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 _____ Home Phone (_____) _____
Primer Nombre *Segundo Nombre* *Telefono del Hogar*

Last Name _____ Work Phone (_____) _____
Apellido *Telefono del Trabajo*

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

Social Security # _____ Sex _____ Date of Birth ____/____/____
Numero de Seguro Social *Sex* *Fecha de Nacimiento*

Relationship _____ DAYTIME PHONE (_____) _____
Relación *Teléfono durante el dia*

First Name _____ Middle _____ EMPLOYER _____
Primer Nombre *Segundo Nombre* *Empleo*

Last Name _____ ADDRESS _____
Apellido *Direccion*

Address _____ CITY _____ STATE _____ ZIP _____
Direccion *Ciudad* *Estado* *Codigo Postal*

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 _____

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.

Welcome to Gemini OB/GYN, LLC. For those of you who have been to our practice before, we appreciate your support and the confidence you have in our practice. For those of you new to our office we will strive to meet your expectations.

Please be advised that we only deliver and work out of **Memorial Hospital West.** If you seek care at any other hospital than **Memorial Hospital West**, we will be unable to care for you while you are in the hospital.

Our providers include the following doctors: Todd M Goldberg, DO, Douglas F Smith, DO and Suzette Rodriguez, MD. We occasionally cross cover with other physicians.

Although we encourage a strong physician/patient relationship, as a group practice we cannot guarantee which provider will be on call at the time of your delivery. Therefore we suggest that you meet all of our providers at least once during the course of your pregnancy. Once again we welcome you to our practice. Please do not hesitate to ask any questions or voice any concerns.

Patient Signature _____ Date _____

Witness _____

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
OBSTETRICS/GYNECOLOGY, LLC

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

I have been furnished information be Gemini OB/GYN, LLC, prepared by Florida Birth-Related Neurological Compensation Association, and have been advised that Todd M. Goldberg, DO, Douglas Smith, DO and Suzette Rodriguez, MD are participating physicians in the program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor, delivery or resuscitation. For specifics on the program, I understand I can contact Florida Birth-Related neurological Compensation (NICA), 1435 Piedmont Drive East, Suite 101, Tallahassee, Florida 32312, 1-800-398-2129. I further acknowledge that I have received a copy of the brochure prepared by NICA.

Dated this_____day of_____, 20___.

_____
Signature

_____
Name of Patient

_____
Social Security

Attest:

_____
Nurse or Physician

_____
Date

See Section 766.316, Florida Statues

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

If you are RH- (if your blood type is A-, O-, B- or AB-) you will need an injection of Rhogham at your 28th week of pregnancy. We will give you a prescription for the medication for you to take to a pharmacy and fill prior to that appointment. It is your responsibility to fill the prescription and bring the injection to your appointment. If for any reason your insurance does not cover this medication it is still your responsibility to obtain the medication. You will have to either pay for the medication or find a pharmacy that will fill the prescription and file/bill it to your insurance. This is not a medication that we stock in the office. If you have any questions, please feel free to ask your nurse. Please sign below to indicate your understanding of this policy. Thank you.

Patient Name and Date

Witness name and Date

Gemini OB/GYN, LLC
Todd Goldberg, DO~ Douglas Smith, DO~ Suzette Rodriguez, MD

Attention All Obstetrical Patients:

During your pregnancy you may be referred to several different specialists that will consult with us on your care. You will see the perinatologist for genetic testing and ultrasounds. You may see other doctors as you medical history and conditions dictate. However you will continue to see us as your primary physician during your pregnancy on a regular basis. You will be seen on a monthly basis and then as your pregnancy progresses you will be seen more frequently as your doctor deems necessary. Please make sure to schedule a follow up appointment before you leave our office after each visit. Thank you for allowing us to participate in your care.

_____

Patient Sign and Date

_____

Witness Sign and Date

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

Dear Patient

Congratulations on your pregnancy! Thank you for choosing the doctors of Gemini OB/GYN to care for you during this most important time in your life. We are honored and grateful for your trust in us. Dr.'s Goldberg, Smith and Rodriguez and our caring staff look forward to treating you for your pregnancy. A few things to think about as you go through your pregnancy:

- As a courtesy to our patients we draw blood in our office. There is a one-time $20.00 courtesy fee not covered by insurance to have us draw your blood for the duration of the pregnancy. If you do not wish to pay the courtesy fee we will be happy to give you a requisition to go to the contracted laboratory of your insurance plan.
- If you have a boy, we offer in office circumcisions for most insurance plans. We feel it is a more personalized service. Please speak with our staff regarding your particular insurance plan.
- We encourage our patients to consider cord blood collection. We have information on several different companies in our office. There is a charge of $150 for the physician to do the collection. This is not covered by insurance.
- We realize that many patients worry about weight gain during pregnancy. We offer nutritional counseling by a certified nutritionist during your pregnancy and several weight loss plans that can be done after your post-partum period. Please speak to your doctor on your next visit. We offer special packages for patients who sign up prior to delivery.
- We encourage you to visit our website at www.geminiobgyn.com for many informative and educational links. You will find valuable and important information on our website.

Again, thank you for choosing Gemini OB/GYN for your obstetrical care. We strive to provide you and your baby with outstanding compassionate care during this important time. You can contact our office at any time with questions or concerns at 954-432-7900.

_____

Patient Signature and Date

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: _____

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 OBSTETRICAL PATIENTS:

For our OB patients, it is our policy to pre-collect any copays, deductible and coinsurance prior to your 32th week of pregnancy. The amount we pre-collect goes into a "bank account" on your account to go towards global maternity. Global maternity is billed AFTER you deliver. We will verify your benefits, and any financial responsibility to be collected will be explained to you as soon as possible.

The $20.00 lab fee covers all of your blood drawing fees here in the office during your pregnancy. It is a convenience fee and non-billable to your insurance company and non-refundable. If you choose to take a requisition to have your blood drawn at an outside lab, then that will be in force for your entire pregnancy. Should you change your mind, you will be charged the $20.00 fee.

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:

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

If you should need to make monthly payments, then you **MUST CONTACT** the office manager to set up a payment plan. We would typically require at least half the balance to be paid and then a minimum monthly payment arrangement. This is discussed on an individual basis per patient due to the typically larger balance of obstetrical patients.

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

Please be advised that only **ONE** ultrasound per pregnancy is clinically indicated unless there is a medical reason to do more.

Please do not ask your doctor to order ultrasounds for any non-medical reason. This is insurance fraud and we cannot participate in that. Our commitment is to providing a board certified level of care that has you and your unborn child's wellbeing in mind. Thank you!

Patient's Signature and Date: _____

Informed Consent

Gemini OBGYN

preparent carrier test

innatal prenatal screen

About these tests

These tests tell you if your baby is at risk for certain genetic diseases. Genetic diseases are caused by changes to a person's genes or chromosomes, which are made of DNA.

The Preparent Carrier Test tells you if you're a carrier of a genetic disease. Being a carrier of a genetic disease means there is a change to one of your genes, and it doesn't work. This test looks at your genes to find out if you are a carrier of certain genetic diseases and at risk to have an affected baby. Your healthcare provider will recommend which ones to test, based on a few factors.

The Innatal Prenatal Screen tells you if your baby may have a chromosomal disease. Chromosomal diseases are a type of genetic disease caused by having an extra or missing chromosome. This test tells you if your baby is at risk for trisomy 21 (Down syndrome), trisomy 18, and trisomy 13. Other diseases may be tested at the request of your provider.

The diseases on both tests were chosen because they have harmful health effects that often start at a young age and do not have a cure. Having a baby with one of these diseases can happen to anyone regardless of age, ethnicity, or family history.

What test results mean

Positive (abnormal) results
mean that your baby's risk to have a certain genetic disease is higher than most other babies. Follow-up testing may be recommended.

Negative (normal) results
mean that your baby's risk to have the diseases tested is low, but not zero.

Benefits

- Finding out these results will help you understand your baby's risk to have the diseases tested.
- Negative results are reassuring. Positive results let you and your provider determine the next steps for the identified risk(s).

Limitations

- Negative results do not guarantee a healthy pregnancy or baby. These tests look for specific changes to certain chromosomes and genes. Changes not targeted by these tests will not be detected.
- False positive, false negative, and failed results are rare, but can happen.

Your privacy is protected

- We keep your results and information private. We only send results to the ordering provider, unless you give us permission to send elsewhere. You can contact us for a copy of your results.
- No other test will be performed or reported on your sample, unless ordered by your provider. Samples received from New York State will be destroyed within 60 days after testing.
- We may contact your provider to obtain follow-up information after your test is complete. This is a standard lab practice, and is required in several states.

Before signing this form, I had the chance to talk about this test with my healthcare provider or someone he/she chose, and genetic counseling has been recommended before and after testing. My questions have been answered and I have all of the information that I need to decide. I understand that this test is voluntary. I have decided that:

Preparent® Carrier Test

- ◯ Yes, I want to receive the **Preparent® Carrier Test**.
- ◯ No, I do not want to receive the **Preparent® Carrier Test**.

Innatal® Prenatal Screen

- ◯ Yes, I want to receive the **Innatal® Prenatal Screen**.
- ◯ No, I do not want to receive the **Innatal® Prenatal Screen**.

PATIENT NAME *(please print)* _____ DATE OF BIRTH _____

PATIENT SIGNATURE _____ DATE _____

5230 S. State Road, Ann Arbor, MI 48108 USA • Tel +1-855-293-2639 • progenity.com

CONSENT FORM FOR FETAL CHROMOSOMAL SCREEN:
FIRST AND SECOND TRIMESTER SCREENING

Babies may be affected with chromosome abnormalities, the most common being Down Syndrome, a disorder that leads to mental retardation and other birth defects. Generally, risk of chromosome abnormalities becomes greater as the age of the expectant mother increases. For mothers 35 years of age or more at the time of delivery, the standard recommendation is to offer a genetic amniocentesis, the removal of a sample of the amniotic fluid for analysis.

Because younger mothers can also have an affected baby, a non-invasive screening test using a blood sample is generally offered is generally offered to those under the age of 35. This test, commonly known as the *alpha-fetoprotein (AFP)*, or *multiple marker screen (AFP4)*, is completed during the second trimester of the pregnancy and detects approximately 60-80% of babies affected with Down syndrome. It also provides information about the baby's risk of Trisomy 18 (a chromosomal disorder that causes severe mental retardation and birth defects), as well as risk of open neural tube defects (ONTD – occur when the developing baby's spine or skull does not form completely, as in spina bifida).

It is important to understand that a screening test is limited; a result that shows increased risk does not mean that the baby actually has an anomaly; a result that is within the normal range does not necessarily mean that there are no abnormalities present. Mothers whose test results show increased risk will be offered further evaluation by invasive testing with amniocentesis, a diagnostic test that identifies most known chromosome abnormalities.

Now, more screening options are available to you as an alternative to the single blood sample in the second trimester. Each option has relative advantages and disadvantages. Your options are as follows:

•FirstScreen (11 weeks - 13 weeks and 6 days)
This screening test, performed in the first trimester of pregnancy, includes a sonogram to measure the amount of fluid accumulation at the back of the baby's neck (Nuchal Translucency) and a blood sample that is tested for special markers. FirstScreen helps to identify babies at increased risk of having Down Syndrome or Trisomy 18, but does not identify risk for ONTD (spina bifida). If you choose this option, another blood sample should be taken in the second trimester to analyze alpha-fetoprotein for the risk of ONTD. FirstScreen detection rates for Down Syndrome and Trisomy 18 are lower than IntegratedScreen, but the results are available earlier in the pregnancy.

•IntegratedScreen
This screening test combines the measurements obtained in the FirstScreen described above with additional information obtained from another blood test, the alpha-fetoprotein 4 (AFP4), taken at approximately 16 – 18 weeks. The result of this screen will not be available until the second trimester of pregnancy, as the results of the second blood sample are needed to complete the analysis. Of all the currently available screening tests, this screen has the highest detection rates for Down Syndrome and Trisomy 18. IntegratedScreen also reports the risk of Open Neural Tube Defect (ONTD).

•Serum IntegratedScreen
This screening test includes first and second trimester blood samples described for the IntegratedScreen. It does not include the sonogram of the baby's neck (Nuchal Translucency). The results of this screen are not available until the second trimester of pregnancy. Like the IntegratedScreen, results include risk of ONTD, but the detection rate for Down Syndrome is slightly lower than that of the IntegratedScreen.

•Multiple Marker Screen (AFP4)
The multiple marker screen is the ***standard screening test*** offered at the present. The Multiple Marker Screen (AFP4), a single blood test obtained at approximately 16 – 18 weeks, measures levels of alpha-fetoprotein (AFP) combined with levels of certain other proteins and hormones from the pregnancy. The quadruple marker test (AFP4), the best second trimester prenatal serum screening test currently available, measures levels of a three additional markers: unconjugated estriol (uE3), human chorionic gonadotropin (hCG), and inhibin A. When tests of these markers are added to the AFP test, the combination gives more information about the risk of having a baby with Down syndrome than the AFP test alone. No testing is performed in the first trimester of pregnancy. The results of this screen are not available until the second trimester of pregnancy. Detection rates for Down Syndrome and trisomy 18 are lower than with the IntegratedScreen, but detection rates for ONTD are the same.

•No screening
You may choose not to undergo any screening test. Some patients who feel that they would not intervene if the baby should have a problem may prefer this option.

•Amniocentesis and genetic counseling

This is a diagnostic test and is the standard option for mothers who are 35 years old or more. This is also the recommended option for mothers who have had a previous baby affected with a chromosome anomaly or ONTD.

The screening tests offer the following performance:

Screen Type	FirstScreen	IntegratedScreen	Serum Integrated Screen	Multiple marker screen	No screen	Amniocentesis
Down Syndrome Detection Rate	83%	92%	87%	81%	–	100%
False Positive Rate	5%	5%	5%	5%	–	Near 0%
Trisomy 18 detection rate	80%	90%	90%	80%	–	100%
ONTD detection Rate	–	80%	80%	80%	–	Near 100%
Risk to the baby	0%	0%	0%	0%	–	0.5% loss

What if your test shows an increased risk?

If your screening test shows an increased risk, it does not mean that a problem has been diagnosed. It only means that your baby should be further evaluated. In that case, you will be offered additional tests which can determine whether the baby has a disorder or if there are other explanations for the test result. If your screening test shows results in the "normal range", it does not guarantee that your baby is normal. It means that the risk of a chromosome problem is low. Other problems or abnormalities may be present or may develop in the baby.

CONSENT

My healthcare provider may release my ultrasound, amniocentesis, chorionic villus sampling, and pregnancy outcome information to the laboratory. I understand that there are benefits and limitations for any test, including false positives and false negative results. All my questions have been satisfactorily answered. I understand that this test is voluntary and I may decline testing at any point. I understand that my insurance company may not cover this service and I agree to provide payment.

Your choices:

-If you are 35 years-old or more at the time of delivery, or have had a previous baby with a chromosome anomaly or Open Neural Tube Defect (ONTD):

I choose:

- ☐ genetic counseling and possible amniocentesis **(the standard recommendation)**
- ☐ no testing at all
- ☐ one of the screens below

-If you are less than 35 years-old at delivery, and have not had a previous baby with a chromosome anomaly or Open Neural Tube Defect (ONTD):

I choose:

- ☐ **FirstScreen** (sonogram for Nuchal Translucency and blood at 11 weeks - 13 weeks and 6 days)
- ☐ **IntegratedScreen** (FirstScreen above plus another blood sample at approximately 16 – 18 weeks)
- ☐ **Serum Integrated Screen** (only the blood samples described for the IntegratedScreen, no sonogram for Nuchal Translucency)
- ☐ **Multiple Marker Screen** (blood sample at approximately 16 – 18 weeks for AFP4)
- ☐ No screen at all

Patient Name (Print) _____ Date _____

Patient Signature _____ Witness _____

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

CONSENT TO HIV-1 ANTIBODY TESTING IN PREGNANCY

The purpose of the test, its potential uses, and the limitations and the meaning of the results have been explained to me. I understand that if the results indicate that my blood contains antibody to HIV, it means that I may have been infected with the HIV virus, which is believed to cause AIDS (acquired Immune Deficiency Syndrome)

AT FIRST PRENATAL VISIT

☐ I authorize my healthcare providers to collect one or more blood specimens from me at the time if my first prenatal visit in order to detect whether or not I have antibodies in my blood to HIV-1 (human immunodeficiency virus). This is the virus which has been associated with AIDS (Acquired Immune Deficiency Syndrome). I understand that my physician will report the test results to me in person and not by telephone or mail. At that time, I will have the opportunity to receive counseling about the meaning of the test results, the possible need for retesting, and other matters. Information regarding measures for the prevention of exposure to, and transmission of HIV has been made available to me.

Consent to Release

I understand that the test results will be confidential and will not be disclosed to any person without my consent unless permitted or required by law. I hereby consent to the release of the test results to All Women's Healthcare of Southern Florida. I understand All Women's Healthcare of Southern Florida will comply strictly with the law regarding access by All Women's Healthcare of Southern Florida employees to the test results. I also consent to the release of the test results to_____.

☐ **REFUSAL OF HIV-1 ANTIBODY TESTING**
With the information presented above having been explained to me completely and clearly in the language I understand, all of my questions having been answered with full knowledge of the consequences, I refuse to give my consent for HIV testing.

_____ _____
Patient Signature Date/Time

_____ _____
Witness Name of Patient (please print)

IN THIRD TRIMESTER

☐ Authorization for Repeat HIV Testing in Third Trimester of Pregnancy
I authorize my health care provider to repeat the testing for sexually transmitted diseases and HIV later in this pregnancy. This consent for repeat testing is limited to the course of my current pregnancy. I understand that my health care provider will discuss testing with me before the retest is performed and will provide me with the test results.

☐ I Decline Repeat HIV Testing in Third Trimester of Pregnancy
With the information presented above having been explained to me completely and clearly in the language I understand, all of my questions having been answered with full knowledge of the consequences, I decline repeat testing for sexually transmitted diseases and HIV later in this pregnancy.

_____ _____
Patient Signature Date/Time

_____ _____
Witness Name of Patient (please print)

GEMINI
OBSTETRICS/GYNECOLOGY, LLC

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 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

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
C		___/___/___

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

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.

GEMINI
OBSTETRICS/GYNECOLOGY, LLC

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

ADVANCE DIRECTIVE "LIVING WILL"

Declaration made this _____day of _____, 20_____.

I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

If, at any time I should have a terminal condition and if my attending physician has determined that there can be no recovery from such a condition and that my death is imminent, I direct that life prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially to process of dying and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort or to alleviate pain.

In the absence of my ability to give directions regarding the use of such life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this declaration shall have no force or effect during the course of my pregnancy.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

_____
Signature of Declaring

The declaring is known to me and I believe her to be of sound mind.

_____ _____
Witness Witness

Help your baby have a healthy start in life!

Please answer the following questions to find out if anything in your life could affect your health or your baby's health. Your answers are confidential. You may qualify for free services from the Healthy Start Program or the Healthy Families Program, no matter what your income level is! (Please complete in ink.)*

Today's Date: _____

	YES	NO
1. Have you graduated from high school or received a GED?	☐ 1	☐ 2
2. Are you married now?	☐ 1	☐ 2
3. Are there any children at home younger than 5 years old?	☐ 1	☐ 2
4. Are there any children at home with medical or special needs?	☐ 1	☐ 2
5. Is this a good time for you to be pregnant?	☐ 1	☐ 2
6. In the last month, have you felt down, depressed or hopeless?	☐ 1	☐ 2
7. In the last month, have you felt alone when facing problems?	☐ 1	☐ 2
8. Have you ever received mental health services or counseling?	☐ 1	☐ 2
9. In the last year, has someone you know tried to hurt you or threaten you?	☐ 1	☐ 2
10. Do you have trouble paying your bills?	☐ 1	☐ 2

11. What race are you? Check one or more.
☐ White ☐ Black ☐ Other

12. In the last month, how many alcoholic drinks did you have per week?
_____ drinks ☐ did not drink

13. In the last month, how many cigarettes did you smoke a day? *(a pack has 20 cigarettes)*
_____ cigarettes ☐ did not smoke

14. Thinking back to just before you got pregnant, did you want to be.....?
☐ pregnant now ☐ pregnant later ☐ not pregnant

15. Is this your first pregnancy?
☐ Yes ☐ No If no, give date your last pregnancy ended.
Date (month/year)

16. Please mark any of the following that have happened.
☐ Had a baby that was not born alive
☐ Had a baby born 3 weeks or more before due date
☐ Had a baby that weighed less than 5 pounds, 8 ounces
☐ None of the above

PATIENT INFORMATION

Name: First	Last	M.I.	Social Security Number:	Date of Birth (mo/day/yr):	17. Age: ☐ 1 < 18
Street address (apartment complex name/number):			County:	City: State: Zip Code:	
Prenatal Care covered by: ☐ Medicaid ☐ Private Insurance _____ ☐ No Insurance ☐ Other _____			Best time to contact me:	Phone #1 _____ Phone #2 _____	

I authorize the exchange of my health information between the Healthy Start Program, Healthy Start Providers, Healthy Start Coalitions, Healthy Families Florida, WIC, Florida Department of Health, and my health care providers for the purposes of providing services, paying for services, improving quality of services or program eligibility. This authorization remains in effect until revoked in writing by me.

Patient Signature: _____ **Date:** _____

Please initial: _____ Yes _____ No I also authorize specific health information to be exchanged as described above, which includes any of my mental health, TB, alcohol/drug abuse, STD, or HIV/AIDS information.

** If you do not want to participate in the screening process, please complete the patient information section only and sign below:*

Signature: _____ *Date:* _____

PROVIDER ONLY

LMP (mo/day/yr):	EDD (mo/day/yr):	18. Pre-Pregnancy: Wt: _____lbs. Height: _____ft. _____in. BMI: _____	☐ 1 < 19.8 ☐ 2 > 35.0
Provider's Name:	Provider's ID:	19. Pregnancy Interval Less Than 18 Months? ☐ N/A ☐ No	☐ 1 Yes
		20. Trimester at 1st Prenatal Visit? _____	☐ 1 2nd
Provider's Phone Number:	Provider's County:	21. Does patient have an illness that requires ongoing medical care? Specify illness: _____ ☐ No	☐ 2 Yes
Healthy Start Screening Score: _____	**Check One: ☐ Referred to Healthy Start. If score <6, specify:** _____ **☐ Not Referred to Healthy Start.**		

Provider's/Interviewer's Signature and Title _____ **Date (mo/day/yr)** _____