff members
- Request prescription refills and referrals
- Request appointments
- View your personal health record

All from the comfort of your home, whenever it is convenient for you!

Online communications do not decrease or diminish any other ways in which you can communicate with your provider. It is an additional option and not a replacement.

The practice may stop providing online communication or change the services provided online at any time without prior notification to you.

The Office of Dr. Jessica White-Videa
2855 N. University Drive, Suite 300
Coral Springs, FL 33065
Telephone (954)317-0772*Fax (954)317-0787

I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communication. I consent to the conditions outlined and I agree to keep my password confidential and notify the office if my email address changes at any time.

I am over the age of 18 and have sole responsibility for my medical care

PRINT PATIENT NAME: ____

DATE OF BIRTH: ____

EMAIL ADDRESS____

please print legibly

**Please download the Healow App and use the information below to gain access to your account.
Provider ID #

[ ] I DO not want to participate in the Patient Portal at this time.

The Office of Dr. Jessica White-Videa
2855 N. University Drive, Suite 300
Coral Springs, FL 33065
Telephone (954)317-0772*Fax (954)317-0787

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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:
You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act, HITECH Act allows people to ask for electronic copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:
We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying "Acknowledgement" form

2013

Reference Policy # 201

Coral Springs, FL 33065
Telephone (954)317-0772*Fax (954)317-0787