Just Ladies Healthcare of the Treasure Coast, LLC

a Division of Florida Woman Care, LLC

DR. JULIETTE LOMAX-HOMIER, FACOG
DR. LEIGH HOPPE, FACOG
DR. DIANE RUHR, FACOG

WE ARE DEDICATED TO PROVIDING YOU WITH THE BEST POSSIBLE HEALTHCARE.
TO HELP US DO THIS, PLEASE FILL OUT THIS FORM COMPLETELY IN INK.
IF YOU HAVE ANY QUESTIONS, WE WILL BE HAPPY TO ASSIST YOU.

Patient Demographic Information

Patient Last Name:_____ First Name:_____ Middle Init: ____

Address:_____ City:_____ State:_____ Zip:_____

Home #:_____ Work#:_____ Ext:_____ Mobile:_____

Date of Birth:_____ SS#:_____-_____-_____ Marital Status: _____

E-mail:_____ Race:_____

Pharmacy:_____ Pharmacy Address: _____

Primary Care Physician:_____ Phone Number:_____

Employer:_____ Occupation:_____

Emergency Contact:_____ Relationship:_____ Phone #: _____

Patient Signature:_____ Date:_____

Signature of Parent or Legal Guardian:_____ Date:_____

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WE WELCOME YOU…..
THANK YOU FOR SELECTING US FOR YOUR HEALTHCARE NEEDS! WE ARE DEDICATED TO PROVIDING YOU WITH THE BEST POSSIBLE HEALTHCARE. IF YOU HAVE ANY QUESTIONS, WE WILL BE HAPPY TO ASSIST YOU.

FINANCIAL PAYMENT POLICIES & CONSENT TO TREAT

OUR OFFICE FILES YOUR INSURANCE AS A COURTESY
Payment is Due at the Time Services are Rendered.
Your Co-pay must be paid at the Time of Service.
All Deductibles & Co-insurance are Due at the Time of Service.

Please note:
Each insurance policy is different. It is Your responsibility to know your policy. If pre-authorization is needed, then it is your responsibility to notify our staff so we may obtain authorization.

In the event of an overpayment on your account. Patient refunds are generated from the corporate office of Florida Woman Care, LLC in Boca Raton, FL. They can take up to 4 weeks to process. They will be refunded, in most instances, in the original method of payment, by credit card or by check.

If you have any questions or are not prepared to pay for your appointment, please notify our staff prior to your appointment.

WE NO LONGER TAKE CHECKS IN THE OFFICE
THERE WILL BE A $30 CHARGE FOR NSF CHECKS WHEN PAID BY MAIL

Any account that is sent to a collection's agency will incur additional fees. These fees will be added to the amount of monies owed to Just Ladies Healthcare of the Treasure Coast. By signing below, the patient/guarantor acknowledges and accepts this charge.

Just Ladies Healthcare of the Treasure Coast participates with most insurance companies. It is the patients' responsibility to verify with their insurance that they will have coverage to receive services from our facility.

I agree to pay for any and all medical services I receive from the doctor that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf (if contracted). I will pay these charges upon written/ verbal notice of their refusal. Failure of your insurance company to pay within 45 days of claim filing date will be considered a refusal to pay.
I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical records. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.
In the event I do not pay charges when due, for these or any other services provided me, I agree to pay all cost of collection, including reasonable attorney fees.
I am aware that if laboratory (including pap smear, blood and urine testing, and biopsies) is obtained, there will be a separate charge from the pathology laboratory for this exam.

******I HEREBY GIVE MY PERMISSION FOR THE DOCTOR TO ADMINISTER MEDICAL TREATMENT. ******

Patient Signature	Print Patient Name	Date
Signature of Parent or Legal Guardian	Print Parent or Legal Guardian Name	Date

By signing this document, I am stating I have read and fully understand the above information.
A photocopy of the authorization and assignment shall be considered as valid as the original.

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NO SHOW/ MISSED APPOINTMENT POLICY

We, at JUST LADIES HEALTHCARE OF THE TREASURE COAST, LLC, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 772-489-6636

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call, text, or email is made/attempted two (2) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the physicians at **JUST LADIES HEALTHCARE OF THE TREASURE COAST, LLC** and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

- ✓ If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.
- ✓ If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.
- ✓ After the first "No-Show/Missed" appointment, you will receive a phone call and/or email warning that you have broken our "No-Show" policy. **JUST LADIES HEALTHCARE OF THE TREASURE COAST, LLC** will assist you to reschedule this appointment if needed.
- ✓ If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive a warning letter from our office and will be assessed a $25.00 no show fee.
- ✓ If you have 3 "No-Show/Missed" appointments within a one-year time, you will receive a second $25 no show fee assessment. Dismissal from the practice will be considered. ***You will be notified by letter if the dismissal was approved.**

I have read and understand JUST LADIES HEALTHCARE OF THE TREASURE COAST, LLC No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify **JUST LADIES HEALTHCARE OF THE TREASURE COAST, LLC** appropriately if I have difficulty keeping my scheduled appointments.

Patient Signature	Print Patient Name	Date of Birth	Date
Signature of Parent or Legal Guardian	Print Parent or Legal Guardian Name		Date

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PATIENT HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

Patient Name:_____ Date of Birth: _____

Notice of Privacy Practices

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that this information may be disclosed electronically by the provider and/or the provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

Release of Information

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other UPM affiliated facilities may be made available to subsequent UPM affiliated admitting facilities to coordinate patient care for the case management purposes. Healthcare information may release to any person or entity liable for payment on the Patient's behalf to verify coverage or payment questions, or for any other purpose related to benefits payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carries for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions, and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I understand that as part of this physician's treatment, payment of healthcare operation, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

By signing this document, I am stating I have read and fully understand and accept the terms of this consent.

Print Patient Name /Parent or Legal Guardian Name	Patient Signature/Parent or Legal Guardian	Date

Consent for Photographing or Other Recording for Security and/or Health Care Operations

_____(Patient Initials) I do consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment, or health care operations purposes or otherwise permitted or required by law.

_____(Patient Initials) I do not consent to photographs, videotapes, digital or audio recording, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes.

Patient Signature: _____

Print Patient's Full Name: _____

Date: _____

Disclosures to Friends and/or Family Members

Name	Relationship	Contact Number

Patient may revoke or modify this specific authorization and that revocation or modification must be done in writing.

Do you want to designate a family member or other individual with whom the provider may discuss your medical condition? If yes, whom?

_____

(Name/Relation to patient)

I give permission for my Protected Health Care information to be disclosed for the purposes of communicating results and care decisions to the family member and others listed below:

Name: _____ Signature: _____ Date: _____

Dear Medicare Patient:

Medicare began paying for special Medicare Annual Wellness Visits on January 1, 2011. These services are intended to help you develop a plan for addressing ongoing medical problems. In general, these services should be performed by your primary care provider.

The services you normally receive in our office are not included in this Medicare Annual Wellness Visit. Specifically, the Medicare Annual Wellness Visit does not include a physical exam, pelvic and breast exam, or the collection of Pap smears. The Medicare Annual Wellness Visit is geared to address your ongoing general medical needs and not specific gynecologic problems or concerns.

The Medicare Annual Wellness Visit should be available to you through your primary care provider. The Well Woman Exam provided by our office is not covered by Medicare.

As always, we are happy to see you for any gynecologic problems you may have, including the ongoing management of menopausal symptoms, bladder problems, and issues with pelvic pain, prolapse, osteoporosis, breast concerns, or other gynecological related conditions. Your normal deductible and co-insurance will apply to these problem-oriented services.

If you have any questions please feel free to call our office (772) 489-6636 and speak with Regina McMillan, Office Manager.

Thank you

Physicians of Just Ladies Healthcare

I agree to pay for any and all medical services I receive from the doctor that my insurance company refuses to pay, for whatever reason

Name: _____ Signature: _____ Date: _____

1304 North Lawnwood Circle, Fort Pierce, FL 34950
Phone (772) 489-6636 Fax (772) 489-5749
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