Bela Vida
Urogynecology

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Ocoee ~ 10131 W Colonial Dr Suite #4 Ocoee FL 34761
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Patient Information

Last Name_____ First Name_____ MI_____DOB _____

Social Security #:_____Mailing Address_____

City_____ State_____ Zip Code_____

Home Phone _____ Cell_____ Work _____

Email Address_____Best way to contact ☐ Home Phone ☐ Cell Phone ☐Work

Ethnicity: ☐ Caucasian ☐ African/American ☐ Hispanic ☐ Asian/American ☐ Other:_____

Preferred Language _____ Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Primary Care Physician:_____ Phone Number:_____

Referring Physician:_____ Phone Number:_____

Emergency Contact (Parent/Guardian if patient is a minor)

Name _____ Relationship _____ Phone # _____

Who is financially responsible for the patient (Guarantor): ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

Last Name _____ First Name _____ DOB _____

Mailing Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell_____ Work_____

Primary Insurance- Please provide insurance card

Insurance Name _____ Policy # _____ Group # _____

Mailing Address _____ City _____ State _____ Zip Code _____

Policy Holder's Name _____ DOB _____ Relationship to Patient_____

Secondary Insurance- Please provide insurance card

Insurance Name _____ Policy # _____ Group # _____

Mailing Address _____ City _____ State _____ Zip Code _____

Policy Holder's Name _____ DOB _____ Relationship to Patient_____

Pharmacy_____ Adress_____Phone_____

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CONSENT FOR MEDICAL TREATMENT

Initials_____ I hereby voluntarily consent my assigned physician and medical staff at Bela Vida Urogynecology to provide evaluation and medical treatment including but not limited to examination, diagnostic test, surgical care and any other medical procedure and medication administration that may be necessary for me.

Initials_____ **INSURANCE ASSIGMENT**: I hereby authorize my insurance benefits to be paid directly to Bela Vida Urogynecology. I understand and agree that, regardless of my insurance status. I am primarily responsible for the balance of my account for any professional services rendered.

Initials_____ **AUTHORIZATION TO RELEASE INFORMATION**: I hereby authorize Bela Vida Urogynecology to release any information acquired in the course of my examination and treatment to any authorized agent for the purposes of healthcare, treatment, and payment. I authorize the release of medical information to my insurers as necessary for determination and payment of benefits; to healthcare providers involved in my care; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs.

Initials_____ **NOTIFICATION OF PRIVACY**: I acknowledge that I have been afforded the opportunity to read the Practice's Notice of Privacy Practices (HIPAA) and I understand I may receive a copy if I requested.

☐ I Agree to receive by email monthly information on new services offer.

Lifetime Medicare Authorization for <u>Medicare Patient Only</u> : I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct and authorize any holder of the medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the physician or organization furnishing the services or authorized such physician or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurances.

Patient Signature: _____ Date:_____

Print Name: _____ Relationship: _____

COMUNICATION AUTHORIZATION: I authorized this facility to disclose and discuss my personal health information with the following family members or individuals:

□ Spouse _____ Phone Number _____

□ Children _____ Phone Number _____

□ Others _____ Phone Number_____

I agree and consent to the Practice releasing information to me in the following alternative manners (please initial the following appropriate spaces:____ Via regular mail ____Via telephone ____Via email Via____ home answering machine ____Via work voice mail ____Via fax to my designated fax number which is:_____

The Practice may refuse to treat you if you / the patient's (or an authorized representative), do not sign this Consent Form. If you revoke this consent form (as can be done in writing) after signing, the Practice has the right to refuse further treatment.

I have read and understand the information in this Consent. I am aware I can request a copy of this consent and I am the patient or the authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

Patient Name:_____ Signature: _____Date:_____

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Financial Policy

- As the patient it is your responsibility to know your insurance benefits and provide our office with accurate and current insurance information. If your insurance plan requires a referral, it is your responsibility to obtain the referral from your primary care physician. If you arrive for your appointment without a referral on file, you have the option to reschedule the appointment or to paid in full for all services rendered.
- Payment is expected at time of service. This includes co-pays, co-insurances and deductibles. Our front desk staff will ask you for payment for any past due balances as well as your portion of the payment for the day of the appointment.
- If you are unable to keep your appointment, it is important to notify us 24 hours prior to your appointment. This will allow us to free your appointment time for other patients. You may be charged a $50 no show fee for office visits or procedure if you fail to notify us.
- NSF Checks/Pre-or Post-Dated Checks: Checks returned for insufficient funds (NSF) will incur a $35.00 charge, and we will automatically redeposit the check. If the check is returned a second time, another $35.00 service charge, plus the face of the check will be charged back to the patient's account and will be due immediately in an alternate form of payment. If you need to pre or post-date a check, please make that arrangement with our front desk staff prior to the appointment.
- If you are scheduled for an **elective service**, an estimate of your portion of the payment will be provided to you. Payment will be expected **before the service is provided**. If you have any **outstanding balance**, we will also expect payment before services are rendered. Failure to make the required payments will result in the service being rescheduled.
- All uncollected balances should be paid within 60 days of the clinic receiving insurance payment. All balances are collected at the time of services are rendered.
- If your insurance does not authorize a procedure or test and you choose to have the procedure or test done anyway, you will be expected to pay the fees for this service. Your insurance cannot be billed in those instances.
- Self-pay patients are required to pay for the office visit before services are rendered. In addition, any remaining balance on your account will be collected at discharge.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY. I HEREBY AGREE TO RENDER PAYMENT IN ACCORDANCE WITH THE TERMS AND CONDITION SET FORTH.

_____ _____

PRINT PATIENT NAME DATE

_____

SIGNATURE OF PATIENT OF RESPONSIBLE PARTY

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Bela Kudish, MD, FACOG
Vivian Aguilar, MD, FACOG
Lucy Burgos, APRN

APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Bela Vida Urogynecology. When you schedule an appointment with our practice, we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment, if necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

Any established patient who fails to show or cancel/reschedule an appointment and has not contacted our office with at least 24 hours in advance will be considered a No Show and charged a $50.00 fee. The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

As a courtesy, we make reminder calls for appointments 3 days in advance. If you do not receive a reminder call or email, the above Policy will remain in effect.

I have read and understand the medical appointment cancellation/no show policy and agree to its terms.

_____	_____	_____
Printed Name	*Signature (Parent/Legal Guardian)*	*Date*