Village Gynecology

1503 Buenos Aires Blvd, Suite # 181 (Bldg #180)
The Villages, FL 32159
(352) 259-5740

We would like to take this opportunity to familiarize you with our **office policies and new patient forms,** which are designed to make it easier to provide you with comprehensive and personalized care.

Practice Hours:
Monday - Thursday: 8:30am to 4:00pm
Friday: 8:30am to 12:00 noon

Scheduling Appointments: We would appreciate patients to call as far in advance as possible to schedule appointments. When making appointments please be specific regarding your medical concerns in order to schedule an appropriate amount of time. Routine annual visits are scheduled for 15 minutes, new patients for 30 minutes, and patients with additional medical problems will be scheduled accordingly.

During Your Appointment: Please arrive 15 minutes prior to your scheduled appointment time for paperwork. To best use appointment time efficiently, please have a clear idea of the purpose of your visit and convey your most important concerns to the nurse during screening. Also remember to bring a list of all of your medications, including over the counter and herbal medications. It is part of our office policy **not to allow** any recording devices and/or video devices to be used by patients/family/friends in the office at any time for any purpose.

Canceling Appointments: If it is necessary to cancel or reschedule your appointment, we require that you call by 10:00 AM two (2) working days in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. Any appointment not cancelled by 10:00 AM two (2) working days in advance will be charged a no show/cancellation fee under the Cancellation Policy on page 8. Please review and sign the Cancellation Policy.

Prescription Refills: If you need a prescription refill, please call during office hours only. We request you call and leave a message with Triage (Medical Asst.), Ext 12, one to two weeks prior to running out of your medication (21 days if ordering by mail). She will need your name, pharmacy's name and phone number, name of medication and dosage. If you call after office hours, the on-call physician does not refill prescriptions. Remember you must be seen on a routine basis in order to receive prescription refills.

Emergencies: If you have a gynecological emergency, call 911 for immediate response or go directly to the emergency room. Our doctors are affiliated with The Villages Regional Hospital. If you are seen in this emergency room, identify our doctors as your Gynecologist and our doctor on call will be notified.

Fees and Payments: We are currently accepting the following insurances: Medicare, Railroad Medicare, CCN Network (employees of Citizens First Bank and Charter School), Blue Cross/Blue Shield, Cigna, United Health Care, IHP-Integrated Health Plan, Beech Street, and United Benefits. We are adding additional insurances on a daily basis. Please ask us for an update when you call to make your appointment. We accept cash, check and credit cards for co-payments. **All Patients with deductibles will be responsible for their payment at the time of service if the deductible has not been met.**

New Patient Consent to the Use and Disclosure of Health Information

For Treatment, Payment, or Healthcare Operations

I, ____________________ understand that as part of my healthcare, Village Gynecology originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and, surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Village Gynecology is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent, this organization may refuse to treat mc as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Village Gynecology reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Village Gynecology change their notice, they will send a copy of any revised notice to the address I've provided (whether US Mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that as part of this organizations treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **accept** /**decline** the terms of this consent.

Patient's Signature ____ **Date** ____________________

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Patient's Name ____

Address____

City___________________________________ State___________ Zip Code____________

Home Phone_______________ Work Phone ________________ Date of Birth____________

SSN____________________ Marital Status_______________ Family Doctor_____________

Spouses
Name _________________ Spouse Date of Birth _____________ Spouse SSN ____________

If your insurance is in your spouses name, even if they are deceased we still need the information on them.

Pharmacy phone number____

Employer Address ____

I agree to allow my Insurance Co. to pay Village Gynecology directly. **Initial**: ____ Date: _____

I authorize the release of information for payment. **Initial:** ___________ Date: ____________

I accept full responsibility for all non-paid fees. **Initial:** ____________ Date: ____________

Insurance Information: Please present your insurance cards to the receptionist for processing.

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WELCOME to our office. We consider it a privilege to have this opportunity to serve you. As of February, 2008, we have made a change in our financial policy. We would like to take this time to help you understand our policy.

For patients who need major treatment or procedures, a payment plan can be arranged. Our Business Office Manager will be happy to assist you. Financial arrangements must be made before treatment begins.

For insurance plans that we are providers for and that we bill, please provide us with your insurance card(s) for copying. After confirmation of your insurance coverage, you will be expected to meet your deductible and pay your percentage. For any amount not covered by your insurance company, you will be billed from this office.

For an insurance company that we are not providers for, we will gladly, as a courtesy to you, do the paper work. (not the billing) After confirmation of your coverage you are requested to pay the amount that is not covered by your insurance company. Please provide us with your insurance card(s) for copying.

If payment is not received from your insurance company within thirty days from the filing date of any insurance claim, the balance will become your responsibility.

There will be a $25.00 service charge for any returned checks. This is above the amount of the check and must be paid by cash, money order or cashier check.

We feel that a firm understanding of the financial involvement is essential for medical benefits before beginning treatment in order to maintain a favorable environment and to assist you, the patient to plan accordingly.

Payment will be expected at the time of service. We thank you for your cooperation.

_______________________________________ ___________________________
(Patient or Guardian Signature) (Date)

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It ***is*** in your best interest to take your medications on a regular basis.

To ensure continuity and avoid lapses in your medication intake, kindly

call our Triage (Medical Asst.), Ext 12,
7-14 days (21 days if ordering by mail)
before you run out of medication.

Please allow 48 to 72 hours turn around time
on refill requests.

Patient Copy

Village Gynecology

Patient Name ________________________________ **ID#**______________________

Medical Database

Medical Conditions (ie: Diabetes, Blood Pressure)				**Previous Surgeries**		
Date	**Problem**			**Date**	**Operation**	

Blood Transfusions:

Obstetrical History / Pregnancies / Miscarriages

Date	**Sex**	**Weight**		**Type of Delivery**

Family History (Parents, Siblings, Children, Aunts, Uncles)

Cancer	
Heart Attack	
Diabetes	
Osteoporosis	
Other	

Social History

Education:

Occupational/Employment:

Marital: Married Single Divorced Widowed (Please Circle One)

History of Physical Abuse: YES NO (Please Circle One)

Gynecological History

Age at first menstrual period: Age at Menopause: Abnormal Pap Smears: YES NO

Method of Contraception used in the past:

Any Prior sexually transmitted diseases: YES NO

Ok to leave message at home or office

Appointment Cancellation Policy

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care. Failure to keep or to arrive on time for scheduled appointments jeopardizes the ability of our office to provide you and our other patients the appropriate care. In order to be respectful of the medical needs of the community, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of treatment. It is our goal to contact each patient to confirm their appointments. We do this as a courtesy to the patient. **Our inability to contact you does not relieve you of your responsibility to keep scheduled appointments.** If it is necessary to cancel or reschedule your appointment, we require that you call by 10:00 AM two (2) working days in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

1. If you cancel or change your appointment by 10:00 AM two (2) working days in advance there is no charge.

2. Any appointment to see your provider that is not cancelled by 10:00 am (2) working days in advance will result in a $50 charge billed to your patient account. Any appointment for Urodynamics, Biofeedback or Ultrasound that is not cancelled by 10:00 AM two (2) working days in advance will result in a $100 charge billed to your account. **This fee is not covered by insurance carriers or Medicare and will be your responsibility to pay before your next visit.**

Our aim here is to open otherwise unused appointments for our patients, not to collect missed appointment fees. It is unfortunate that we must create this policy, but we want our patients to understand that late cancellations and no-shows are not taken lightly. Please be respectful of our staff and other patient's time. Patients should be aware of the costs associated with using a limited resource like healthcare and try to use medical resources judiciously. Patients who continue to not show up for appointments or cancel at the last minute are indicating that they are choosing not to respectfully utilize our services.

________________________________ ____________________________

Signature Date