Brian Haley, MD

Board Certified Obstetrician / Gynecologist

Patient Name: _____
Last First Middle

Date of Birth: _____/_____/_____ Social Security #: _____ Marital Status: S M W D

Home Address: _____

_____

Home Phone: _____ Cell Phone: _____

Email (to be used for patient portal):_____

Spouse Name: _____ Spouse Contact Number: _____

Employer: _____ Employer Phone:_____

Emergency Contact: _____Relationship: _____

Emergency Contact Phone: _____

Primary Care Physician: _____ Phone: _____

I was referred to Dr. Haley by: _____

Insurance Company: _____ Phone Number: _____

Member ID: _____ Group Number: _____

Subscriber: _____ Subscriber Date of Birth: _____/_____/_____

Pharmacy Name: _____ Phone: _____

Address: _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Brian Haley, M.D.

I understand that I am financially responsible to all charges whether or not paid by said insurance. I will be responsible for expenses associated with all collection, including reasonable attorney fees and court costs. Co-payments are due at the time of the visit. Self-pay patients are responsible for payments at the time of their visit.

I authorize Brian Haley, M.D. to release all information necessary to secure payment.

Patient Signature: _____ Date: _____

7301 A West Palmetto Park Road, Suite 305A, Boca Raton, FL 33433
Phone **(561) 372-9161** Fax: **(877) 651-1244** Web: **drbrianhaleymd.com**

Brian Haley, MD

Board Certified Obstetrician / Gynecologist

Medical History

Name: _____ Date of Birth: _____/_____/_____ Date: _____/_____/20_____

Medical & Family History:

	Current	Past	Family		Current	Past	Family
Seizures/Epilepsy	_____	_____	_____	High Cholesterol	_____	_____	_____
Stroke	_____	_____	_____	Thyroid problems	_____	_____	_____
Stomach/Duodenal	_____	_____	_____	Blood Clots	_____	_____	_____
Migraine Headaches	_____	_____	_____	Phlebitis	_____	_____	_____
Heart Disease/Murmurs	_____	_____	_____	Bleeding Disorders	_____	_____	_____
Asthma/Lung Disease	_____	_____	_____	Specify Type	_____	_____	_____
High Blood Pressure	_____	_____	_____	Sickle Cell	_____	_____	_____
Diabetes	_____	_____	_____	Cancer	_____	_____	_____
Liver problems	_____	_____	_____	Specify Type	_____	_____	_____
Osteoporosis	_____	_____	_____	Anemia	_____	_____	_____

Other Medical Problems: _____

_____

Medication Allergies: _____

_____

Current medications:

	Medication	Dose	Frequency		Medication	Dose	Frequency
1	_____	_____	_____	4	_____	_____	_____
2	_____	_____	_____	5	_____	_____	_____
3	_____	_____	_____	6	_____	_____	_____

Obstetric/Surgical History (please include all pregnancies)

	Date	Procedure	Complication (if any)
1			
2			
3			
4			
5			
6			
7			

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PAYMENT POLICY

Please read and sign this form as it concerns you, the patient.

YOU ARE RESPONSIBLE FOR YOUR INSURANCE POLICY

Due to many changes in Insurance policies, we cannot be responsible for interpreting each individual policy. It is the patient's responsibility to know your individual coverage and its limitations, as well as who is in an In-Network Provider for your plan.

We urge you to check with your insurance company regarding your benefits. Failure to comply could result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is a contract between you and your insurance company. It is your responsibility to know or find out, whether or not our provider is In-Network for your specific insurance plan.

Referrals

If you need a referral from your insurance company or your Primary Care Provider (PCP) to be seen in this office, the referral must be present and handed to the front office staff at the time of your visit. If it is not available, your appointment will be rescheduled and it will be your responsibility to obtain one. We encourage you to call your PCP and have your referral faxed to us prior to your appointment.

Non-Participating/Out of Network Provider Policy

If we are not a participating provider with your insurance company/plan, we will collect our fee in full at the time of service.

If the physician is considered out-of-network provider with your insurance company/plan, we will collect all out-of-network co-payments and fees at the time of service.

Your Financial Responsibility

You are responsible for paying any co-payments, co-insurance, deductibles, etc. Because we are considered specialists, some diagnostic and invasive procedures are not considered part of your standard office visit co-payment and may be applied toward your deductible and/or co-insurance.

Please call your insurance company and take the time to learn about your specific plan and what services it covers.

Patient Name: _____
Please Print

Patient Signature: _____ Date: _____

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NO SHOW/MISSED APPOINTMENT POLICY

We understand that unexpected situations may occur. However, missed appointments and late cancellations prevent other patients from receiving care and impact our ability to provide timely service.

When our office books your appointment, we are setting aside a dedicated time slot for you. We only ask that if you must reschedule your appointment that you please provide us with at least 24 hours' notice. This policy enables us to better utilize our appointment slots for those in need of our medical care.

Effective September 9, 2026, a no-show or cancellation with less than 24 hours' notice will be subject to the following fees:

- 1st no-show: $25 fee
- 2nd no-show: $50 fee
- 3rd no-show: $75 fee and **dismissal from the practice**

The applicable fee will be **charged to the credit/debit card on file** and is the patient's responsibility. No-show fees are not billed to insurance.

The practice may waive a fee in the event of an emergency or other extenuating circumstance, at the practice's discretion.

By signing below, I acknowledge that I have read and understand the No-Show & Late Cancellation Policy and authorize the practice to charge the applicable fee to the card on file.

Printed Name: _____

Signature: _____

Date: _____

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MALPRACTICE ACKNOWLEDGEMENT

Due to the current medical malpractice crisis, Dr. Haley does not carry medical malpractice insurance.

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. Your doctor has decided not to carry medical malpractice insurance. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

F.S. 458.320(5)(G)(1)

Printed Name: _____

Signature: _____

Date: _____

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PROTECTED HEALTH INFORMATION
PATIENT CONSENT

Patient Name: _____ Date of Birth: _____

Patient Address: _____

_____

PATIENT CONTACT

All calls regarding your care, test results and appointments will be made to your cell phone number. If you would like us to contact you at an alternative phone number, please indicate that number below.

Alternative Contact Number: _____

_____ I hereby authorize this practice to contact me by telephone and if I am not present, they may leave a message on my answering machine or with the persons listed below.

OR

_____ I prefer that you ***DO NOT*** leave messages on my answering machine.

I, _____, authorize Brian Haley, M.D. to release my Protected Health Information (PHI) to the people I have listed below if I am not available. (Please include restrictions, if any, of your PHI to each individual).

Individual/Relationship to Patient	Restrictions (If Applicable)
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature: _____

Date: _____

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name: _____ Date: _____
Please Print

Patient Signature: _____

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CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

I hereby consent to a medically indicated physical examination. This may include, but is not limited to, a female gynecological exam which may include a rectal exam and a pelvic exam and an ultrasound exam which may include a probe placed in the vagina. This will be performed by Brian Haley, M.D. and any of their licensed ultrasound technicians. This consent will remain active until I withdraw my consent in writing.

Patient Name: _____ Date: _____
Please Print

Patient Signature: _____

NOTICE OF LAB CONVENIENCE FEE

Due to an increase in volume, our practice we will be charging a $25 convenience fee each time you choose to have your blood drawn in our office. This is not a covered service by your insurance company and should not be submitted to your insurance company for reimbursement.

If you prefer to go to an outside lab, i.e. Quest or LabCorp, we will print you a lab prescription and you can schedule your appointment with them. Please be reminded that your next visit may be dependent upon us having the results. Therefore, your blood should be drawn in a timely fashion. Please call prior to your appointment to confirm that we have received your outside lab results.

Any laboratory services, whether drawn in our office or at an outside lab, will be submitted to the appropriate laboratory based on your insurance company. Some insurance companies may apply services to your copay, deducible and/or coinsurance. You are responsible for paying any bills that you receive from the laboratory. These fees are separate from the $25 convenience fee. If you have questions about your financial responsibility for laboratory charges, please contact your insurance company. If you have questions about a bill that you have received from a laboratory company, please contact that company directly.

Patient Name: _____ Date: _____
Please Print

Patient Signature: _____

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CONSENT FOR VOICE AND TEXT MESSAGING COMMUNICATION

I understand that in order for the office of Brian Haley, M.D. to leave detailed messages containing specific medical information on my voicemail, answering machine, I need to give my permission to Brian Haley, M.D.

I further understand that in order for Brian Haley, M.D. to text detailed messages containing specific medical information to my cell phone, I need to give my written express permission to Brian Haley, M.D. I also understand that my healthcare information at Brian Haley, M.D. is protected and a copy of the Notice of Privacy Practices is available upon my request.

In order to receive text messages from Brian Haley, M.D. I must enable my cell phone to receive text messages from phone numbers that are not in my contacts. The text messages will most likely come from a phone number you are not familiar with.

If I decide to opt out from receiving text message notifications from Brian Haley, M.D., understand that I must allow two weeks to ensure that my results have arrived. After two weeks, I will have to call the office for results. If I do decide to opt out, it is my responsibility to call the office for results.

Consent for Messages

I give my written express consent to Brian Haley, M.D. to leave detailed messages on my voicemail/answering machine and/or to text message me about my NORMAL lab results, diagnostic and/or imaging results, prescription information, or appointment reminders. No abnormal results will be communicated via our automated system.

Patient Name: _____ Date: _____
(Please Print)

Patient Signature: _____ Cell #: _____
(# to be used for text message notifications)

It is my responsibility to keep this information up to date, as I recognize that my information may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that I must provide written notice in order to revoke this consent.

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EMAIL CONSENT & ACKNOWLEDGMENT FORM

1. Risk of using email to communicate with your provider:

Brian Haley, M.D. (to be referred to as provider for the remainder of this form) offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before using email communication. These include, but are not limited to, the following risks:

a) Emails can be circulated, forwarded, and stored in numerous paper and electronic files
b) Emails can be immediately broadcast worldwide and be received by unintended recipients
c) Email senders can easily type in the wrong email address
d) Email is easier to falsify handwritten or signed documents
e) Back up copies of email may exist even after the sender or recipient has deleted his or her copy
f) Employers and on-line services have a right to archive and inspect emails transmitted through their system
g) Email can be intercepted, altered, forwarded, or used without authorization or detection
h) Email can be used to introduce viruses into the computer system
i) Email can be used as evidence in court

2. Conditions for the use of email:

Brian Haley, M.D. will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the provider cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not caused by provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of email includes agreement with the following conditions:

a) All emails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those emails.
b) Provider may forward emails internally to provider staff and agents necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c) The patient is responsible for protecting his/her password or other means of access to email. Provider is not liable for breaches of confidentiality caused by the patient or a third party.
d) Provider shall not engage in email communication that is unlawful, such as unlawfully practicing medicine across state lines.
e) It is the patient's responsibility to follow-up and/or schedule an appointment.

3. Patient responsibility and instructions: to communicate by email, the patient shall:

a) Limit or avoid using his/her employer's computer.
b) Inform provider of changes in his/her email address.
c) Confirm that he/she has received and read the email from the provider.
d) Put the patient's name in the body of the email.
e) Include the category of the communication in the emails subject line for, for routing purposes (e.g. billing and questions).
f) Take precautions to preserve the confidentiality of email, such as using screen savers and safeguarding his/her computer password.
g) Withdraw consent only by email or written communication to provider.

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4. Termination of the email relationship

The provider shall have the right to immediately terminate the email relationship with you if determined in the sole provider discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the provider determine to be unacceptable.

5. Patient acknowledgement and agreement

I have discussed with the provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my provider may impose to communicate with patients by email. Any questions I have had were answered.

6. Hold Harmless

I agree to indemnify and hold harmless the provider and its trustees, officers, directors, employees, agents, information provider and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the provider, and any breach by me of these restrictions and conditions.

Patient Name: _____ Date: _____
Please Print

Patient Signature: _____

Patient Email: _____

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PATIENT PAYMENT METHOD AND STORAGE AUTHORIZATION

This Patient Payment Method and Storage Authorization ("Authorization") allows this Practice to maintain a payment method on file and process authorized charges for patient-responsible amounts arising from healthcare services received by you and provided by the Practice.

Patient Name:	
Date of Birth:	
Responsible Party (if different from Patient):	

1. **Authorization**. I authorize the Practice to securely maintain my designated payment method on file and to charge such payment method for amounts for which I am financially responsible arising from healthcare services provided to me by the Practice. This Authorization is intended to facilitate payment of patient-responsible balances and reduce the need for multiple billing statements and collection activities.

2. **Authorized Charges**. I authorize the Practice to charge my payment method on file for:

   - copayments, deductibles, coinsurance, and other amounts due at the time of service;
   - balances determined to be my responsibility after insurance claims have been processed and adjudicated;
   - charges for services not covered by insurance or services for which I have agreed to be financially responsible;
   - self-pay services;
   - outstanding balances owed to the Practice; and
   - missed appointment, late cancellation, returned payment, or other fees disclosed by the Practice in advance and permitted by applicable law.

3. **Insurance Billing**. Where applicable, the Practice will submit claims to my health plan in accordance with its normal billing procedures. I understand that insurance coverage and payment determinations are made solely by my health plan and not by the Practice. I agree that any amount determined to be my responsibility following claim adjudication may be charged to my payment method on file.

4. **Notice of Charges**. The Practice may provide notice of balances due through statements, patient portal messages, text messages, telephone communication, or other authorized methods of communication. I acknowledge that receipt of such notice is not required before an otherwise authorized charge is processed.

5. **Recurring Authorization**. I understand and agree that this Authorization permits recurring future charges to my payment method for patient-responsible balances arising from healthcare services provided to me by the Practice while this Authorization remains in effect. No additional signature shall be required for each authorized charge.

6. **Payment Information Security**. I understand that payment information may be stored and processed by the Practice and/or its authorized payment processing vendors using commercially reasonable safeguards designed to protect payment information. Such information will be maintained in a confidential and secure manner. The Practice does not store security codes (CVV/CVC) and utilizes payment processing systems designed to comply with applicable payment card industry standards.

7. **Updated Payment Information**. If my payment method expires, is replaced, or otherwise changes, I agree to provide updated payment information upon request.

8. **Billing Questions and Disputed Charges**. If I believe a charge was processed in error, I agree to promptly contact the Practice's billing team so that the matter may be reviewed and addressed.

9. **Revocation**. I may revoke this Authorization at any time by providing written notice to the Practice. Revocation will only apply to future charges and will not affect: (i) charges processed before the Practice has had a reasonable opportunity to act upon the revocation; (ii) balances previously incurred; or (iii) my responsibility to pay for healthcare services provided to me by the Practice.

10. **Financial Responsibility**. I acknowledge that I remain financially responsible for all amounts owed for services provided to me or to any patient for whom I am legally responsible, regardless of insurance coverage, denial of benefits, termination of this Authorization, or the status of any payment method on file.

11. **Acknowledgment**. By signing below, I certify that I am the authorized holder or user of the payment method designated for this Authorization. I acknowledge that I have read and understand this Authorization, have had the opportunity to ask questions, and voluntarily authorize the Practice to store and charge my payment method on file as described herein.

Patient / Responsible Party Signature:	
Printed Name:	
Relationship to Patient (if applicable):	
Date:	

Payment Method Information

Cardholder Name:	
Type of Payment Method:	☐ Visa ☐ Mastercard ☐ American Express ☐ Discover ☐ Debit Card ☐ HSA/FSA Card ☐ Other: _____
Card Number:	
Expiration Date:	

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Board Certified Obstetrician / Gynecologist

Important Notice Regarding Insurance Billing and Office Visits

Over the past 20 years, Dr. Haley has always made every effort to help his patients and accommodate their needs by addressing additional concerns during their scheduled wellness visits.

However, insurance companies have become increasingly strict regarding what services they will and will not cover. As a result, our office must make some changes to how certain visits are scheduled and billed.

Wellness Visits:
During your wellness visit, Dr. Haley may not be able to address additional medical problems or concerns. If an additional problem is addressed, it may need to be billed as a separate office visit to your insurance company, which could result in an additional charge to you, or you may need to come back on a separate day.

Pelvic Ultrasounds:
If a pelvic ultrasound is ordered, the ultrasound appointment will need to be scheduled on a separate day from your doctor's appointment to discuss the results.

We understand that these changes may be inconvenient, and we appreciate your understanding. These policies are necessary to comply with current insurance billing requirements while continuing to provide quality care to our patients.

Thank you for your understanding and for allowing us to continue caring for you.

By signing below, I acknowledge that I have read and understand the **Important Notice Regarding Insurance Billing and Office Visits.**

Printed Name: _____

Signature: _____

Date: _____

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