Patient Demographic Form

Date:_____ Referring Doctor/Office: _____

Personal Contact

Name: _____Date of Birth: _____Social Sec #: _____

Maiden Name: _____

Home Address: _____City: _____State: _____Zip: _____

Home Phone: _____Cell Phone:_____Email:_____

Occupation:_____Employer: _____Work #: _____

Pharmacy Name _____ Pharmacy Number _____

Emergency Contact

Emergency Contact Name: _____

Relationship:_____

Contact Phone #: _____

Insurance

Primary Insurance Company: _____Policy #: _____Group#: _____

Subscriber Name: _____Relationship to subscriber:_____

Subscriber's Social Sec #:_____Date of birth:_____

▫ CHECK HERE IF YOU HAVE SECONDARY INSURANCE

Secondary Insurance Company: _____Policy #: _____Group #:_____

Subscriber Name: _____Relationship to subscriber:_____

Subscriber Social Sec #: _____Date of birth: _____

Signature™ Perinatal Center

Authorization to Release Protected Health Information

I authorize Signature Perinatal Center to discuss and share protected health information (PHI), including appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with my referring OBGYN provider, any medical consultants, my insurance carrier and those I listed below. I understand that my health care provider will use his/her judgment in sharing PHI in order to facilitate continuity of care. The release of copies of medical records will require a signed HIPAA-compliant authorization form. This permission is considered on-going until otherwise indicated, in writing.

PHI may be released to the following (i.e. physician, spouse, family member):

	Name	Relationship
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____

The practice staff have my permission to share my PHI with family members or others who are present in the room with me/us during my appointment. ☐ Y ☐ N

Preferred method of contact for test results (please check all that apply):

	May we leave a message?
☐ Patient portal	☐ Y ☐ N
☐ Cell phone: _____	☐ Y ☐ N
☐ Work phone: _____	☐ Y ☐ N
☐ E-mail: _____	☐ Y ☐ N

☐ I give permission for Signature Perinatal Center to communicate with me via the patient portal

_____
Print Name of Patient/*Authorized Representative

_____ _____
Signature of Patient/*Authorized Representative Today's Date

*Authorized representative's authority to act on patient's behalf include parent/legal guardian or power of attorney. Evidence of authority must be provided and on file with the practice.

FINANCIAL POLICY

Thank you for choosing Signature Perinatal Center as your perinatal provider. We strive to ensure a clear understanding of your financial responsibility with respect to the medical services we provide.

DEMOGRAPHIC/INSURANCE INFORMATION: Signature Perinatal Center requires a copy of your insurance card and current demographic information on file. It is your responsibility to inform our office of any changes in demographics, insurance, or financial responsibility. Although we will make every effort to contact you if we identify any outdated information (i.e. returned mail, insurance denials, etc.), failure to notify us in a timely manner can result in denial of insurance which will result in full office visit, ultrasound, surgical, and other ancillary services being your responsibility and outstanding balances will be due at the time of your next appointment.

CO-PAYS/PAYMENT POLICY: We require payment of co-pays and deductibles at the time of service and reserve the right to refuse treatment and reschedule your appointment if not paid in a timely manner. We accept Cash, Visa, MasterCard, Discover and American Express. We also accept payment by check and debit cards.

INSURANCE AND CLAIM FILING: We participate with many insurance plans, and we will submit claims to your insurance carrier as a courtesy to you. Please keep in mind that payment for services remains your responsibility. We bill your insurance company in accordance with all federal, state, and other contractual requirements in cases where we have an agreement, or we are a participating provider. We expect payment in full if your insurance company delays processing of your claim for over 60 days. You agree to pay any portion of the charges not covered by insurance. If your insurance company sends payments directly to you, send or drop- off the payment to Signature Perinatal Center at the address below and we will apply it to your account.

UNINSURED PATIENTS (SELF-PAY): If you do not have insurance, our office will make every effort to contact you prior to your appointment to advise you of your potential cost. The amounts quoted are an estimate and can increase based on the level of care provided. Signature Perinatal Center offers patients without insurance a discount and requires at least 50% of the estimated cost at the time of service.

MEDICAID: We will file Medicaid claims for patients who reside in the state of Florida. If you have assistance from another state, you will be responsible for payment of the services you receive and the filing of your own claims.
Please refer to Florida Administrative Code 59G - 1.050 General Medicaid Policy for additional guidelines for billing recipients of Florida Medicaid for non-covered services.

OUTSTANDING BALANCES: We will make every effort to inform patients of their balance via electronic portal, mailed statement, and/or telephone. Signature Perinatal Center's billing department will determine the amounts to be paid for payment arrangements. Non-payment on your account, default on a mutually established payment arrangement or not paying in accordance with this policy may result in the account being sent to collections. We reserve the right to require payment for any outstanding balance at, or before the time of service. ***Services include, but are not limited to, any in office consultations/visits, ultrasounds exams, inpatient consultations, and virtual health counseling services.***

Signature Perinatal Center reserves the right to send patients accounts to collections for unpaid balances older than 120 days, unless you make payment arrangements with our billing office. If your account is placed for collection, a collection fee will be added to your account, along with any attorney fees and/or court costs that may be necessary for recovery of the outstanding balance. In the event of a returned check, there will be a $35 non-sufficient funds charge added to the balance due. This must be paid within 7 days. If any special arrangements need to be made, please contact our billing department by calling 954-603-3933.

DEPENDENTS/SPECIAL CIRCUMSTANCES: You are responsible for payment of services rendered to your dependents on your account. In cases where a written court order allows payment for medical costs associated with a dependent, it is your responsibility to obtain reimbursement from the other party involved. If any special arrangements need to be made, please contact our billing department by calling 954-603-3933.

CREDIT CARD ON FILE POLICY: Signature Perinatal Center is committed to making our billing process as simple and easy as possible. We require that all patients provide a credit card on file with our office. We will scan your card with a secure, PCI compliant card reader and all financial information will be stored in a secure, encrypted location with all security means in place to protect your information. For security reasons only the last four digits will be visible to our staff. Credit cards on file will be used to pay account balances after your insurance processes your claim. **If we do not receive payment for the amount listed on your statement within 60 days, we will run the credit card on file for the full amount owed. Your signature below authorizes Signature Perinatal Center to use the credit card on file for any outstanding balances.** In the event of default (non-payment of your account, not paying in accordance with the aforementioned policy), Signature Perinatal Services reserves the right to send your account to a collection agency. We understand that a third-party may be rendering payment for services on your behalf (i.e. spouse, parent, etc.). This financial policy is inclusive of payment methods provided by third parties and it is your responsibility as the patient to inform your guarantor of this financial policy.

FORMS/LETTERS/MEDICAL RECORDS: We may bill $5/per page for forms that a provider completes on your behalf. We charge $1/per page reproduction fee for medical records requested for personal use for the first 25 pages, and $0.25 per page to follow. Signature Perinatal Center reserves the right to increase the cost for forms/letters depending on the amount of time and resources necessary to fulfill the request.

HIPAA/NOTICE OF PRIVACY ACKNOWLEDGEMENT: I acknowledge that the Notice of Privacy Practices is available (If you would like a copy, please request one at the front desk). I acknowledge that due to the current HIPAA laws, my doctor is required to obtain a written consent to disclose any Private Health Information in the presence of anyone other than myself.

ATTESTATION STATEMENT:

I have read, understand, and agree to Signature Perinatal Center's Financial Policy. I understand that charges not covered by my insurance company, as well as any applicable copayments, coinsurances, deductibles, and other charges applied to the patient by insurance or Signature Perinatal Center are my responsibility. I acknowledge that these policies do not obligate Signature Perinatal Center to extend credit or transgress from this policy.

I authorize my insurance benefits be paid directly to Signature Perinatal Center.

I authorize Signature Perinatal Center to use the credit card on file for any outstanding balances.

I authorize Signature Perinatal Center to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim in accordance with company policies and state and federal laws.

_____
Name of Patient/Responsible Party

_____ _____
Patient Signature/Responsible Party Date

**Copies of all signed consents are available on your patient portal for review.

Signature™ Perinatal Center

Informed Consent for Ultrasonography

Your physician has requested that you have an ultrasound examination of your pregnancy. This information sheet addresses some important questions about this diagnostic procedure.

What is ultrasound and what can it show about my pregnancy?
Ultrasound imaging (or sonography) is a medical tool that can help a physician evaluate your pregnancy. It utilizes high-frequency sound waves to produce gray-scale images of your uterus and developing baby.

Is ultrasound safe?
There has been extensive research on the safety of ultrasound for over 20 years. Unlike x-ray or CT imaging, there is no ionizing radiation exposure associated with ultrasound and there has been no evidence that diagnostic ultrasound causes harm to either mother or the developing fetus when used by appropriately trained health care providers.

Types of exams
A **basic sonogram** provides information about placenta location, fetal position, single or multiple gestation, gestational age, amniotic fluid, and possibly, fetal malformations.

A **complete or genetic sonogram** ("Level II") is a more detailed exam providing all the information of a basic sonogram, as well as more specific evaluation of pregnancy abnormalities, including fetal anomalies and/or growth abnormalities.

A **vaginal sonogram** utilizes a special vaginal probe to provide detailed evaluation of maternal pelvic structures, such as the uterus, ovaries and cervix. It may also be helpful in assessing a very early pregnancy or a fetus presenting low in the pelvis.

Does a normal ultrasound guarantee that my baby will be normal?
No, a normal ultrasound cannot guarantee that your baby is normal. While a basic sonogram will detect many abnormalities, it is not definitive for fetal malformations. Even after normal interpretation of a test, some babies are born with anomalies that were not identified during ultrasound examination(s). *Please be advised, even after a complete sonogram, the examiner may not identify fetal abnormalities which are later diagnosed after birth.*

We are an ultrasound teaching center
Physicians and technologists may be present during your examination to improve their ultrasound skills. This is a very important part of their training but requires your permission and will only be allowed with your expressed consent. *You may request that no observers attend your ultrasound study.*

We are committed to clinical research
Signature Perinatal Center is committed to continued education and clinical research to improve accuracy of diagnostic ultrasound. Your study may be included in future clinical research; however, all patient information will be protected and kept anonymous.

May I get a photo of my exam?
Your sonographer will gladly offer you a photo of your baby. By signing our consent and providing your cell phone number we can send you digital photos today.

Consent
Should you have any questions regarding ultrasonography, please do not hesitate to discuss them with your physician or the ultrasound technologist before undergoing the procedure. By signing this document prior to your ultrasound examination, you acknowledge that you have read and understood the information contained herein and have given informed consent to this procedure.

_____ _____

Patient Signature Date

CONSENT FOR PELVIC EXAMINATION

1. I understand that a "pelvic examination" means the series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, gloved hands or other instrumentation such as ultrasound.

2. I hereby authorize and consent to a "pelvic examination(s)" as defined above and under § 456.51, F.S. during my operation and/or procedure.

3. I hereby authorize and consent to members of Signature Perinatal Center's medical staff, nursing staff, sonographer and other health care providers, as well as medical students, and/or other students, residents, or fellows receiving training as health care practitioners to perform such a "pelvic examination" on me.

By signing below, I am certifying that I consent to a pelvic examination.

Name of Patient: _____ Relationship to Patient: _____

SIGNED: _____ Date: _____

RELEASE OF MEDICAL RECORDS

I hereby authorize Signature Perinatal Center permission to obtain copies of my prior medical records for review by my provider/medical team. My medical records can be released to:

Signature Perinatal Center
2151 E Commercial Blvd
Suite 202
Fort Lauderdale, FL 33308
954-603-3933
Fax: 844-722-0043

Please submit the following requested information by fax or mail for the patient listed below.

- ✓ Consultation Reports
- ✓ Office Visit/Progress Notes
- ✓ Ultrasound Reports
- ✓ Discharge Summary
- ✓ Lab Results
- ✓ Pathology Report
- ✓ Labor & Delivery Records
- ✓ Prenatal Records
- ✓ Imaging Reports (CT, MRI, etc)
- ✓ Operative/Surgical Reports

I understand that this release can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. To revoke this consent, written notice must be given to the practice at the address listed above.

Signature Perinatal Center and its physicians are released from any legal responsibility of liability; for the release of the above information to the extent indicated and authorized herein.

This consent expires in 280 days.

Patient's Name (print)	Date of Birth	SSN #

Patient's Signature	Today's Date

Digital Images of your ultrasound with Tricefy™

Signature™ Perinatal Center

☐ I want my ultrasound images delivered digitally as an email/text.

Email Address: _____

Mobile Phone Number: _____

☐ I authorize Signature Perinatal Center to send digital images of my ultrasound.

☐ I have read, understand, and agree to the disclaimer.

☐ I acknowledge that I will have access to my images for 90 days from my ultrasound exam date.

It is highly recommended that you download and store your images on your computer or other device since they will be removed from the server at the end of 90 days.

Name: _____

Signature:_____Date:_____

Patient Disclaimer and Authorization

Tricefy™ is a communication service licensed to Signature Perinatal Center (hereafter called: "SPC"). This Disclaimer and Authorization Agreement sets forth the terms and conditions under which you, the undersigned patient authorize SPC to transmit your ultrasound examination through Trice Imaging, Inc. to a mobile phone number or email address of your choice. This Agreement will become effective on the date of your signature and will terminate after all images throughout your current pregnancy are sent to you.

After you complete and sign this Agreement, a mobile telephone number or email address you designate will be entered into our ultrasound system and re-verified with you. When your ultrasound screening is complete, in accordance with the SPC policies and procedures, the sonographer will trigger the ultrasound machine to send an encrypted copy of your examination to the Tricefy™ server. The server will reformat and encrypt the file and provide access to the examination through your mobile phone number by a text or email. The Physician will have the discretion to determine whether your ultrasound screening is complete and whether to transmit your images to Tricefy™. The Physician has the right to refuse to transmit or to delay the transmission of your images. Both the text and email message will contain secure links and instructions on how to access the images. Images and videos can be accessed and downloaded to your mobile phone and computer.

You agree to pay all costs for the services. Transmission of the images through Trice Imaging, Inc. is not a medical service and is for entertainment purposes only. The transmitted images are not considered diagnostic medical images and are not a part of your medical record; they are not to be used for your health care, diagnosis or treatment. If you want to see your medical records, you need to contact SPC, who is responsible for maintaining your medical records. Neither SPC nor Trice Imaging, Inc. is responsible for the security of the transmitted images once the text and email recipients you have designated downloads the images. By directing SPC to transmit the images to an email address and telephone number that you specify, you authorize SPC and Trice Imaging, Inc. to provide the images to the person who owns or uses the email address and telephone number and any persons who may have access to the telephone number and email address. Once the images have been accessed and each link to them is broken, the services are complete. We would recommend immediate download of any images, as the link to the images will only be active for a maximum of 90 days. Any transmission of additional images will be considered new services, the cost for which the patient is obligated to pay. Trice Imaging, Inc. will not store the images on its server for you.

As a licensee of Tricefy™ through Trice Imaging, Inc., SPC is permitted to offer the services under the terms and conditions of the license. This is the sole agreement between Trice Imaging, Inc. and SPC.