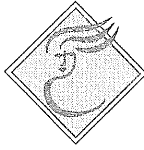

Omega Women's Center, LLC

David Hochberger, MD
Mitchell Feldman, MD
Francis J. Fazzano, Jr., MD
Lona Sasser, D.O.
Brooke Slaton, MD
Tali Rombro, D.O.

Marin Rands, CNM, MSN

Welcome to the practice of Omega Women's Center, LLC. Attached you will find the forms we require to be completed upon entering our practice. Please take the time to complete these prior to your visit and bring them with you to your first appointment. If you have not given your insurance information in detail when making your appointment, please call the appointment desk (954-755-1411 x 2) prior to your visit so we may verify your benefits before you arrive. This will decrease your wait time to see your chosen provider. Thank you in advance for the completion of the attached forms. We look forward to meeting you and providing you with the quality healthcare you deserve.

Sincerely.

The Physicians and Staff of Omega Women's Center, LLC

Omega 1, Suite 201 • 1801 University Drive • Coral Springs, Florida 33071
Tel. 954-755-1411 • Fax. 954-755-8823 • www.omegawomenscenter.com

OMEGA WOMEN'S CENTER, LLC   New/Update PATIENT FORM

(please print clearly)

PT NAME: ______________________________ **DATE:** __________

SS # ______________________ POLICY HOLDER ______________________

STREET: ______________________ STREET: ______________________

APT# ______________________ APT# ______________________

CITY __________ ST ____ ZIP ______ CITY __________ ST ____ ZIP ______

TEL# __________ CELL# __________ TEL# ______________________

DOB ___/___/___ Lang. Spoken ______ Relationship ______________________

Marital Status S ( ) M ( ) W ( ) D ( ) Referred by: ______________________

Alternate Address ______________________ e-mail # __________ tel # __________

EMPLOYER ______________________ SPOUSE: ______________________

EMPLOYER: ______________________

Address ______________________ Address ______________________

Phone: ______________________ Phone: ______________________

IN CASE OF EMERGENCY PLEASE NOTIFY:

______________________ PHONE: ______________________

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU:

______________________ PHONE: ______________________

MEDICAL INSURANCE: MEDICARE # ______________________

PRIMARY ______________________ **SECONDARY** ______________________

INSURED: ______________________ INSURED: ______________________

ID# ______________________ ID# ______________________

GROUP# ______________________ GROUP# ______________________

ASSIGNMENT OF BENEFITS, TO FACILITATE PROCESSING OF ANY INSURANCE CLAIMS

a. I hereby assign all medical and or surgical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Omega Women's Center.

b. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignor to release all information necessary to secure the payment.

c. Payments **MUST** be made at the time of each visit, UNLESS PRIOR PAYMENT ARRANGEMENTS HAVE BEEN MADE. A surcharge of 35% will be added to any accounts sent to our collection department.

I HAVE READ AND UNDERSTAND THE ABOVE:

Signed by: ______________________ Date: ______________________

OMEGA WOMEN'S CENTER, LLC
(954) 755-1411
1801 University Drive, Suite 201
Coral Springs, FL 33071

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have the right to privacy regarding my protected health information. I understand that this information can and will be used to:

- ❖ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ❖ Obtain payment from third-party payers.
- ❖ Conduct normal healthcare operations such as quality assessment and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that my request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to patient: ______________________

Signature: ________________________________ Date: ____________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

How would you like to be contacted by us?

Patient's rights of disclosures: 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

WORK
_____ OK to leave detailed message
_____ Leave message with callback number only

Written communication
_____ OK to mail to home
_____ OK to fax to home ____________________fax number
_____ OK to fax to work _____________________fax number

List all persons in your household who, in your absence, may make requests on your behalf, and with whom we may speak regarding your medical information.

NAME Relationship

____
____
____
____

Patient Signature: ___________________________Date: __________________

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REQUEST FOR RELEASE OF MEDICAL RECORDS

To: ____
Physician or Hospital Name

____
Address

____
City State Zip Code

I Hereby authorize that my medical records be released to:

OMEGA WOMEN'S CENTER
1801 University Drive
Suite 201
Coral Springs, FL 33071

Please include the following information:

- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Pathology Reports
- ☐ Labor & Delivery, Prenatal Records
- ☐ Office Records

Reason for release:

- ☐ Insurance change
- ☐ 2nd opinion or consultation
- ☐ Transferring to another physician
- ☐ Moving out of area

______________________ ______________ ______________________
Patient's Name (print) DOB SS #

____
Patients' name at time of procedure / Date of Procedure

______________________ / ______________________ ______________
Patient's Signature Witness Date

____ ______________
Signature of employee releasing records Date