The Women's Wellness Center of South Florida

Tara A. Solomon, M.D., FACOG

PATIENT DEMOGRAPHICS

COPIES OF DRIVER'S LICENSE AND INSURANCE CARD(S) ARE REQUIRED

PATIENT'S NAME: _____ DOB: _____
(As printed on insurance card - if applicable) *(MM/DD/YYYY)*

STREET ADDRESS: _____ APT./STE./UNIT: _____

CITY: _____ STATE: _____ ZIP: _____

MOBILE PHONE #: _____ MOBILE PHONE CARRIER: _____
(Required to receive appointment reminders)

HOME/SECONDARY PHONE #: _____

EMAIL ADDRESS: _____
(Required to receive test results and appointment reminders)

MARITAL STATUS: ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED

OCCUPATION: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

MEDICAL INSURANCE PROVIDER: _____ PHONE #: _____

GROUP ID: _____ POLICY/MEMBER ID: _____

POLICY HOLDER NAME: _____ DOB: _____
(If different from patient)

MEDICAL BILLING/CLAIMS ADDRESS: PO BOX_____
City State Zip Code

I CERTIFY THAT THIS INFORMATION IS TRUE, AND CORRECT, TO THE BEST OF MY KNOWLWDGE. I WILL NOTIFY THE OFFICE OF ANY AND ALL CHANGES TO THE ABOVE INFORMATION AND TO ANY CHANGES IN MY HEALTH OR MEDICAL CARE.

_____ _____
SIGNATURE (*Guardian signature if under 18)* DATE

The Women's Wellness Center of South Florida
Tara A. Solomon, M.D., FACOG

PATIENT CONTACT FORM

PATIENT'S NAME: _____

hereby authorize The Women's Wellness Center of South Florida to contact me regarding appointments, test results, and other personal, medical, or health-related information using the following methods:

☐ TELEPHONE CALL WITH OPTIONAL VOICEMAIL

☐ SMS (TEXT MESSAGE)

☐ EMAIL

OTHER CONTACT INFORMATION

The following people, other than a duly designated guardian or conservator, are authorized to discuss my medical condition or billing information with a healthcare professional in this practice:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

EMERENCY CONTACT NAME: _____ PHONE #: _____

EMERGENCY CONTACT'S RELATIONSHIP TO YOU: _____

_____ _____

SIGNATURE (*Guardian signature if under 18)* DATE

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NATURE OF INITIAL VISIT: _____

EXISTING MEDICAL CONDITIONS

- ☐ Medication Allergies *(Please specify):* _____
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Endometriosis
- ☐ Gastric Reflux
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Neurological Disorders
- ☐ Ulcers
- ☐ Family History *(Please specify)*: _____
- ☐ Other *(Please specify)*: _____
- ☐ Surgeries:. _____

_____ _____

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AUTHORIZATION & RELEASE

I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me during the period of such care, to third party payors and/or other health practitioners.

I authorize, and request my insurance company to pay directly to the doctor, or doctor's group, insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

IF I DO NOT PAY THE ENTIRE NEW BALANCE WITHIN 25 DAYS OF THE MONTHLY BILLING DATE, A LATE CHARGE OF I.5% ON THE BALANCETHEN UNPAID AND OWED MAY BE ASSESSED EACH MONTH.

I REALIZE THAT FAILURE TO KEEP THIS ACCOUNT CURRENT MAY RESULT IN BEING UNABLE TO RECEIVE ADDITIONAL SERVICES, EXCEPT FOR EMERGENCIES, OR WHERE THERE IS PREPAYMENT FOR ADDITIONAL SERVICES.

IN THE CASE OF DEFAULT ON PAYMENT OF THIS ACCOUNT, I AGREE TO PAY COLLECTION COSTS AND REASONABLE ATTORNEY FEES INCURRED IN ATTEMPTING TO COLLECT ON THE AMOUNT OF ANY FUTURE OUTSTANDING ACCOUNT BALANCES.

_____ _____

SIGNATURE (*Guardian signature if under 18)* DATE

The Women's Wellness Center of South Florida

Tara A. Solomon, M.D.

Office Policies Agreement and Consent for Services

Appointments

Appointments can be made by contacting the office directly at 954-984-8892 or texting 561-425-8890 during normal business hours or by scheduling after your exam at check out. It is our practice to schedule appointments in advance to provide you with consistency and the most convenient appointment times for your schedule. Please understand that early morning and late afternoon appointments are in high demand and you may have to be patient in receiving those time slots. We will gladly alert you to any cancellations should you be interested. However, it may be necessary for patients to leave work or school for professional appointments and if this is necessary, we will provide an excuse slip as documentation of the appointment.

Missed Appointment Policy

Your appointment time is reserved for you alone. We have a list of people waiting for earlier appointments. Please be courteous, and when at all possible, provide as much notice as you can. If you must cancel or reschedule an appointment, we ask that you provide notice of at least 24 hours. Should you have a late cancellation/reschedule, no show or late arrival for your appointment, this will be considered a missed appointment. We define a missed appointment in the following ways:

Same Day or Late Cancellation: Notice of less than 24 hours of your inability to attend a scheduled appointment.

No Show: Failure to provide any notice of your inability to attend the appointment *prior* to the appointment time.

Late Arrival: Arrival of 15 minutes or more late for your appointment without notice and your appointment needing to be rescheduled.

Missed appointments exclude serious emergencies or sudden illness. The death of a family member, natural disaster, accident, weather conditions, or severe illness of a family member living at the home, all qualify as emergencies. A business meeting, final exam, another appointment, minor illness, sleeping in, would not qualify as an excused appointment.

We use the following guideline in cases of missed appointments.

New Patient: If you do not show up for your first scheduled appointment with no notification, you will be placed at end of the current wait list and receive a $100 charge. We will not reschedule anyone missing more than one initial appointment.

First Missed Appointment: There will be no missed appointment charge assessed for the first incident – this only applies for existing patients.

Second and Third Missed Appointment: A missed appointment fee of $25 will be assessed for no show or late cancellations. This fee will be charged to your account and will need to be paid prior to your next visit.

After Three Missed Appointments: After having three missed appointments in a 12-month period, any additional missed appointments will result in either a discharge from services at our office or the option to pay our full out of pocket fee for the scheduled service for the subsequent missed appointment.

Note: This is a reminder that insurance companies will not pay for missed appointment fees, and you acknowledge that any fee incurred due to a missed appointment will be your responsibility.

_____ _____

signature *date*

_____

print name

HIPAA PRIVACY RULE PATIENT CONSENT AND ACKNOWLEDGEMENT

I consent to the use of disclosure of my protected health information by the facility, for the purpose of providing me with health care treatment, getting paid for those services, and conducting the health care operation portion of its business. I also acknowledge that I received and read the facility's Notice of Privacy Practices.

I understand the following:

- **"My protected health information" ("PHI") means my health related information either collected from me or received by the facility from any other source, and it includes information about my past, present and future physical or mental health.**
- **If I refuse to sign this Consent and Acknowledgment, the facility has the right to refuse me as a patient.**
- **I have the right to ask the facility, in writing, to limit the way in which it uses or discloses my protected health information but the facility does not have to agree to my request. However, if the facility does agree, thin it is bound by that agreement.**
- **I have the right to revoke the Consent portion of this document at any time by providing the facility with a written request specifically stating my desire to revoke my consent to the facility use of my PHI. The facility must accept this revocation but may then refuse to provide me with further health care treatment.**
- **If I revoke the consent portion of this document, it is effective except to the extent that the facility has already used or disclosed my protected health information in reliance on this Consent and Acknowledgment.**

Before I signed this Consent and Acknowledgment, I reviewed the facilities Notice of Priva Practices and understand the following with respect to the Notice:

- **The facility has the right to change the terms of the Notice at any time but if it does, it must post the new Notice in the waiting room and give me a copy if I request one.**
  The Notice describes in detail, the types of uses and disclosures of my protected health information that the facility may make in treating me, getting paid for that treatment of in carrying out its health care operations.
- **The Notice also describes my rights with respect to my protected health information and the facility's obligations to protect the confidentiality of that information.**

I have read and understand this information and have received a copy of this Consent and Acknowledgment. I am the patient or I am authorized to act on behalf of the patient for the reason described below.

_____ _____

SIGNATURE (*Guardian signature if under 18)* DATE

I, _____, have read the notice of the Health Insurance Portability and Accountability Act ("HIPAA") provided to me by The Women's Wellness Center of South Florida.

I understand that if I feel that my privacy rights have been violated, I may file a complaint with the Secretary of the Department of Health and Human Services.

All of my questions have been answered.

_____ _____

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The Women's Wellness Center of South Florida
Tara A. Solomon, M.D., FACOG

PREFERRED PHARMACY: _____ PHONE #: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CURRENT PRESCRIBED MEDICATIONS:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

CURRENT VITAMINS/SUPPLEMENTS:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

ONLY FILL THE FOLLOWING FORMS OUT IF THEY APPLY TO YOU

The Women's Wellness Center of South Florida
Tara A. Solomon, M.D., FACOG

CONSENT FOR HORMONE REPLACEMENT THERAPY

I have been informed of the risks of natural and/or synthetic hormone replacement therapy by Dr. Tara A. Solomon. These risks include, but are not limited to: stroke, heart attack, breast cancer, breast cancer recurrence, deep venous thrombosis, pulmonary embolus, endometrial cancer.

I understand and agree to stay up to date on my routine wellness screenings which are performed annually. I am required to provide my annual mammogram screening reports and pap smear results.

I understand and agree to have my blood tested for any hormone levels Dr. Tara Solomon may request.

I understand and agree that if I fail to stay up to date on my annual wellness screenings and/or have the requested blood tests completed within the specific timeframes, any prescriptions I have been prescribed by Dr. Tara Solomon will be discontinued.

_____ _____

signature *date*

_____

print name

_____

Tara A. Solomon, M.D.

The Women's Wellness Center of South Florida, LLC

Tara A. Solomon, MD
3850 Coconut Creek Pkwy, Ste 1
Coconut Creek, FL 33066
Ph. 954-984-8892 Fax 954-984-8810

RECORDS RELEASE

- ☐ PELVIC/BREAST EXAM OFFICE NOTES
- ☐ PAP SMEAR REPORT
- ☐ BIOPSY/COLPOSCOPY REPORTS
- ☐ BONE DENSITY REPORTS
- ☐ PROGRESS NOTES
- ☐ _____
- ☐ _____
- ☐ _____

TO: _____

ADDRESS: _____

PHONE: _____ FAX: _____

Please release the above records via email or fax for the following patient to:
Tara A. Solomon, MD
3850 Coconut Creek Pkwy, Ste 1, Coconut Creek, FL 33066
Ph. 954-984-8892 Fax 954-984-8810 Email: drtsolomon5@gmail.com

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

PHONE #: _____ SSN: _____

PATIENT SIGNATURE: _____ DATE: _____

WITNESS: _____