NORTH FLORIDA OB/GYN, LLC
Fellows of the American College of Obstetricians and Gynecologists
836 Prudential Drive, Suite 1600, Jacksonville FL, 32207
Phone number: 904-399-4862
Fax Number: 904-402-8948

Wade Barnes, M.D.
MaryEllen Wechter, M.D., M.P.H.
Amanda K. Henry, Administrator

Dear Patient:

North Florida OB/GYN, LLC would like to welcome all new and existing patients to our office.

Enclosed is our history and physical form that should be filled out **prior** to your scheduled appointment time. We ask that you fax or mail the form back to our office **prior** to your appointment. If you do not have enough time to mail the forms back to us, you may bring the completed forms to your appointment.

Our e-mail is a non-secure line. Please do not e-mail your forms back.

In order to expedite your visit, it is important to arrive at our office for your appointment 30 minutes early. You will also need your current insurance card or proof of benefits, a state issued ID such as a driver's license and any co-payments, co-insurances or deductibles that apply to your visit. If you are unable to keep your appointment, you must notify us within 24 hours to avoid a no-show fee.

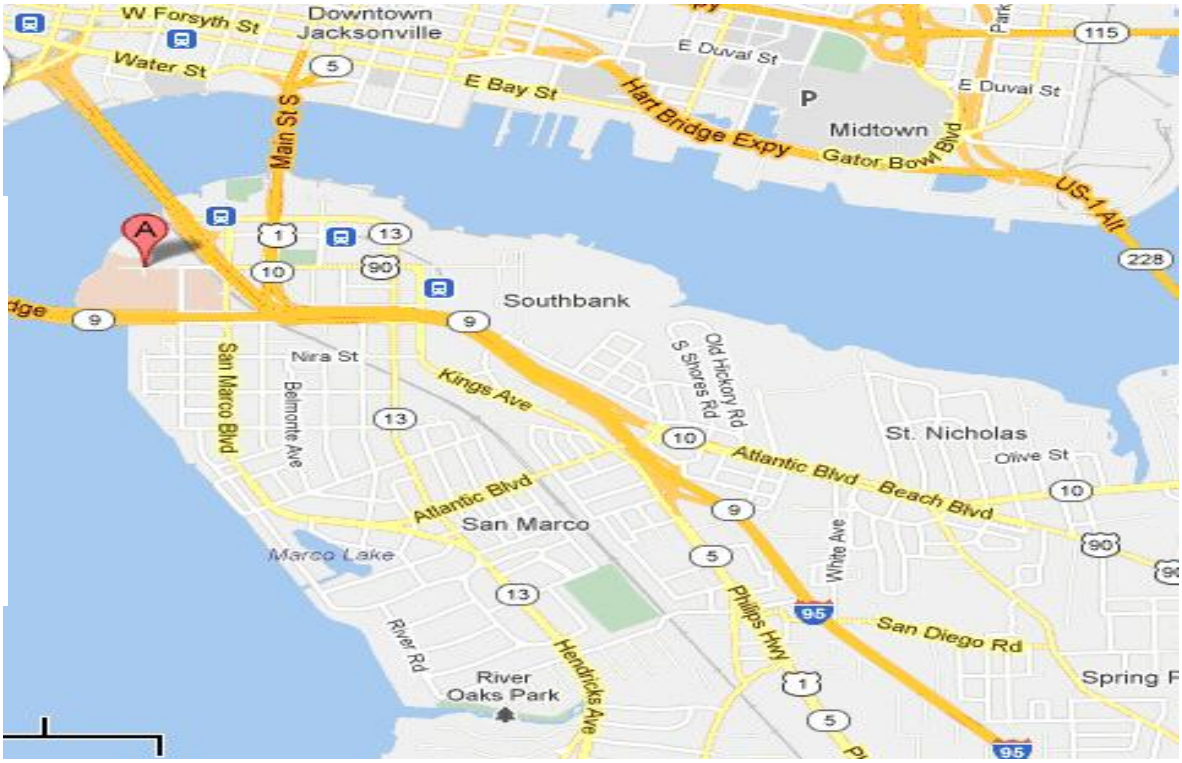
If you have any questions, please feel free to call us at (904) 399-4862.

Please fax or mail your forms back as soon as possible to avoid a delay in your appointment. We will see you soon.

Fax forms: (904) 402-8948
Mail forms:
North Florida OB/GYN, LLC
836 Prudential Drive, Suite 1600
Jacksonville, Fl 32207

North Florida OB/GYN (904) 399-4862

Map of:
836 Prudential Drive
Suite 1600
Jacksonville, FL 32207



Downtown office map shown above:

Your appointment is at 836 Prudential Drive Suite 1600, Jacksonville, FL 32207

Downtown:
836 Prudential Dr, Suite 1600
Jacksonville, FL 32207

Phone number: 904-399-4862
Fax Press: 904-402-8948

Name:_____ **D.O.B.**_____ **today's date**_____
Referred by:_____ **Occupation:**_____
Reason for visit: Well-Woman screening ***or*** Problem:_____

Do you have any medication allergies? If yes- list below

Drug	Reaction	Drug	Reaction

Are you allergic to Latex? No/ Yes Reaction:_____
Are you allergic to iodine? No/ Yes Reaction:_____
Are you allergic to IV contrast No/ Yes Reaction:_____

List all medicines you take- Include over-the-counter, and herbal/ dietary supplements

Drug	Dose	How often?	Drug	Dose	How often

Pharmacy name, address, phone:_____

Menstrual History:
1st day of last period:_____ Age at onset:_____ Regular? Yes/ No
Flow: light / mod / heavy Cycle length start to start:_____ # days of bleeding:____
Postmenopausal? Yes/ No Year of Last period_____

Do you currently have?
__Pelvic pain
__Bleeding between periods
__Bleeding after intercourse
__Vaginal discharge
__Vaginal irritation
__Leaking of urine
__Other_____
__Night sweats/ hot flashes
__Pain with periods
__Pain with intercourse
__Bleeding after menopause

Medical History: Do YOU have any of the following?

__Heart disease
__Heart Murmur/ MVP
__High Blood Pressure
__High Cholesterol
__Stroke
__Migraine headaches
__Depression
__Anxiety
__Bleeding disorder
__Deep venous clot
__Pulmonary embolus
__Anemia
__Thyroid disease
__Osteoporosis
__Diabetes
__Kidney problems
__Reflux/ IBS/ Ulcer
__Hemorrhoids
__Colitis/ Crohns
__Hepatitis
__Seizures
__Breast problems
__Abnormal Pap
__Fibroids
__Endometriosis
__Infertility
__Polycystic Ovarian Synd
__STD
__HIV+/ AIDS
__Cancer:
__Other:_____
_____

Have you ever had a blood transfusion? No / Yes When?_____
Are you willing to have a blood transfusion to save your life? No/ Yes

List any surgeries

Date	Surgery

Pregnancy History

# of pregnancies:_____# births:_____# miscarriages:_____# abortions_____# children_____

Date/ Year	Baby's sex	Birth weight	Term/ preterm	Vaginal/C-sec.	Complications?

Family history: (Include mother/father/ grandparents/ aunts/ uncles/ siblings/ children)

	Whom?		Whom?		Whom?
High blood pressure		Birth Defect		Breast Cancer	
High cholesterol		Thyroid disorder		Ovarian Cancer	
Heart disease		Osteoporosis		Uterine Cancer	
Stroke		Alzheimer's		Colon Cancer	
Diabetes				Melanoma	
Blood Clots				Other Cancer	

Do you drink alcohol? Never / Occasionally / Daily
Any past or current tobacco use? Never/ Past/ Current **How much?**_____
Any past or current drug use? Never/ Past/ Current **What kind?**_____
Special Diet (circle) Diabetic/ Vegetarian/ Weight Watchers/ Atkins/ Other:_____
Type/ Amount of exercise:_____
Marital History: Single/Married/ Separated/Divorced/ Widowed
Living situation: alone/ with spouse or partner/ with parents or custodian/ other
Currently sexually active? Yes/ No **With opposite sex** or **With Same sex**
Have you had a new partner in the last 6 months? Yes/ No
Current birth control method: None/ Pill / Patch/ Ring/ injection/ IUD/ tubal ligation/ partner has vasectomy/ condoms/ abstinence/ hysterectomy/ Natural Family planning/
Do you use condoms? Never/ rarely/ most of the time/ always
Any current or past abuse, domestic violence, or sexual abuse? No/ Yes _____

Health Screening: (give date)
Last Pap Smear:_____
Last Mammogram:_____
Last Bone Density:_____
Last Colonoscopy:_____
Last Cholesterol screen:_____
HIV testing:_____

Vaccine history: (give date)
Last Flu vaccine:_____
Last Tetanus/ Pertussis:_____
Hepatitis B Series:_____
Gardisil or Cervarix series:_____
Pneumovax:_____

These Non-Covered Services include:

- **A $25.00 fee will be charged if co-payments, co-insurance or any out of pocket responsibility is not paid at the time of service.**
- **All checks will be automatically deducted from your account. If the check is declined, you will be charged a NSF check fee of $25.00.**
- **A "No-Show" charge of $50.00 will be applied to your account for all missed appointments or cancellations made less than 24 hours before appointment time. All appointments must be canceled or rescheduled during regular business hours.**
- **Procedure cancelations made less than 24 hours before appointment time will be charged a $100.00 fee. All appointments must be canceled or rescheduled during regular business hours.**
- **Forms to be completed (Disability, Life Insurance, FMLA) must be paid in advance. The charge is $25.00 is applied per each set of forms. Please leave your forms with us and allow 7-10 days for completion.**
- **A charge is applied for copies of your medical records. The state law has set this price at $1.00 per page up to 25 pages, then 25 cents per page for the remaining pages.**
- **Return to work/out of work letters are $5.00 per letter.**
- **Certified letter fee of $7.00**
- **Elective, optional ultrasound fees are due at the time of service.**

Patients name_____

Patients signature_____

Patients DOB_____

Date_____

NORTH FLORIDA OB GYN LLC
Consent for Medical Information Release

There are times we are asked to give family members or others information on test results, especially if you will not be available to receive them. If you would like for us to give out information regarding your treatment and/or test results to your family or friends, please fill in their name and their relationship to you. **Please designate which type of information each person may receive** by checking the items we may release and any item we should not disclose. Make your own notes if necessary for clarification.

Definitions:

All Information: Any and All information we have in our file related to you which may include billing information, appointments, treatment, test results, etc. and information on sexually transmitted disease; HIV/AIDS, birth control, pregnancy and mental health information

Appointment Only: Only information related to appointment dates and times.

STD's/HIV: Information related to sexually transmitted disease including HIV, AIDS, HPV, dysplasia, abnormal paps, herpes, GC, Chlamydia, syphilis, vaginitis, Trichomonas, etc.

Preg/Ab: Information related to pregnancy and abortion.

BC: Information related to preventing pregnancy including birth control pills, diaphragms, condoms, IUD's, etc.

Relationship	Name of person allowed to receive info.	Type of info which may be released
Mother	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
Father	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
Spouse	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
_____	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC
_____	_____	□ All info □ Appts only □ STD's/HIV □ Preg/Ab □ BC

□ **NO INFORMATION TO BE RELEASED**

This consent to release information will remain in effect until revoked in writing.

_____	_____	_____
Print Patient's Name	Patient Signature	Date
_____	_____	_____
Staff Witness	Date	Division

North Florida OB GYN LLC

Confidential Patient Information Form - Form must be filled out <u>completely</u> to ensure correct claim processing.

Social Security _____**Patient** _____
(Last) (First) (Middle Initial)

Date of Birth_____**Address**_____
(Street #) (City) (State) (Zip)

Home Tel#: _____**Work Tel#:** _____**Patient Cell #** _____

(If Cell # is provided, the office may text you appointment reminders) Employer_____

Patient E-Mail_____ **Marital Status** _____ **Employment Status** _____
(S M D W Sep) **(***FT PT Ret N*

How did you hear about our office? _____**Student**_____ *(FT PT)*

Referring Physician _____**Primary Care Physician** _____

Emergency Contact _____ **Relationship**_____ **Phone #** _____

Spouse's name or other responsible party:_____ **Phone #** _____

Pharmacy Name, Phone #, Fax # and address_____

<u>Primary Insurance</u>: _____**Subscriber (Insured) Name** _____

Subscriber: Date of Birth_____ Social Security # _____Employer_____

ID#_____ **Group Name & #**_____ **Patient Relationship to Insured**_____
(Self, Spouse, Child)

Insurance Address_____
(City) (State) (Zip)

<u>Second Insurance</u>: _____ **Subscriber (Insured) Name**_____

Subscriber: Date of Birth_____ Social Security # _____Employer_____

ID#_____ **Group Name & #**_____ **Patient Relationship to Insured**_____
(Self, Spouse, Child)

Insurance Address_____

I understand that I am directly and primarily responsible to North Florida Obstetrical & Gynecological Associates, P.A., the parent company of North Florida OB GYN, LLC, for its customary fee for the services rendered to me by North Florida OB GYN, LLC. I realize that if my insurance company fails to pay or if there is any delay in paying North Florida Obstetrical & Gynecological Associates, P.A., it is my responsibility to pay my doctor's bill directly. I further understand and agree if I fail to make timely payments to North Florida Obstetrical & Gynecological Associates, P.A., that I will be responsible for any and all reasonable cost of collection including filing fees as well as any reasonable attorney's fee(s).

For the services rendered by North Florida OB GYN, LLC, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits either to myself or the party who accepts assignment (North Florida Obstetrical & Gynecological Associates, P.A.). I authorize payment of medical benefits to the physician who submits the claim. I agree to hold North Florida OB GYN, LLC harmless from any and all costs, liability and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent. North Florida OB GYN, LLC and other PA subsidiaries may share one electronic medical record. To facilitate the provision of my medical care, I consent for North Florida OB GYN, LLC to access my medical records maintained by any other PA subsidiary.

I understand the office may employ an Advanced Registered Nurse Practitioner ("ARNP"), Midwife ("ARNP/CNM") or Physician Assistant ("PA"), and if I am scheduled with them, I am willing to see them instead of the doctor. I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I consent to electronic access to my medication history.

This form was last modified on **10/1/2015**. I acknowledge that I have read this authorization and fully understand its contents.

Signature_____Date_____

Patient Name: _____ NORTH FLORIDA OB GYN, LLC FINANCIAL AGREEMENT

PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have had the opportunity to review a copy of **North Florida OB GYN LLC's Privacy Notice** dated **September 01, 2013** ("Notice"). I understand that I am responsible to read this Notice and notify North Florida OB GYN, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand the notice included electronic access to my medication history. North Florida OB GYN has the right to revise this Notice at anytime and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.nfobgyn.com. North Florida OB GYN will provide me with a copy of its most recent Notice upon my request.

Patient Signature: _____ Date of Birth:_____

Parent, Guardian or Legal Representative Signature:_____

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at North Florida OB GYN, LLC. I am responsible for any applicable deductible, co-insurance or co-payments prior to the provision of services. For surgery and pregnancy, North Florida OB GYN LLC will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, procedure or pregnancy, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. Any patient credits will be applied to my other outstanding patient balances prior to any refund issued. I further understand that such payment is not contingent on any insurance, settlement or judgment payment

North Florida OB GYN, LLC is a wholly owned subsidiary of North Florida Obstetrical & Gynecological Associates, P.A. (“PA”) who may file a claim for payment and accept assignment with my insurance company as required by contractual agreement. If the insurance company fails to pay in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is **my responsibility** to provide North Florida OB GYN with a copy of my **current insurance** card and, if required by my insurance, **to obtain a referral** from my Primary Care Physician. North Florida OB GYN is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of the services provided. **I will notify North Florida OB GYN immediately upon any change to my insurance**.

INSURANCE WAIVER , NON-COVERED SERVICES WAIVER and OUTSIDE LAB SERVICES

I understand that if I do not have a copy of a current insurance card and/or valid referral, North Florida OB GYN is not obligated to see me. But if I still wish to be seen, I can be seen as a "Private Pay" patient. I agree that neither the PA, nor I, will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service I desire, suggested or provided that is not covered under my insurance plan “Non-Covered Services”; I understand I must pay for Non-Covered Services. If feasible, a waiver will be completed for each Private Pay visit or Non-Covered Service. I understand services sent to an outside lab are billed to my insurance or me by the lab and I will receive a separate invoice from the lab.

ANNUAL EXAMS (Including Medicare Annual Visits)

Annual "well-women" exams are preventive visits and are not paid for by all insurance carriers. Medicare only pays for a portion of this exam (Pap, Pelvic and Breast Exam) once every two (2) years. I understand I am responsible for payment, if the exam or portion of the exam is not covered by my insurance.

Annual exams do not typically include problems I may be having – as problem visits may require longer time. If I am experiencing problems, the office may be required to reschedule another visit to address these concerns.

CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. North Florida OB GYN, LLC and other PA subsidiaries may share one electronic medical record ("EMR"). To facilitate the provision of my medical care, I consent for North Florida OB GYN, LLC to access my medical records maintained by any other PA subsidiary.

ADDITIONAL INFORMATION

Payment may be made to the PA in the form of: Cash, Check, Debit and Credit Cards. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to me by North Florida OB GYN, LLC. Patient credits are applied to other outstanding patient balances prior to any refunds that may be issued, including balances owed to other wholly owned subsidiaries of the PA.

I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged if I do not cancel my scheduled appointment, for not paying my co-pay and/or co-insurance or patient responsibility including deductible at the time of service, for telephone management services, for educational materials, for payment agreements which extend beyond 12 months, and for other administrative expenses not covered by my insurance plan.

ASSIGNMENT OF BENEFITS

For the services rendered by North Florida OB GYN, LLC, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits either to myself or to the party who accepts assignment (North Florida Obstetrical & Gynecological Associates, P.A.). I agree to hold North Florida OB GYN, LLC harmless from any and all costs, liability and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

SIGNATURE

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient's Printed name _____Patient's Date of Birth:_____

Patient's Signature:_____ Date signed:_____

Parent, Guardian or Legal Representative Signature:_____

Employee's signature who reviewed intake of form:_____

Follow your health with North Florida, on our Secure Portal

ALL OF YOUR NORMAL LAB RESULTS WILL COME TO YOU VIA OUR SECURE PORTAL

You will also be able to view your health information, see your medications, request an appointment, see your upcoming appointments or ask your provider questions concerning your health. Get it all, through our FREE and SECURE patient portal.

Steps to join:

- Fill out the bottom portion of this sheet
- Our staff will send you a "Follow My Health" invitation to the email listed below
- From your email, click on the link to create your account
- You may create a username with FMH or use your existing Yahoo, G-Mail, Facebook, or Microsoft account to log into your FMH account
- You will then agree to use this user name and password to access FMH
- You will have a one-time invitation code (the last 4 of your SSN or the year you were born)
- Read our HIPAA statement
- You will then go to your health record
- You can send messages to our office by clicking "send a message"
- Use the "My Health" tab to access your labs, vitals, and medication list

If you need assistance

Support Hotline: (888) 670-9775

Email: support@followmyhealth.com

Follow and be engaged in your health!
Sign up below; you will receive an invitation in your email shortly. Keep this sheet, follow the instructions and be on you way to a convenient way to manage your health!
Get the FREE app in the iTunes or Google Play store.

(Tear here)

Sign up to receive your patient portal invitation

Name _____

Date of Birth _____

Last 4 of SS# _____

Email address _____

Signature _____