Bethesda Health
Physician Group
BAPTIST HEALTH SOUTH FLORIDA

PATIENT INFORMATION

Patient Name: _____ Single/ Mar/ Div/ Wid (circle)
Last First Middle

DOB: _____ Age: _____ Sex: M / F Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Employer Name: _____ Occupation: _____

Primary Language: _____ Email: _____

Do you have a living will/directive? Y / N Who referred you? _____

Race: African American / Asian / Asian Indian / Black / Haitian / Laotian / White / Other: _____
(Please cicle)

Ethnicity: Central Amer. / Cuban / Dominican / Hispanic or Latino / Not Hispanic / Puerto Rican
Other: _____

PHARMACY INFO

Pharmacy Name: _____ Pharm Telephone: _____

Address (**OR intersection**): _____

IN CASE OF EMERGENCY

Name of emergency contact: _____ Relationship: _____

Home phone: _____ Work phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Bethesda Health Physician Group** or insurance company to release any information required to process my claims.

Signature: _____ Date: _____

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CONSENT RECORD

1. FINANCIAL AGREEMENT-I hereby guarantee payment of all charges incurred for services render by Bethesda Health Physician Group by authorized treating physician(s). Further, I guarantee payment of all attorney fees, court costs and collection charges incurred in the event collection action is initiated by Bethesda Health Physician Group.
2. MEDICARE/MEDICAID ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATIN AND PAYMENT REQUEST. I assign benefits and request that payment be made directly to Bethesda Health Physician Group. I understand that I am responsible for any deductibles and co-payments applicable.
3. USES AND DISCLOSURES OF HEALTH INFORMATION – I understand that Bethesda Health Physician Group will use and disclose my personal health information to provide treatment and process claims. This includes release of information to insurance carriers, 3rd party payers or their agents, with any right to privacy waived including any treatment for mental illness, alcohol abuse, drug abuse or HIV as may be necessary. Further, my information and medical records may be disclosed to members of the hospital's medical staff involved in my subsequent care and treatment. For details of uses and disclosures, refer to Notice of Privacy Practices.
4. CONSENT FOR GENERAL MEDICAL TREATMENT – I hereby authorize Bethesda Health Physician Group in charge of my care to administer any treatment, receive results of tests and services rendered, to administer medications deemed necessary or advisable in my diagnosis and treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments of examinations at Bethesda Health Physician Group.
5. PRIVACY PRACTICES – I have been made aware of Bethesda's Privacy practices as described in the Notice of Privacy Practices.
6. I authorized the release of any medical information necessary to process my claims. I assign benefits and request payment be made to Bethesda Health Physician Group. I permit a copy of these authorizations to be used in place of the original. I accept responsibility for all charges incurred and I am responsible for payment. Where applicable, regulations pertaining to Medicare assignment and HMO assignment of benefits apply.
7. I authorize Bethesda Health Physician Group to electronically obtain and submit immunization and medication records through the electronic portal or exchange with whom we have a relationship.

I understand that this consent is subject to revocation at any time to the extent that action has been taken in reliance thereon. I certify that I have read the foregoing, received a copy thereof, and I am the patient, the patient's legal representative or dully authorized by the patient as the patient's general agent to execute the above and accept its terms. I also fully understand the consent contained in this record and voluntarily execute it.

Patient Signature: _____ Date: _____
If other than patient, state relationship

Witness Signature: _____

PATIENT CONTACT

Contact Information*
The following people, other than duly designated guardian or conservator, are authorized to discuss my medical condition or billing information:

1. _____
Name Relationship Phone Number

2. _____
Name Relationship Phone Number

Print Name: _____ Date: _____

Signature: _____ Phone number: _____

***Please Note:** This contact information will remain in effect unless change is received from you in writing.

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
I hereby authorize that my Medical Records be released from or to (circle one)

Physician Name/Clinic: _____

Address: _____

I hereby authorize that my Medical Records be released to or from (circle one) Fax: 561-733-2602

Physician Name/Clinic: Dr Aaron Deutsch

Address: 1325 S Congress Ave Suite 103 Boynton Beach Fl, 33426

Information Requested

- O For dates of service: From: _____ Through: _____
- O Physician notes
- O Lab results
- O X-ray reports
- O Complete record
- O Other: _____

Purpose for Use of Disclosure of Protected Health Information

- O Permanent Transfer
- O Referral
- O Other: _____

Note: fee may be assessed for records requested for personal use

Patient Information

Printed Name: _____ Date of Birth: _____ SSN #: _____

SENSITIVE INFORMATION: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time; I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

ORTHER RIGHTS: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: *(If I do not specify an expiration date, event, or condition, this authorization will expire in twelve (12) months.)*

Signature of Patient or legal representative: _____

If signed by legal representative, relationship to patient: _____ Date: _____

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Maternal-Fetal Medicine of the Palm Beaches

Aaron B. Deutsch, M.D.

OB Ultrasound (Sonogram) Consent Form

An ultrasound of your fetus (unborn child) has been ordered by your physician.

An ultrasound is a diagnostic tool that may help with monitoring and/or making decisions regarding your pregnancy. It does not treat any condition. It is used only to monitor potential conditions.

The ultrasound was ordered to help diagnose potential problems or monitor the growth and progress of your baby by estimating the baby's weight. Note: (Estimating the baby's weight with ultrasound can be highly inaccurate). There are many reasons or indications for this test being ordered. Some of these include evaluation of your baby for birth defects, growth parameters, amniotic fluid volume, Doppler flow studies and position of the placenta.

Although the quality of most ultrasounds is excellent, a number of disorders and defects cannot be identified with the use of ultrasound. Factors that can limit the accuracy of ultrasound include but are not limited to, the age of your baby at time of the ultrasound, the positioning of the baby in the womb, your body type and composition, and scarring left from previous surgeries. From time to time it is not possible to image the necessary organs to make a complete evaluation.

Ultrasound cannot guarantee the gender of your baby. The sex of your child can only be confirmed once it is born.

It is very important to know that some potential problems develop at different times in your pregnancy. A normal ultrasound does not guarantee that a problem many not appear at a later date during your pregnancy. A normal ultrasound also does not rule out potential birth defects, and does not mean or guarantee that a genetic or chromosomal defect is absent. Many potential birth defects can appear normal during a diagnostic ultrasound and some problems may be missed.

I UNDERSTAND THAT AN ULTRASOUND CANNOT DIAGNOS ALL BIRTH DEFECTS. I HAVE READ THIS CONSENT AND UNDERSTAND THE INFORMATION OUTLINED ABOVE AND I HAVE HAD ALL OF MY QUESTIONS ANSWERED TO MY SATIFACTION. BY SIGNING THIS CONSENT I AGREE TO HAVE AN ULTRASOUND AND ACCEPT THE LIMITATIONS OF THE PROCEDURE.

Print Name _____

Signature _____ Date _____

Witness _____ Date _____

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Appointment Cancellation/No Show Policy

Our practice is committed to providing quality healthcare to our patients. We work diligently to maintain the highest level of personalized services and make every effort to accommodate our patient's needs for visits in a timely manner.

We understand that emergencies arise, however, when a patient cancels an appointment without adequate notice or misses an appointment without any notice, we cannot use the time to service the needs of other patients. You will receive a call two days before your appointment to confirm your appointment. Failure to cancel or reschedule your appointment at least 24 hours prior to your scheduled appointment will result in the following:

- 1st occurrence: Verbal warning
- 2nd occurrence: $25 charge with additional warning of possible discharge
- 3rd occurrence: Provider can approve discharging the patient from the practice

Thank you for your consideration and understanding of our policy. Please sign below attesting that you have read and understand the cancellation/no show policy.

Patient Signature Date

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Maternal-Fetal Medicine of the Palm Beaches

We at Maternal Fetal Medicine of the Palm Beaches are **NOT** responsible to verify your lab benefits prior to any blood draws. We therefore ask that you be familiar with your own insurance and lab benefits.

I understand that all lab work ordered by my physician and sent to an outside lab will be billed separately by the lab to my own insurance company. I also understand that I am responsible to pay for all lab charges, whether or not I have insurance and whether or not it is a covered benefit of my insurance.

I understand that the laboratory will bill me separately for any lab charges and in the event I receive a bill from the lab I will be responsible for contacting the customer service number on the invoice.

Print Name: _____
Signature: _____
Date: _____