

Women's Pelvic Surgery Center of Orlando

Kathy Y Jones, MD

508 North Mills Avenue, Suite C, Orlando, Florida 32803

Ph: 407-228-8066 Fax: 407-228-8438

Please Print

DATE _____

Patient's Last Name _____ First _____ Middle Initial _____

Patient's Social Security Number _____ Date of Birth _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Do you have an alternate address? If yes, please print _____

Telephone: Home _____ Business _____ E-Mail _____

Sex: Male Female

Marital Status: Single Married Divorced Widowed Separated

Employment Status: Full Time Part Time Retired Other: _____

Employer _____ Occupation _____

Employer Address _____ Student Status: Full Time Part Time

Please Note: If you are not the primary policy holder on your insurance, this information is REQUIRED to accurately bill your insurance for the services rendered.

Spouse/Parent Name: Last _____ First _____ Middle Initial _____

SSN _____ Brthdate _____ Employer _____

Address _____ Phone _____

Spouse/Parent Name: Last _____ First _____ Middle Initial _____

SSN _____ Brthdate _____ Employer _____

Address _____ Phone _____

Emergency Contact or Nearest Relative not living with you _____

Relationship _____ Phone _____

Referring Physician _____

Address _____ Phone _____

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE READY FOR THE RECEPTIONIST. PAYMENT FOR PROFESSIONAL SERVICES IS DUE AND PAYABLE WHEN SERVICES ARE RENDERED.

PLEASE COMPLETE REVERSE SIDE.

Women's Pelvic Surgery Center of Orlando

Insurance Information and Assignment

Please Print

Primary Insurance Co: _____ Secondary Insurance Co: _____

Insured's Name: _____ Insured's Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

I hereby authorize my insurance benefits to be paid directly to Women's Pelvic Surgery Center of Orlando. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

Patient Name

Patient Signature

Date

Routine Physical Exam Financial Waiver

Routine physicals are an important part of your health care maintenance and are intended to assess your overall health. If you are experiencing specific problems, please schedule an office visit separate from your physical exam to address those concerns. Please be aware of the following:

- Your insurance company may or may not cover your physical examination. Please consult with your insurance company prior to your scheduled appointment regarding payment for your physical. If you have had your annual gynecological exam somewhere else it may prevent us from being paid by your insurance company for today's physical exam.
- If your insurance company does cover a physical exam annually, please ensure that it has been at least 365 days since your last physical exam.
- Diagnostic testing which may include Lab, X-rays and EKG's may not be covered by your insurance policy when performed as part of a physical.
- The American College of Obstetrics and Gynecology (ACOG) has recommended STD testing for all sexually active women less than 30 years of age or have a history of a sexually transmitted disease. Screening for Chlamydia and gonorrhea will routinely be performed as a part of your gynecological examination. Please mark **NO** here _____ if you wish to decline this testing.
- Women age 30 and older may want to screen for HPV infections of the cervix. We offer HPV screening with your Pap smear. HPV screening may not be covered by your insurance. Please mark **YES**___ or **NO**___ for HPV screening.
- ACOG has recommended HIV testing for women between 19 and 64 years old as a routine part of their care. HIV screening may or may not be covered by your insurance. Please mark **YES**___ or **NO**___ for HIV screening.

I acknowledge that I have read and understand the billing policies for my routine physical exam. I understand that if my insurance company does not pay for all or part of my physical exam that the balance in full is my responsibility.

Patient Name

Patient Signature

Date

Laboratory Billing

All patients are responsible for knowing their correct information including which lab their lab work is to be sent. We will submit specimens based on the information provided by the patient. Any misinformation resulting in specimens being sent to the wrong lab will be the patient's financial responsibility.

LAB USED: _____ Patient Signature: _____ Date: _____

Consent for Evaluation or Treatment

The undersigned hereby consents to whatever evaluation or treatment the assigned physician may deem necessary to the patient name above.

Patient, Parent, Legal Guardian or Authorized Representative

Date