Date _____
Fecha

Patient Registration
Registración del Paciente

FOR INTERNAL USE ONLY
PATIENT NUMBER _____

Patient Information - *Información del Paciente*

Social Security # _____
Numero de Seguro Social
First Name _____ Middle _____
Primer Nombre *Segundo Nombre*
Last Name _____
Apellido
Sex _____ Date of Birth ____/____/____
Sexo *Fecha de Nacimiento*
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Estado Civil *Casada* *Soltera* *Divorciada* *Viuda*

(Check One) ☐ Employed ☐ Retired ☐ Full-Time Student
Marque Uno *Empleada* *Retirada* *Estudiante Tiempo Completo*
☐ Other _____
Otro
Employer _____
Empleador

Home Address _____
Direccion del Hogar
_____
City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*
Email Address _____
Home Phone (_____) _____
Telefono del Hogar
Work Phone (_____) _____
Telefono del Trabajo
Cell Phone (_____) _____
Telefono Cellular
Referring Physician _____
Referida Por el Dr:
How did you hear of us? _____
Como usted supo de nosotros?

Insurance Information - *Información del Seguro*

Please provide your insurance card to the receptionist - *Por favor entregue su tarjeta de seguro a la recepcionista*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other _____

Insurance company _____
Compañia de Seguro
Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado *Relación*
Policy # _____ Group # _____ Phone ( ) _____
Numero de Poliza *Numero de Grupo* *Telefono*

Secondary Insurance Information - *Información del Seguro Secundario*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other _____

Insurance company _____
Compañia de Seguro
Insured / Card Holder's Name _____ Relationship _____
Nombre del Asegurado *Relación*
Policy # _____ Group # _____ Phone ( ) _____
Numero de Poliza *Numero de Grupo* *Telefono*

Emergency Contact - *En Emergencias, contactar a:*

First Name _____ Middle _____
Primer Nombre *Segundo Nombre*
Last Name _____
Apellido

Home Phone (_____) _____
Telefono del Hogar
Work Phone (_____) _____
Telefono del Trabajo

Spouse / Guarantor / Responsible Party - *Esposo / Persona Responsable*

Social Security # _____
Numero de Seguro Social
Relationship _____
Relación
First Name _____ Middle _____
Primer Nombre *Segundo Nombre*
Last Name _____
Apellido
Address _____
Direccion
City _____ State _____ Zip _____
Ciudad *Estado* *Codigo Postal*

Sex _____ Date of Birth ____/____/____
Sex *Fecha de Nacimiento*
DAYTIME PHONE (_____) _____
Teléfono durante el dia
EMPLOYER _____
Empleo
ADDRESS _____
Direccion
CITY _____ STATE _____ ZIP _____
Ciudad *Estado* *Codigo Postal*

Signature Required Please See Reverse Side
Firma Requerida. Por Favor mire al Dorso

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept most major credit cards. 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 for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos ciertas tarjetas de credito. Su seguro medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsable de los gastos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to S.458.320 (5)(g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida law.

Hemos elegido no llevar seguro de negligencia medica o no demostrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (la ley 5) (g). Florida impone penas contra los medicos de los no-asegurado que no pueden satisfacer los juicios adversos que se presentan de demandas de la negligencia medica. Este aviso esta conforme a la ley de la Florida.

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 carrier, HMO or other third party payor, for services rendered by the physician. I understand that I am financially responsible to the physician for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a el medico todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Yo entiendo que soy responsible por todos los cargos no cubiertos bajo mi seguro medico.

PATIENT'S / GUARANTOR'S SIGNATURE

DATE

CANCER FAMILY HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Physician seeing: _____ Today's Date: _____

This is a screening tool for cancers that run in families. Please INCLUDE these family members:
Mother/Father/Sister/Brother/Children
Aunt/Uncle/Grandparent/Niece/Nephew/ 1st Cousin

Please only circle YES if your history exactly matches the questions on this form

		Cancer Family History	SELF	Please list your FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Breast cancer diagnosed at age 49 or less				
Y	N	**TWO** relatives on the same side of the family with breast cancer, one diagnosed at age 50 or younger				
Y	N	Ovarian cancer at any age				
Y	N	**THREE** relatives on the same side of the family diagnosed with breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with a breast, ovarian, prostate or pancreatic cancer in the family				
Y	N	Male breast or metastatic prostate cancer at any age				
Y	N	Pancreatic cancer at any age				
Y	N	Endometrial/ uterine or colon cancer diagnosed before age 50				
Y	N	**THREE** or more of the following cancers on the same side the family at any age: colon, endometrial, ovarian, gastric/stomach, pancreatic, brain, small bowel, renal/pelvic				
Have you ever been tested for BRCA or Lynch Syndrome before?						

Patient is appropriate for testing: **Y / N** Patient accepted genetic testing: **Y / N**

Patient Signature: _____ Provider Signature: _____

GEMINI
OBSTETRICS/GYNECOLOGY, LLC

Todd M. Goldberg, D.O., F.A.C.O.O.G.
Douglas Smith, D.O., F.A.C.O.O.G.
Suzette M. Rodriguez, M.D., F.A.C.O.G.

Dear Patient,

In an effort to provide the best experience during your office visit today, please take a few minutes to complete the following questions. It will help us keep current on very important health issues affecting you and it will allow the most efficient use of time with the Doctor. Thank you!

MENSTRUAL PERIODS

1. How long does your average monthly period last? _____days
2. Do you ever feel as though your periods impact the quality of your life? Yes___ No__
3. Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods? Yes___ No___

URINARY/PELVIC HEALTH

1. Do you ever leak urine when you cough, laugh, sneeze or work out? Yes___ No___
2. Do you ever feel as though you have to urinate urgently? Yes___ No___
3. Do you feel like you have to urinate too frequently? Yes___ No___
4. Do you ever experience painful urination?
5. Do you have pelvic pain, pressure, weakness or a feeling of heaviness? Yes___ No___
6. Have these problems worsened since childbirth? Yes___ No___
7. Do you experience painful intercourse? Yes___ No___

WEIGHT LOSS/ AESTHETICS

1. Are you interested in more information about our weight loss programs? Yes___ No___
2. Are you interested in bioidentical hormone pellet therapy? Yes___ No___
3. Are you interested in Botox/ Dysport? Yes ___ No___
4. Are you interested in information regarding laser vaginal rejuvenation? Yes___ No___

Please print your first and last name _____

Cell Phone Number _____

Date Completed _____

603 N. Flamingo Road • Suite 361, Pembroke Pines, Fl 33028 • Phone: (954) 432-7900 Fax: (954) 433-4903
2300 N. Commerce Parkway • Suite 205, Weston, Fl 33326 • Phone: (954) 389-3855 Fax: (954) 389-4018

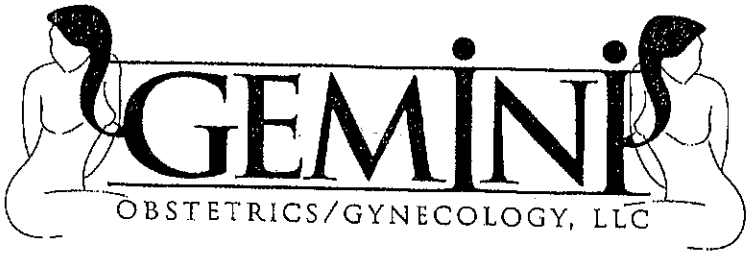
Gemini OB/GYN
Todd Goldberg, DO~ Douglas Smith, DO~ Suzette Rodriguez, MD
603 N Flamingo Road, Suite 361 Pembroke Pines, FL 33028
2300 N Commerce Parkway, Suite 205 Weston, FL 33326
T-954-432-7900~ F-954-433-4903

I, _____hereby consent to a medically indicated physical examination. This may include but is not limited to a pelvic examination. This will be performed by the providers of Gemini OB/GYN, LLC. This consent will remain active until I withdraw my consent in writing.

Print Name: _____

Signature: _____

Date: _____



Todd Goldberg, D.O. FACOOG Douglas Smith, D.O. FACOOG Suzette Rodriguez, M.D. FACOG
603 N. Flamingo Road/Suite 361, Pembroke Pines, Florida 33028 – Phone #954-432-7900/Fax: 954-433-4903
2300 N. Commerce Pky/Suite 205, Weston, Florida 33326 – Phone #954-389-3855

Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Gemini OB/GYN, LLC to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Gemini OB/GYN, LLC.

I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am financially responsible for all charges including costs of collection and litigation if necessary.

Date_____ Signature_____
(patient, parent, or guardian)

Physician Financial Responsibility

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non insured physicians who fail to satisfy adverse judgment arising from claims of medical malpractice. This notice is pursuant to Florida law.

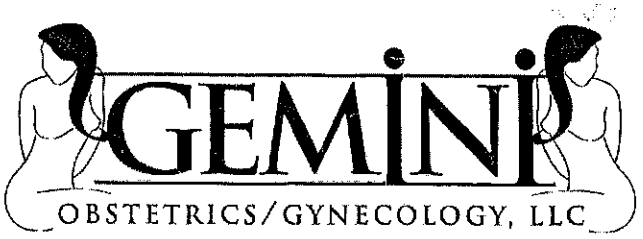
Date_____ Signature_____
(patient, parent, or guardian)

Medical Malpractice Agreement

Further, I understand that I am entering into a contractual relationship with Gemini OB/GYN, LLC for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Gemini OB/GYN, LLC, I (the patient) and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Gemini OB/GYN, LLC.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use ABMS board-certified expert medical witness(es) in the same or similar specialty as Gemini OB/GYN, LLC. Furthermore, I agree that these expert witness(es) will adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case. In further consideration for this, Gemini OB/GYN, LLC, agree to the same stipulations.

_____ _____
Date Patient



Todd Goldberg, D.O. FACOOG Douglas Smith, D.O. FACOOG Suzette Rodriguez, M.D. FACOG
603 N. Flamingo Road/Suite 301, Pembroke Pines, Florida 33028 – Phone #954-432-7900/Fax: 954-433-4903
2300 N. Commerce Pky/Suite 205, Weston, Florida 33326 – Phone #954-389-3855

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I acknowledge that there was a copy of the Notice of Privacy Practices posted describing how my health information may be used or disclosed under the federal law. Provided that "Gemini OB/GYN, LLC continues in its good faith effort to comply with the requirements of the federal privacy act law, I hereby consent to the use and disclosure of my health information for the purposes and the activities permitted under the federal privacy law, which are described in the Notices of Privacy Practices.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the notice may be changed at any time. I may obtain a revised copy of the notice by calling (954)-432-7900 or by requesting one while at your office.

I also authorize Dr. Todd M Goldberg, DO, Dr. Douglas Smith, DO and Dr. Suzette M Rodriguez, MD and staff to release all medical information to the following:

Name	Date	Relationship to Patient
Name	Date	Relationship to Patient
Patient Name Printed	Date	Signature of Patient

Gemini OB/GYN

Cancellation Policy/No Show Policy
For Doctor Appointments and Surgery

1. *Cancellation/ No Show Policy for Doctor/ultrasound Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be billed to or covered by your insurance company.

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 20 minutes past their scheduled time we may have to reschedule the appointment to later that day or another day.

3. *Cancellation/ No Show Policy for Surgery*

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 3 days (72 hours) in advance you will be charged a two hundred fifty dollar fee ($250); this is will not be billed to or covered by your insurance company.

4. Account balances

We will require that patients with self-pay balance (deductible/co-insurance/uncollected copays) pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____	_____	____/____/____
Print Name Patient	**Signature Patient/Guardian**	**Date**

Patient Account #_____

(Office Use Only)

Authorization for Release of Information

Name of Patient _____ Date of Birth ____/____/____

Gemini OB/GYN is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity To Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released** Check each that can be given to person/entity on the left in the same section.
Voice Mail	Results of lab tests/x-rays Other ☐
Spouse_____	Financial ☐ Medical as follows below ☐
Parent (provide name) _____	Financial ☐ Medical as follows below ☐
Other (provide name) _____ _____	Financial ☐ Medical as follows below ☐

Patient Information:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization maybe subject to disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. THIS AUTHORIZATION SHALL IN BE EFFECT UNTILL REVOKED BY PATIENT.

_____ Date____/_____/_____

(Signature of Patient or Personal Representative

GEMINI OB/GYN, LLC.

Todd M. Goldberg, D.O., F.A.C.O.O.G. Douglas Smith, D.O.,F.A.C.O.O.G.
Suzette M. Rodriguez, M.D.,F.A.C.O.G.
603 N. Flamingo Rd Suite 361 Pembroke Pines, Fl 33028 954-432-7900 Fax 954-433-4903
2300 N. Commerce Parkway Suite 205 Weston, Fl 33326 954-389-3855 Fax 954-389-4018

PAYMENT POLICY GYN PATIENTS:

Our office policy regarding copays, deductibles and coinsurance amounts is as follows.

For GYN patients, any copays for that day's services, as well as the lab draw fee are due upon arrival. If benefits have been verified to show that you have any remaining deductible that has not been met and/or coinsurance, then we will pre-collect on that amount that will be due. The minimum amount that we will collect upfront will be $130.00. If the charges are covered in full by your insurance company once the claim is completely processed, then we will refund you the difference.

The $10.00 lab draw fee is not billable to insurance and is non-refundable. This is a convenience fee. This is a per visit fee as necessary. If you would rather be given a requisition and go to a lab elsewhere to have your blood drawn, then you must inform the medical assistant prior to having your blood drawn.

If for any reason, we have not pre-collected or if the information that was provided to us by you or your insurance was incorrect, which results in a balance due by you, then the following is the office policy for the balance due:

We would prefer the balance to be paid in full after you receive the first statement from us.

If you should need to make monthly payments, we can accept $50 monthly for balances that are $150 or less and $100 monthly for anything over $150.00. You can send in a check monthly with your statement or you can set up a recurring payment plan by credit card that is automatically charged by the billing manager at a designated time each month.

If two consecutive statements are sent to you, without a payment on account we will start the collection process.

If you need to make any other payment arrangements, you would need to call the office and contact the office manager to set up a payment plan.

Thank you in advance for your cooperation. We strive to maintain a positive experience with all of our patients.

INIT. X _____

GEMINI OB/GYN, LLC.
Todd M. Goldberg, D.O., F.A.C.O.O.G. Douglas Smith, D.O.,F.A.C.O.O.G.
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LAB FEES:

Our office charges a fee for having your lab work drawn here in the office.

OB (obstetrical) patients: $20 for the entire pregnancy

GYN patients: $10 per visit

These fees are to be paid the day of your lab work. If you DO NOT wish to pay this fee, you will be given a requisition to go to the lab of your choice. We will not draw the labs here.

This is a convenience fee and not billable/payable by your insurance company.