WOMEN'S CENTER OF FLORIDA
EMORY MEDICAL CORPORATION
PATIENT REGISTRATION & CONSENT FORM

NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PHONE: (____) _____ WORK: (____) _____ CELL: (____) _____
SOCIAL SECURITY # ____-____-_____ DRIVERS LICENSE # _____ STATE ____ EXP _____
EMAIL ADDRESS _____
WHAT IS YOUR PREFERRED METHOD OF COMMUNICATION? ___ EMAIL ___CELLPHONE ___HOME PHONE ___MAIL
HOW DID YOU HEAR ABOUT US? _____
LANGUAGE: ____ ENGLISH ____ SPANISH ____ INDIAN (INCLUDES HINDU/TAMIL) ____ OTHER
ETHNICITY: ____ HISPANIC OR LATINO ____ NOT HISPANIC OR LATINO ____ REFUSE TO REPORT
RACE: ____AFRICAN AMERICAN ____ASIAN ____HISPANIC ____NATIVE HAWAIIAN/PACIFIC ISLANDER
____ WHITE ____OTHER ____REFUSE TO REPORT

SPOUSE OR PARENT'S NAME: _____ PHONE (____) _____
EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____
ADDRESS: _____ PHONE: (____) _____

RESPONSIBLE PARTY & INSURANCE INFORMATION

PATIENT MUST DISCLOSE ALL INSURANCE POLICIES, FAILURE TO DO SO WILL RESULT IN DENIAL OF CLAIMS, FOR WHICH PATIENT WILL BECOME RESPONSIBLE.

Do you have Medicaid? _____Yes _____No
EMPLOYER NAME: _____ TELEPHONE # _____
EMPLOYER ADDRESS: _____ CITY _____ STATE ____ ZIP _____
OCUPATION: _____
PRIMARY CARE PHYSICIAN: _____ TELEPHONE# _____

PRIMARY INSURANCE CO. NAME: _____ ID # _____ GROUP# _____
SUBCRIBERS NAME IF NOT PATIENT: _____ SS# _____ RELATIONSHIP _____

SECONDARY INSURANCE CO. NAME: _____ ID # _____ GROUP# _____
SUBCRIBERS NAME IF NOT PATIENT: _____ SS# _____ RELATIONSHIP _____

SOCIAL HISTORY
PERSONAL STATUS: _____ MINOR _____ STUDENT _____ SINGLE _____ MARRIED _____ DIVORCED
Alcohol: _____ amount per week; Smoking: _____ cig. Per day; Coffee/Tea/Soda: _____ amount per week; Recreational Drugs ___Y ___N

HEALTH HISTORY
Menstrual Age at onset _____; ____Regular ____Irregular; Pain/Cramps with menstrual flow ___ Yes ___ No; Days of flow/cycle: _____
No. of pregnancies _____: No. of Live Births ___; No. of miscarriage/terminations ___; Birth Control method _____
Date of last Pap: _____ Date of last Mammogram: _____

SURGICAL HISTORY

DATE	SURGERY / HOSPITALIZATION	DATE	SURGERY / HOSPITALIZATION

ALLERGIES:
_____

MEDICAL HISTORY:
_____
_____

CURRENT MEDICATIONS:
_____
_____

_____ _____
Patient/Representative Signature Date

_____ _____
Witness Signature Date

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CONSENT TO TREATMENT: The undersigned hereby consents to the following, for Emory Medical Corporation and its Providers:

a. Performance of any Lab tests including drug toxicology testing.
b. Performance of other medical tests considered medically necessary or advisable based on the judgments of the attending physician or their assigned designees may be done in house or by and outside facility.

FINANCIAL RESPONSIBILITY: I assume full financial responsibly for the services, treatments or tests that I may receive.

a. I understand that Third Party Venders may be utilized for Labs or Pathologies collected during treatment and I may be responsible for these charges. I understand that I may provide the information for my preferred vender if I have one. A list of the venders the practice uses may be requested by me in writing prior to my office visit should I require the need for it.
b. I understand that having insurance does not terminate that responsibility and I may have to fill out paperwork or contact my insurance provider to facilitate payments. Failure to disclose all insurance will result in denial of claims.
c. In consideration of the services to be rendered to the patient, I individually promise to pay the patient's account at the rates stated in Emory Medical Corporation price list (known as the "Charge Master) effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on Charge Master, or if the charge is listed as zero. An estimate of the anticipated charges for services to be provided to the patient is available upon request from the billing department. Estimates may vary significantly form the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services. As a courtesy to you, Emory Medical Corporation will bill your insurance company, but it is not obligated to do so. By signing this registration you are legally appointing Emory Medical Corporation to act on your behalf as Appointed Representative with your Insurance Company(s) for claims but not limited to claim submissions, or filing appeals and grievances.
d. Regardless, you agree that except where prohibited by law, the financial responsibility for the services rendered belongs to you, the undersigned. You agree to pay for any services that are not covered by your insurance company. This includes, but is not limited to coinsurance, deductibles, non covered benefits due to policy limits or policy exclusions as well as failure to comply with your insurance requirements. If collection is initiated you will be responsible for all collection costs including attorney's fees and court costs or any other cost of litigation.

OFFICE POLICIE & FEES: Providers of Emory Medical Corporation, only provide inpatient Obstetrics and Gynecology services at Shands Lake Shore Regional Medical Center in Lake City Florida.

a. Leaving the office without being discharge will be considered leaving against medical advice (AMA).
b. I may be discharge from the practice if I am not compliant with treatment, with office appointments or for an unpaid account. All unpaid accounts will be turned over to collections group after 90 days and I will be responsible for all expenses needed to recover.
c. The address and phone number provided is the address and phone of record and I will be responsible for updating my record.
d. All cancelled checks are subject to a $50 charge and all costs associated with recovery or payment including attorney fees. There will be a $50 cancelled or missed appointment fee if not notified prior to 24 hours before your appointment. All prepaid fees are non refundable.

HIV/AIDS CONSENT: If I have been offered the blood test for detection of the Human Immunodeficiency Virus (HIV), I understand HIV is the causative agent of Acquired Immune Deficiency Syndrome (AIDS).

a. I understand that this test may not be conclusive because a positive result means additional test may be needed and a negative result does not necessarily eliminate consideration of AIDS.
b. I have also been informed that the results of this blood test will only be release to those healthcare personal and insurance companies, providing medical care and coverage to me as allowed by Federal and State law.
c. I understand that these test results will be a part of my medical record and will be released if I have signed an authorization for release of medical information.
d. I understand that not all health insurance plans will pay for HIV testing. Should my insurance company decline coverage I understand that I will be expected to pay for it myself.
e. I am aware that additional information regarding HIV/AIDS and antibody testing is available at my request and therefore acknowledge that I have had the opportunity to ask any questions I have regarding the test prior to giving my consent. I hereby give my consent for the performance of the HIV blood test and to the release of the results as outlined above.

RELEASE & STORAGE OF MEDICAL RECORDS

a. I fully understand that I am entitled to my medical records, which can be pulled with advanced notice and printed or electronically copied for me, after I have paid the charges associated with it.
b. I also understand that medical records can be given to me ONLY IN PERSON or released to my health care provider after a release of medical record consent is obtained.
c. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment has been recommended. The consent will remain in full force for all treatments received past and future until revoked in writing.
d. All communication with Emory Medical Corporation must be done in writing via Certified Mail ONLY (no other for mo communication will be considered valid).
e. I understand that all records are stored electronically by Emory Medical Corporation and are fully backed up daily by vendors to ensure safety but can be lost due to unforeseen circumstances beyond our control and Emory Medical Corporation or its providers are no liable.
f. I understand that Emory Medical Corporation may include consent/records at satellite offices under common ownership.
g. A photocopy/electronically stored copy of consent/records shall be considered as valid as the original. Accordingly, paper records may be destroyed by the Corporation. All contracts and agreements will survive the termination of relationship.
h. I authorize Emory Medical Corporation to release medical information about me to the Social Security Administration or its Intermediaries for any insurance claims being made for services provided to me. I assign Emory Medical corporation benefits payable for services provided to me.
i. I understand and acknowledge that Emory Medical Corporation will use and disclose my information for the purpose of treatment, payment and healthcare operations as described in the Notice of Privacy Practices.
j. I authorize Emory Medical Corporation to use and display photographs of me (the Patient) or my baby that was delivered by any of the healthcare providers at Emory Medical Corporation for use in any Practice publication, Practice Display or Practice website, for the limited scope of promotional displays/slideshows set up within. With the limitation of photographs taken with my knowledge for intent to share or given to practice to be displayed.

ACKNOWLEDGEMENT OF UNDERSTANDING /RIGHT TO REFUSE: I understand that I have the right to refuse any service, tests or procedure before it's performed. I acknowledge that Emory Medical Corporation has given or made available to me copies of any forms that I have signed. I certify that I have read and fully understand the above statements and voluntarily consent to its consent and all my questions and concerns have fully answered to my satisfaction.

Patients Printed Name	Patients Signature	Date
Witness Printed Name	Witness Signature	Date
Physician Signature		

Women's Center of Florida An Emory Medical Corporation

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HEALTHCARE PROVIDER-PATIENT BINDER ARBITRATION AGREEMENT

1. Agreement to Binding Arbitration. It is agreed and understood that any dispute as to medical negligence, or any controversy which arises out of or in any way relates to the diagnosis, treatment, or care of the patient by the undersigned healthcare provider, Emory Medical locations, personnel or its providers, will be resolved by arbitration as described in this Agreement.

2. Waiver of Jury Trial. BY ENTERING INTO THIS AGREEMENT, THE PARTIES UNDERSTAND THAT THEY ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY CLAIM OR DISPUTE BETWEEN THEM DECIDED IN A COURT OF LAW BEFORE A JURY. The parties agree that by entering into this Agreement, they voluntarily waive this right for any and all present and future disputes and claims that arise between them.

3. All Claims Must Be Arbitrated. It is the intention of the parties that this Agreement binds all parties whose claims may arise out of or are related to the diagnosis, care, treatment, or services provided by the undersigned healthcare provider, or any member of the undersigned healthcare provider's office staff, including, but not limited to, the patient, the patient's estate, the patient's spouse and any children, whether born or unborn, the biological father of the child/children, and any other heirs of the patient, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" shall mean the mother and the mother's expected child or children.

4. Procedures and Applicable Law. Any and all present and future disputes and claims shall be resolved by the parties and/or claimants in accordance with the following:

   a. Pursuit. The parties or claimants shall have the benefit of pre-suit notice, investigation, and discovery as provided in Florida Statutes, Chapter 766.In the event the claim is not resolved as provided by 766.106 or 766.207, then any and all claims shall be resolved by arbitration pursuant to this Agreement.

   b. Initiation of Arbitration Proceedings. Written notice of the demand for arbitration shall be provided to the opposing party within 60 days from the termination of the pursuit process, or within the remainder of the stature of limitations, whichever is greater. Written notice shall be sent certified mail, return receipt requested.

   c. Legal Representation. The parties or claimants are entitled to be represented by legal counsel during any and all arbitration proceedings or hearings.

   d. Selection of the Arbitration Panel. The arbitration will be conducted by three arbitrators who will hear the dispute and render a binding decision. Each side shall appoint one arbitrator with experience in medical malpractice claims arbitration (hereinafter referred to as a "party arbitrator"), and one alternate arbitrator within thirty (30) days of the written demand for arbitration, and shall notify the other party of such appointment. In the event of multiple plaintiffs or multiple defendants, the arbitrator selected by the side with multiple parties shall be the choice of those parties. A neutral arbitrator shall be selected by the party arbitrators (excluding alternates), within thirty (30) days of their appointment, In the event of a party arbitrator's inability to complete the arbitration process, then the alternate arbitrator will be provided opportunity to review the proceedings to date, and will replace the departing arbitrator . The arbitrators shall appoint a time and place for the hearing, which shall be held within a reasonable time after the appointment of the neutral arbitrator.

   e. Applicable Law. Except as provided herein, the parties agree that the arbitration shall be conducted in accordance with the Florida Arbitration Code, found in Florida Statutes, Chapter 682. Except as provided herein, the parties agree that Florida law applicable to medical malpractice claims and damages shall be applied, including, but not limited to, those concerning the Wrongful Death Act.

   f. Limitation on Non-Economic Damages. With respect to a claim for personal injury or wrongful death arising from medical negligence, or any controversy which arises out of or in any way relates to the diagnosis, treatment, or care of the patient, noneconomic damages shall not exceed $250,000, regardless of the number of the number of defendants and claimants.

   g. Decision and Award of Arbitrators Final and Binding. The parties to this Agreement hereby agree that the decision and award of the arbitrators is final and binding on both parties. The award rendered by the arbitrators may be entered in any court having jurisdiction thereof. The decision of the arbitrators only may be appealed in a limited amount of circumstances, which are those consistent with the provisions of the Florida Arbitration Code.

5. NICA. This Agreement shall not be construed as a waiver of any law related to Florida's Birth-Related Neurological Injury Compensation Plan (hereinafter referred to as the "Plan"). If a party to this Agreement requests to submit a claim under the Plan, all arbitration proceedings shall be stayed until a decision is made regarding the compensability of the claim under the Plan.

6. Nature of the Proceedings. The parties that the arbitration proceedings are to be private. The privacy of the parties and of the arbitration. Proceedings shall be preserved and confidentiality shall be maintained.

7. Arbitration Expenses. Expenses of the arbitration shall be shared equally by the parties to this Agreement, except that each party shall be responsible for the payment of its own legal counsel fees, witness fees, or other fees incurred by a party for its own benefit.

8. Term and Termination. This Agreement shall be effective as of the date it is signed and shall remain in effect until terminated pursuant to the provisions herein. Any party may cancel the Agreement upon any anniversary date of this agreement, provided that written notice is sent to the other party at the last known address no later than 60 days prior to such anniversary date.The patient understands that he or she will not receive further diagnosis, care, and/or treatment upon the termination of this Agreement. The patient also understands the Agreement will remain in effect for any diagnosis, care, and/or treatment rendered prior to the termination of the Agreement.

9. Right to Refuse. The patient has the right to refuse to accept this Agreement, at which time a listing of available physicians in the same medical specialty will be provided to the patient. The patient understands he or she is not required to use the undersigned provider, and that there are numerous other providers who are qualified to diagnose, treat, and/or care for the patient.

10. Entire Agreement; Severability. This Agreement contains the entire agreement by and among the parties to date with respect to the subject matter hereof and supersedes any and all prior agreements and understandings, whether oral or written, with respect to such matters. In the event that anyone or more of the provisions contained herein shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision of this Agreement, but this Agreement shall be construed as if such invalid, illegal or unenforceable provision or provisions had never been contained herein unless the deletion of such provision or provisions would result in such a material change as to cause continued performance of this Agreement as contemplated herein to be unreasonable or materially and adversely frustrate the objectives of the parties as expressed in this Agreement.

11. Governing Law. This Agreement is governed by the laws of the State of Florida.

12. Patient Acknowledgments. By signing this Agreement, the patient hereby acknowledges the foregoing:
    a. Right of Counsel. By signing this Agreement, the patient acknowledges and understands that this Agreement is a legal document, and that he or she has the right to consult with an attorney of his or her choice prior to signing this Agreement, and to receive explanations or clarification of any of the terms of this Agreement.

    b. No Undue Influence. The patient hereby acknowledges that he or she has not been pressured, induced, coerced, or intimidated in any way into signing this Agreement, and has signed this Agreement of his or her own free will and accord. The patient further acknowledges that he or she has not signed this Agreement under duress.

    c. Receipt of Copy of Arbitration Agreement. The patient hereby acknowledges that he/she has received a copy of this Arbitration Agreement.

    d. The Patient's Understanding of the Terms of the Agreement: By signing this Agreement, the patient hereby acknowledges that he/she has read this Agreement and understands and agrees to is terms. The patient acknowledges that he/she has been given every opportunity to ask questions and receive answers concerning the specifics and intent of this Agreement.

NOTICE

BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE RELATED TO YOUR MEDICAL DIAGNOSIS, CARE AND/OR TREATMENT DECIDED BY ARBITRATION. IN DOING SO, YOU ARE GIVING UP YOUR RIGHT TO A JURY TRIAL. This Agreement shall be effective as of the date of the signature of the patient and/or the patient's representative below. Upon such signature, this Agreement shall be deemed to be fully executed and binding upon all parties.

Patient printed Name	Patient Signature	Date
Parent/Guardian Printed Name	Parent/Guardian Signature	Date
HealthCare Provider Signature	Date	