SERGIO J. CABRERA, M.D. F.A.C.O.G.
OBSTETRICS & GYNECOLOGY
131 E. Redstone Ave. Suite 102
Crestview, FL 32539
Tel: 850-398-8940 Fax: 850-398-8943

Jeremiah 1:5 Before I formed you in the womb I knew you. Before you were born I sanctified you.

OFFICE GUIDELINES - PLEASE READ CAREFULLY

By federal law and managed care contract law, this office is required to collect co-payment, co-insurance and deductible for each encounter. Please help us comply with these requirements by making your co-payment today.

We accept cash and most major debit/credit cards, NO CHECKS. Penalty for not following this requirement could result in termination and cancellation of coverage for the patient. If you have a balance in our office and it is not satisfied, we reserve the right to place with a collection agency with a 30% fee added to your balance.

Call us if you need to cancel or reschedule your appointment 24 hours in advance. **You may call our office after hours and leave a voicemail.** Office visit cancellation fee is $65—ultrasound fee is $40. This fee is expected to be paid before or at your next visit. Our office has a one time forgiveness in which your office visit fee may be waived. **NO SHOW FEES WILL BE ASSESSED.**

We ask that you PLEASE FIND ALTERNATE CHILDCARE on the day of your scheduled appointment, if possible, in consideration to other patients. Because of limited space, ONLY TWO PEOPLE ARE ALLOWED IN EXAM ROOMS. We strongly recommend you NOT bring children into the exam room.

If you are pregnant we ask that you provide a URINE SAMPLE AT EVERY DOCTOR VISIT.

No fee will be applied if medical records are sent to another physician. If patient requests a printed copy of medical records, a $25 minimum fee will be applied according to the number of pages. THANK YOU FOR YOUR COOPERATION!

DATE:____________________

SIGN:________________________________ PRINT:___________________________

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PATIENT INFORMATION

Upon registering, please present proof of insurance including Medicare and/or Medicaid. Payment is expected at the time of service unless special arrangements are made.

Patient Information

Name________________________________
Physical Address_______________________
City__________________ST______ZIP_______
Mailing Address________________________
City__________________ST______ZIP_______
Phone________________Marital Status_____
Date of Birth___/___/___ Age_____ Sex___
Driver's License #_________________ST___
Social Security # _______________________

Patient Employer/School

Employer/School________________________
Occupation____________________________
Address_______________________________
Phone________________________Ext_______
If Student: _____Full-time ______Part-time

Insurance Information

Company______________________________
____
Insured's Name_________________________
Insured's D.O.B.________________________
Insured's Address (If different than patient's)__________
____
Policy#_______________________________
Group#_______________________________

Pharmacy of Choice

Name_____________________________
City______________________________

Patient's Significant Other or Guardian

Name_____________________________
Relationship_______________________
D.O.B.___/___/___
Phone#____________
Address (If different than patient)____________
____
May we discuss general patient information with this person (appointment date/time, treatment, payment, etc.)? YES_____ NO_____

Emergency Contact Information

Name_____________________________
Phone_____________________________
Relationship_______________________
May we discuss general patient information with this person (appointment date/time, treatment, payment, etc.)? YES_____ NO_____

Name_____________________________
Phone_____________________________
Relationship_______________________
May we discuss general patient information with this person (appointment date/time, treatment, payment, etc.)? YES_____ NO_____

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not they are covered by my insurance plan.

______________________________________ ______________________________
Patient/Guardian Date

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HISTORY & PHYSICAL

Name______________________________ Date______________
Address______________________________
Date of Birth______________ Age________ Allergies______________
Medications______________________________
Occupation______________________ Live With______________
Chief Complaint______________________________

Menstrual History

Last Menstrual Period	Age at First Period	Duration of Period	Age at Menopause
Current Contraception	Past Contraception	Last Pap Test	Last Mammogram

Obstetrical History

(Deliveries, Miscarriages, Abortions, Premature Births)

Month/Year	Epidural/ Anesthesia?	Weeks Gestation	Hours in Labor	Vaginal or C-Section?	Sex	Weight	Live or Stillbirth	Complications

Other Gynecological History

____
____

Past Medical History

Please Check	You	Family	Which Family Member?	Please Check	You	Family	Which Family Member?
Heart Disease				Anemia/Blood Disorders			
Hypertension				Blood Transfusions			
Headaches				Varicose Veins/Phlebitis			
HEENT				Diabetes			
Respiratory/Lung Dis.				Thyroid Disease			
Breast Disease/Cancer				Cancer			
Jaundice/Hepatitis				Epilepsy/Neural Disorder			
Gall Bladder Disease				Strokes			
Bowel Disorders				Gyn/Pregnancy Problems			
Kidney Problems				Smoking: Cigs per Day			
Urinary Tract Problems				Alcohol: Oz per Week			
GI/Peptic Ulcer Disease				Street Drugs			

Does anything run in your family history?______________________________

Hospitalizations/Major Surgeries	Month/Year	Illness/Operation

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Dear Patient:

In order to serve you better, please write your three main concerns or questions for the doctor and/or nurse.

1. ______________________________
____
____

2. ______________________________
____
____

3. ______________________________
____
____

Name: ______________________

Date: __________

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NOTICE OF PRIVACY POLICY AND PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice

Our office respects the privacy of personal information and understands the importance of keeping this information confidential and secure. This notice describes our privacy practices with respect to your health information. Our privacy practices apply to current and former patients.

Types of Personal and Health Information We Collect

We collect a variety of personal health information when delivering health care. You provide some of this information when you initially come into our office, such as address, social security number and health history. We also receive additional personal and health information such as eligibility through our transactions with employers, insurance companies and other health care providers. We limit the collection of personal information to that which is necessary to administer our business, provide quality service and meet regulatory requirements.

How We Protect Personal and Health Information

We treat personal and health information securely and confidentially. We limit access to personal information to only those persons who need to know that information to provide services to patients (i.e., billing clerks and medical assistants). These persons are trained on the importance of safeguarding this information and must comply with our procedures and applicable law. We meet physical, electronic and procedural security standards to protect personal and health information and maintain internal procedures to promote the integrity and accuracy of that information.

Disclosure of Personal and Health Information

We may share any of the personal and health information we collect with our associates as permitted by law. We may also disclose this information to non-associated entities or individuals as permitted or required by law. Non-associates with whom we may disclose information as permitted by law include: attorneys, accountants, auditors, a patient's authorized representative, other healthcare providers, public health authorities, coroners, medical examiners, funeral directors, organ donation organizations, institutional review boards for research purposes, third party administrators, insurers, and law enforcement or regulatory authorities.

We may also disclose any personal and health information we collect in order to provide appointment reminders or to give you information about other treatments or health related benefits and services that may be of interest to you. In addition, in the event that this office is sold or merged with another office, your personal and health information will become the property of the new owner. We do not disclose personal or health information to any third parties without a patient's request or authorization.

Individual Rights to Access & Correct Personal Health Information

We have procedures for a patient to access the personal and health information we collect, and other than the information we collect in connection with, or in anticipation of, a lawsuit or legal claim, we will make this information available to the patient upon written request. Our goal is to keep our patient information up-to-date and to correct inaccurate information. We have procedures in place to ensure the integrity of our information and for the timely correction of incorrect information. If you believe that any personal or health information we have about you is not accurate, please let us know by contacting the Office Manager.

Further Information

The practice reserves the right to amend this Notice of Privacy Policy and Practices at any time in the future. Until such amendment is made, the practice is required by law to comply with this notice. Further questions regarding this notice may be directed to the Office Manager by phone: (850)398-8940 or in person at 131 E. Redstone Ave. Suite 102 Crestview, FL 32539.

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PRIVACY POLICY AND PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Policy and Practices and I have been provided an opportunity to review it.

Name____ Birth Date___________

Signature____________________________________ Date________________

SPECIMEN COLLECTION/TESTING CONSENT

Please be advised that during your examination with Dr. Cabrera, there may be specimens (pap smear, culture, biopsy, etc.) obtained. This office does not perform laboratory testing on these; each specimen will be sent to an outside reference laboratory to be interpreted by a licensed pathologist/cytologist. This office does not charge for the collection of these specimens, however, you will receive a statement from the laboratory for services rendered. This office is not associated in any way with the reference laboratory therefore, any questions regarding your statement will need tobe directed to the laboratory performing the service at the phone number on your statement.

*Please be advised that during your examination with Dr. Cabrera a Urine Drug Screen will be performed on Obstetric patients

I have read the above statement and do hereby consent to testing.

Signature ____________________________________ Date________________

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CONSENT FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996, this practice may use your health information for the purposes of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Privacy Policy and Practices. You have the right to review this notice prior to signing this consent form. You may request restrictions on the uses and disclosures described in the Notice of Privacy Policy and Practices by describing the requested restrictions in the "Restriction Request Section" of this form. You may revoke this consent at any time by signing and dating the revocation and returning to this office.

CONSENT SECTION

I, ______________________________ (print name) hereby consent to the use and disclosure of my personal health information for the purpose of treatment, payment and healthcare operations. My signature below indicates that I have been given an opportunity to read the Notice of Privacy Policy and Practices and to have any questions answered before signing. I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request of this form. I also understand that this practice is not required to accept my restriction request. I understand that I may revoke this consent at any time by signing the revocation section of this form and returning it to this practice. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

Signature____ Date________________

RESTRICTION REQUEST SECTION

I hereby request the following restrictions on the uses and disclosures of my health information. (Please describe the requested restrictions in detail):

____

____

REVOCATION SECTION

I hereby revoke this consent for use and disclosure of health information effective this ______ day of _____________, 20________

Signature____

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AUTHORIZATION TO RELEASE INFORMATION

Dr. Sergio J. Cabrera may disclose all or part of this patient's records to any insurance company or association and the Federal or State Government as such information may be necessary for the completion of all health care claims associated with services rendered. I understand this information to be released may include information pertaining to mental or psychiatric related conditions and/or drug or alcohol abuse and HIV/AIDS. A copy shall be as valid as the original.

ASSIGNMENT OF BENEFITS

I hereby authorize payment to Dr. Sergio J. Cabrera, benefits herein specified and otherwise payable to me for any services rendered by the physician subsequent to this date and for such other charges as may be made by physician. I hereby agree to pay the same and also agree that in the event medical coverage is insufficient to pay the indebtedness incurred and should there be any monies over and above the necessary to pay this registration, I agree that said physician may apply this overage against any amount which is owed by myself, spouse or legal dependents of myself or spouse at the time payment is made by my insurance plan.

I certify that the information given by me in applying under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this related medical claim(s). I request this payment of Authorized Benefits be made on or in my behalf to stated physician. A copy shall be valid as the original. I, the undersigned, certify that I have read the foregoing and am the patient, or duly authorized by the patient as the patient's general agent, to execute the above and accept its terms. I certify that this assignment of benefits shall remain in effect for the lifetime of this patient unless revoked in writing via certified mail to 131 E. Redstone Ave, Suite 102 Crestview, FL 32539.

Name______________________________ Date______________________

Signature__________________________ Witness_____________________

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PERSONAL REPRESENTATIVE/CONFIDENTIAL COMMUNICATION REQUEST

In accordance with the Health Information Portability and Accountability Act of 1996, you have the right to request a personal representative to act on your behalf and that communications concerning your personal health information is made through confidential channels. This practice will not question your request and make every effort to accommodate all reasonable requests.

1. Please list family members or other persons, if any, we may inform or discuss your general medical condition and diagnosis (including treatment, payment and health care operations) with.
   Name ______________________________ D.O.B.______________
   Name ______________________________ D.O.B.______________

2. Please print the address where you would like your statements and any other correspondence from our office sent.
   ____
   ____

3. Please print the telephone number(s) where you want to receive calls and/or text messages about appointments, lab and x-ray results or any other health care information. I am fully aware that cell phones are not considered a secure/private line.
   (_____) ____________________ (_____) ____________________

4. Please indicate if confidential messages (i.e., appointment reminders, lab results, etc.) can be left on your voicemail or answering machine.
   Yes ________ No ________

I understand that I may revoke this designation at any time. I understand revocation must be in writing and furnished to this office personally or via certified mail. I understand that any such revocation does not apply to the extent that persons authorized have already acted in reliance on this designation.

Patient/Guardian Signature______________________________________

Date ____________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Clinic Name: Sergio J. Cabrera, M.D. F.A.C.O.G. Clinic Address: 131 E. Redstone Ave. Suite 102

FAX: 850-398-8943 PHONE: 850-398-8940 Crestview, FL 32539

Patient Name ______________________ DOB ______________

Address ______________________ SS# ______________

Receive Records From:

____

____

____

Release Records To:

____

____

____

Please send a copy of my records as indicated for date(s) of treatment: ______________

______ Operative Records ______ Lab Reports ______ H&P ______ Radiology Reports

______ Prenatal Records ______ Discharge Summary ______ Pathology ______ Other

Purpose for releasing medical information: ______________________

____

______________________ SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN

______________ DATE

______________________ WITNESS

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and the special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted disease and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. The authorization can be revoked but not retroactive to the release of information made in good faith.

______________________ SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN

______________ DATE

______________________ WITNESS

Permission to FAX records for medical emergency? ☐ Yes ☐ No