



## 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 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: \_\_\_\_\_

Address \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

Phone: \_\_\_\_\_

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: \_\_\_\_\_

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**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: \_\_\_\_\_

## Prenatal Diagnosis Screening

Please answer each question. If you are unsure please leave blank and discuss with your physician or midwife.

Genetic Questions	Yes	No	Gen. Medical & Social Questions	Yes	No
Will you be age 35 or older when your baby is due?			Have you take any medications since conception? Explain: _____		
Your age when Baby is due? _____ Father's Age? _____			Did you receive a blood transfusion? Explain _____		
Have you or the baby's father or anyone in either family ever had:			Have you or the baby's father ever been diagnosed with any of the following:		
Down's Syndrome			Herpes		
Spina Bifida (Open Spine)			Chlamydia		
Hemophilia			Syphillis		
Muscular Dystrophy			Hepatitis		
Cystic Fibrosis			Urethritis		
Thalassemia			Aids		
			Venereal Warts		
			Gonorrhea or PID		
Do you or the baby's father or any close relatives in either family have any inherited genetic disease or birth defect not listed above? If Yes, please describe: _____			Have you or the baby's father been exposed at work or at home to environmental toxins during or prior to pregnancy? (I.e. organic solvents, x-ray radiation, anesthetic gases, German measles, or chicken pox)		
Have you or the baby's father ever had a stillborn child or 3 or more spontaneous losses? If yes please describe _____			If yes to the above, please give a brief description: _____		
Do you or the baby's father have any close relatives of Jewish decent who lived in Eastern Europe?			Since you conceived have you consumed alcoholic beverages? If yes, how many drinks do you have per week? _____		
If yes, to the above question have you or the baby's father had a Tay-Sach's screening?			Have you or the baby's father used marijuana, narcotics, cocaine, or other drugs..prior to or during pregnancy? If yes, please explain _____		
Are you or the baby's father of Italian, Greek, or Mediterranean background?			Have you smoked since conception? If yes, how much? _____		
If yes to the above question have you or the baby's father had a Thalassemia screening?			Do you drink Caffeine products? If yes, how many per day? _____		
Are you or the baby's father of Philippine or Oriental background?			What method of birth control did you use prior to pregnancy? _____ Date stopped _____		
If yes to the above question have you or the baby's father had a Alpha-Thalassemia screening?			Do you agree to be tested for AIDS?		
Are you or the baby's father or any close relatives of African-American decent? If yes, have you or they had a sickle cell screening?			Are you at risk for hepatitis? (I.e. healthcare worker exposed to blood, traveled to the orient, use intravenous drugs, or have contact with a hepatitis B carrier?)		

\_\_\_\_\_ Check here if you have confidential issues that you wish to discuss alone with your Physician/Midwife

PATIENT NAME: \_\_\_\_\_

ACCT #: \_\_\_\_\_

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(954) 755-1411 • FAX (954) 755-8823

## 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:**

**Reason for release:**

- |   |  |
|---|--|
| <input type="checkbox"/> Operative Report                   | <input type="checkbox"/> Insurance change                  |
| <input type="checkbox"/> Discharge Summary                  | <input type="checkbox"/> 2nd opinion or consultation       |
| <input type="checkbox"/> Pathology Reports                  | <input type="checkbox"/> Transferring to another physician |
| <input type="checkbox"/> Labor & Delivery, Prenatal Records | <input type="checkbox"/> Moving out of area                |
| <input type="checkbox"/> Office Records                     |  |

\_\_\_\_\_  
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