Welcome to our office

Robert F. Chaitin, M.D.

Today's Date _____ Age _____

Patient _____ Date of Birth _____

Home Address _____
Street *City* *Zip*

Home Phone _____ Cell Phone _____

Email _____ Preferred Pharmacy & Location _____

Primary Language Spoken _____ Race _____

Patient Employed by _____ Occupation _____
(Or Responsible Person)

Business Address _____
Street *City* *Zip*

Business Phone _____ Social Security Number _____

Name of Spouse _____
First Name *Middle Name* *Maiden Name* *Last Name*

Spouse Employed by _____ Occupation _____

Business Address _____
Street *City* *Zip*

Business Phone _____ Social Security Number _____

Reason for initial visit _____

How did you find out about our office? _____

Relative or friend not living with you *(for emergency purposes)* _____ Phone (w) _____ (h) _____

Name of Family Physician _____

Do you have Medical or Surgical Insurance? ❑ No ❑ Yes

Insurance Company _____

Group and Membership Number _____

COMMUNICATION CONSENT

It is the office policy of Robert F. Chaitin, M.D. and staff not to release confidential and/or unauthorized information by home telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we will not leave a message if the name or telephone number is not on the recorded message to identify the patient. Also, information will not be left with an unauthorized person who may answer the telephone.
This authorizes Robert F. Chaitin, M.D. and/or his staff to leave medical information pertaining to my care by the following methods and I will assume responsibility to notify them whenever this information changes:

Home / Answering Machine _____ ❑ Yes ❑ No

Work _____ ❑ Yes ❑ No Cell _____ ❑ Yes ❑ No

If you would like to have information released to someone other than yourself, please list the names and relationships of authorized people:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I, the undersigned, verify that the above information is correct. I give permission to Robert F. Chaitin, M.D. to file my medical insurance claims for me and to release any medical records necessary to accomplish this filing process. I will be responsible for any non-covered service by my insurance.

Signature: _____ Date: _____

FINANCIAL POLICY FOR ROBERT F. CHAITIN, M.D.

Thank you for choosing us as your healthcare provider. We are committed to your health and striving to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance form before being seen by the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, AND CREDIT CARDS.

REGARDING INSURANCE If you belong to an insurance that we are not a provider for, then you are required to pay 100% for the medical services rendered. You will be given a receipt with the appropriate codes so that you can be reimbursed by your insurance company. The balance is your responsibility whether your insurance company pays or not. We cannot file your insurance billings unless your insurance information is complete. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits, we require that you provide a credit card with an authorization to bill that account for the balance of the bill. If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to your credit card or an extended payment plan if already approved. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable under the Medicare Program and/or other medical insurance.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER All copays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers or that the service is not covered, please refer to the above paragraph.

MINOR PATIENTS The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/Mastercard, or payment by cash or check at time of service.

RETURNED CHECKS WILL BE SUBJECT TO A $50.00 FEE.

MISSED APPOINTMENTS Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at a rate of $25.00. Please help us serve you better by keeping scheduled appointments.

LAB WORK We will send your lab work to the lab that your insurance is contracted with. You will be billed directly by the lab for any tests that we order. If you have questions regarding a bill that you received from a lab, please contact the lab directly.

SURGERIES The specialist that schedules your surgery will check with your insurance company for coverage on the procedure you are having done. We will estimate how much your surgery will cost and what your responsibility will be. That financial responsibility must be paid prior to surgery. Checking your benefits does not guarantee payment.. The patient is ultimately responsible for payment. If your insurance company does not pay within a reasonable time, you will be billed for services.

IN-OFFICE PROCEDURES Prior to being scheduled for an office procedure, we will check with your insurance company for coverage. If you do not have coverage, the procedure must be paid for at the time of service, unless specific arrangements have been made with the billing manager.

MATERNITY After your first OB visit, we will contact your insurance company and verify your benefits. Routine office visits are generally included with the delivery. Ultrasounds, non-stress tests, lab, facility fees, vaccinations, and non-pregnancy related office visits are billed separately and will require separate co-payments, deductibles and/or co-insurance amounts. We will estimate how much you will owe for the delivery only. This amount is expected to be paid by week 27 of your pregnancy. You can pay it all at once, or make payments. Any amounts for non-included services will be billed to you separately. We will reimburse you for any overpayment that we may have received within 30 days of receipt of payment from your insurance company.

After your first visit, our billing department will be checking with your insurance company and contacting you to discuss the financial part of your pregnancy and work out all payment agreements. We want to make this special time as worry-free for you as possible.

In the event your account becomes delinquent and is referred to an outside agency for further collection efforts, you will be responsible for any and all collection fees in addition to the unpaid balance of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, ROBERT F. CHAITIN M.D.,P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that ROBERT F. CHAITIN M.D.,P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that ROBERT F. CHAITIN M.D.,P.A. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should ROBERT F. CHAITIN M.D.,P.A. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, 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.

I fully understand and accept / decline the terms of this consent.

_____

Patient's Signature

_____

Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.

Robert F. Chaitin, M.D.

Patient Name_____ Date of Birth_____ SSN_____

Today's Date_____
Usual Weight_____
Occupation_____
Exercise/Recreation_____
Smoking/amount per day_____
Caffeine/amount per day_____
Street Drugs/type & amount per day_____
Alcohol/amount per day_____

LIST ALL MEDICATIONS AND STRENGTH

Please indicate any personal history below:

Constitutional Symptoms

Good general health lately	Yes	No
Recent Weight Change	Yes	No
Fatigue	Yes	No

Eyes

Eye disease or injury	Yes	No
Wear glasses/contact lenses	Yes	No

Ears/Nose/Mouth/Throat

Chronic Sinus problem/Rhinitis	Yes	No
Sore throat/Voice Change	Yes	No

Cardiovascular

Heart Trouble	Yes	No
Chest Pain or Palpitation	Yes	No
Swelling of hands/feet	Yes	No

Respiratory

Shortness of Breath	Yes	No
Wheezing	Yes	No

Gastrointestinal

Loss of appetite	Yes	No
Change in Bowel Movement	Yes	No
Nausea or Vomiting	Yes	No
Frequent diarrhea	Yes	No
Constipation	Yes	No
Rectal Bleeding/Blood in stool	Yes	No
Abdominal Cramping	Yes	No

Genitourinary

Burning or painful urination	Yes	No
Blood in urine	Yes	No
Incontinence (Leaking urine)	Yes	No
Kidney stones	Yes	No

Gynecological

Pain with periods	Yes	No
Irregular periods	Yes	No
Vaginal Discharge	Yes	No
Bleeding/spotting between periods	Yes	No
Night sweats	Yes	No
Hot flashes	Yes	No
Sexual Difficulty	Yes	No

Number of pregnancies _____
Number of miscarriages_____
Terminations/Abortions_____
Vaginal Deliveries _____
C-Sections _____
Last pap smear _____
Age period began _____
Length of period/Days _____
Days between periods _____
Sexually transmitted Disease _____
History of abnormal pap_____
Last menstrual period _____
Birth Control _____

Musculoskeletal

Joint pain/stiffness	Yes	No
Muscle pain	Yes	No
Back pain	Yes	No

Integumentary (Skin or Breast)

Rash or itching	Yes	No
Breast Pain	Yes	No
Breast lump/discharge	Yes	No
Breast Cancer History	Yes	No

Neurological

Frequent Headaches	Yes	No
Light Headedness	Yes	No
Convulsions/Seizures	Yes	No

Psychiatric

Nervousness	Yes	No
Depression	Yes	No
Insomnia	Yes	No

Endocrine

Glandular or

Hormonal Issues	Yes	No
Excessive thirst	Yes	No

Hematologic/Lymphatic

Easy bruising	Yes	No
Anemia	Yes	No
Phlebitis	Yes	No
Transfusion	Yes	No
Enlarged Glands	Yes	No

List Allergies:

_____
_____
_____

List Current Medical Conditions:

_____
_____
_____
_____
_____
_____

List All Surgeries:

_____
_____
_____
_____
_____

Family History

Has any blood relative had any of the following: Circle "yes" or "no". If yes please tell us who.

Cancer/type	Yes	No _____	High Blood Pressure	Yes	No _____
Diabetes	Yes	No _____	Epilepsy	Yes	No _____
Heart Disease	Yes	No_____	Anemia	Yes	No _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature_____ Reviewiing Physician Signature_____

Date_____

Robert F. Chaitin, M.D.

Obstetrics & Gynecology

3385 Burns Road, Suite #201

Palm Beach Gardens, FL 33410

Phone: (561) 622-0779 Fax: (561) 622-2314

Consent Form to Release/Receive Medical Records

Date: _____

Please check one:

_____I authorize Robert F. Chaitin, M.D. to request my medical records from:

_____

_____

_____

_____Please release my medical records to:

_____

_____

_____

I hereby authorize the selected above to either release or receive my medical records including office notes, x-rays, operative reports, and any information regarding medical consultations and treatment I have received.

Patient's Name: _____

Date of Birth: _____Last 4 digits of Social Security Number: _____

Patient OR Guardian Signature:_____

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with HIPAA privacy regulations.

IMPORTANT NOTICE FROM: ROBERT F. CHAITIN, M.D., P.A.

Dear Patient:

Under Florida Law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED TO BECOME SELF-INSURED AND NOT CARRY COMMERCIAL 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 judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law, Title XXXII, Chapter 458.320.

The undersigned patient acknowledges that he or she has received a copy, read and understands this Medical Malpractice Insurance Notice.

Furthermore, the undersigned acknowledges this notice was not signed under duress and that all of the patient's questions relating heretofore have been answered to the patient's satisfaction.

_____
Date

_____ _____
Print Patient Name Patient or Guardian Signature

_____
Witness