2024

PLEASE PRINT EMAIL: _____

PATIENT CHART # _____

PCP / OB DOCTOR _____ PCP / OB PH# _____ FAX# _____

NAME: _____ SEX: ☐F ☐M EMAIL: _____

SOCIAL SECURITY # _____ BIRTHDATE: _____ MARITAL STATUS: ☐M ☐S ☐W ☐D

RELIGION _____ AGE _____ HOME # _____ CELL # _____ WORK # _____

STREET ADDRESS: _____ APT # _____

CITY _____ STATE _____ ZIP _____

DRIVER LICENSE # _____ DRIVER'S LICENSE STATE _____

EMPLOYER / SCHOOL _____ TITLE _____ PHONE # _____

STREET ADDRESS: _____ CITY _____ STATE _____ ZIP _____

SPOUSE NAME: _____AGE _____ DOB _____

SPOUSE EMPLOYER _____ TITLE _____ PHONE # _____

STREET ADDRESS: _____ CITY _____ STATE _____ ZIP _____

TRANSLATOR NEEDED ☐YES ☐NO PRIMARY LANGUAGE SPOKEN _____ REFERRED BY: _____

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY OTHER THAN SOMEONE LIVING WITH YOU

NAME _____ PHONE _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

IF PATIENT IS A MINOR OR IF INSURANCE IS UNDER PARENTS OR GUARDIAN PLEASE COMPLETE FOLLOWING

FATHER'S NAME: _____

EMPLOYED BY: _____

POSITION: _____

PHONE: _____

MOTHER'S NAME: _____

EMPLOYED BY: _____

POSITION: _____

PHONE: _____

PRIMARY INSURANCE	**SECONDARY INSURANCE**
INSURANCE CO. NAME_____	INSURANCE CO. NAME _____
ADDRESS _____	ADDRESS _____
CITY _____ STATE _____ ZIP _____	CITY _____ STATE _____ ZIP _____
I.D.# _____	I.D.# _____
GROUP NAME OR # _____	GROUP NAME OR # _____
INSURED'S FULL NAME _____	INSURED'S FULL NAME _____
IS THIS AN EMPLOYER PLAN: _____	IS THIS AN EMPLOYER PLAN: _____
INSURED'S SOCIAL SEC # _____	INSURED'S SOCIAL SEC # _____
INSURED'S D.O.B. _____	INSURED'S D.O.B. _____
RELATIONSHIP TO INSURED _____ (Self –Husband – Wife – Child – Other)	RELATIONSHIP TO INSURED_____ (Self –Husband – Wife – Child – Other)

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

I,_____AUTHORIZE **S.E.PERINATAL ASSOCIATES** TO RELEASE OR DISCUSS INFORMATION RELATED TO MY MEDICAL CONDITION (INCLUDING INFORMATION RELATED TO MY TREATMENT PLAN, MEDICATION INFORMATION AND/OR BILLING INFORMATION) TO THE FOLLOWING NAMED PERSONS:

1. _____ Relation: _____ Phone #: _____
2. _____ Relation: _____ Phone #: _____
3. _____ Relation: _____ Phone #: _____

- *****PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED ABOVE ON THIS LIST WILL NOT BE GIVEN ANY INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LIST AT ANY TIME.**
- ***** YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT WISH TO**

PHARMACY INFORMATION

NAME: _____ PHONE #: _____ City: _____

Guarantor of payment

I fully understand that I am responsible for payment to the physicians in the office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney fees and cost in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

Authorization to release information

I hereby authorize the physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claims.

Assignment of insurance benefits

If insurance claims are filed by his office on my behalf, I hereby authorize direct payment of any benefits to the physicians in this office for medical or surgical treatment received by me. In this circumstance, I understand that I am fully responsible for any charges not covered by insurance. I permit copy of the authorization to be used in place of the original.

Signature _____ Date of birth: _____ Date: _____

Advanced Directive

Do you have an advance directive/living will? _____ if yes, please provide us with a copy for our records. If no, please let us know if you require information.

I hereby authorize the use of and/or disclosures of any telephone number, provided by me or on my behalf, that is assigned to a residential line, cellular telephone services, paging services, fax machine, computer, or any other services or devices for which the called party is charged for the call for purpose of billing and collection payment for medical services rendered to me. This consent applies to any call made using an automatic telephone dialing system of an artificial or prerecorded voice.

IMPORTANT INFORMATION REGARDING ULTRASOUND EXAMINATION

What is an ultrasound?

Ultrasound uses the same principle as sonar. Sound waves from the ultrasound probe (far beyond the range of human hearing) bounce off of the uterus, placenta and baby, making echoes which a computer converts into detailed images. In essence, an ultrasound exam is a series of pictures of the baby and organs in the mother's pelvis.

Are ultrasounds safe?

There has been extensive evaluation of the safety of diagnostic ultrasound. There is no documented evidence that diagnostic ultrasound causes harm to either the mother or the baby when ordinary power and frequency is used. Ultrasound exams done in our facility are done using the lowest power level that can reasonably achieve a meaningful image.

Does a normal ultrasound prove that my baby will have no abnormalities?

Ultrasound examination can detect many abnormalities, but some abnormalities are not detectable by ultrasound. The exam gives information about the size and shape of the baby and the baby's organs but does not give complete information about the function of the baby's organs or tell us that the baby is completely "healthy". Abnormalities of brain function such as mental retardation cannot be detected by ultrasound. Additionally, there are many conditions that evolve over time, appearing normal at the time of the ultrasound exam but become apparent later in the pregnancy.

You should realize that even with a complete ultrasound exam, we may be unable to find existing fetal abnormalities or those abnormalities that can appear later in the pregnancy or after birth. Thus, although ultrasound examination is a very helpful diagnostic tool, it should not be considered absolute proof that the baby is normal.

Can an ultrasound determine if there are chromosomal abnormalities?

Findings on ultrasound exam can be an indicator of potential chromosomal abnormalities but are not definitive. Currently, the only way to assess the baby's chromosomes with certainty is to actually obtain a sample of the baby's cells by amniocentesis, chorionic villus sampling or fetal blood sampling. Some pregnancies are at increased risk for fetal chromosome abnormalities, either because of the mother's age, because of results of blood screening test, or because of findings on the ultrasound exam. It is important to realize that an ultrasound exam cannot tell for certain whether the baby's chromosome count is normal or abnormal. A normal ultrasound examination does not guarantee that the chromosomes are normal.

If you have any questions concerning ultrasound, please do not hesitate to ask the ultrasound technologist, perinatologist or your doctor. You are requested to sign this document before your ultrasound examination to acknowledge that you have read and understood the information on this form and have had the opportunity to ask questions.

_____ _____

Patient/Guardian Signature Date

_____ _____

Printed Name Date of Birth

Envision HEALTHCARE

PATIENT AGREEMENT FOR CANCELLATIONS AND NO SHOW

Thank you for choosing our practice to assist you with your care. We appreciate your trust and are committed to providing you with high-quality, compassionate care.

We value our patients and tailor their treatment plans accordingly to their unique needs; in doing so, we allocate time for each appointment accordingly. We realize that circumstances beyond your control may not allow you to provide the 24-hour notification. Failure of a patient to notify the office to cancel or change their appointment without 24-hour notice is considered a "No-Show." To help remind patients of their appointment, we have implemented an automated reminder system. Please ensure we always have your correct and most up-to-date phone numbers or email addresses throughout the course of your treatment to allow us to better serve you.

The "no-show" appointments will be documented in the patient's record.

Charges for "no-show" appointments are as follows:

- **Office visit $50.00**
- **Procedure or surgical center visit $100.00.**

This letter will serve as a notice about the office no-show policy and fees.

I acknowledge that I have read and understand the policy:

_____

Print Name

_____ _____

Signature **Date**

Jaime Rodriguez, M.D., F.A.C.O.G
Cesar Rosa, M.D., F.A.C.O.G
Adolfo Gonzalez Garcia, M.D., F.A.C.O.G
Jerry Gilles, M.D., F.A.C.O.G
Marcella Rodriguez, D.O.
Jamie Lenis, APRN

Southeast Perinatal Associates

Committed to turning high-risk pregnancies into low-risk deliveries.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices for the company and its subsidiaries and affiliates. I understand that copies of the Notice of Privacy Practice are available on the company's website and paper copies are out and available in the office and that I can take one of these copies with me. The Notice of Privacy Practices is required to be provided to me under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, including as it has been amended by the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), Title XIII of Division A and Title IV of Division B or the American Recovery and Reinvestment Act of 2009 and any implementing regulations.

Effective Date of Notice: September 23, 2013

Patient: _____ Date: _____
(Print name)

Patient Signature: _____

Or

Patient's Representative: _____ Date: _____

Relationship to Patient: _____

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Jamie Lenis, APRN

OFFICE PHILOSOPHY

As a Perinatal Specialist, we feel it is extremely important to spend as much time as necessary with each patient to fully address you and your baby's medical problems. This enables me to explain my suggestions and recommendations in depth and answer any questions you may have during your visit. My staff schedules patients accordingly and we do try to be as efficient as possible in order to expedite your entrance and departure from this office. Please be reassured that this office and staff does value your time, however, it is not uncommon to have a prolonged waiting period. On many occasions I am delayed for such matters as patients' medical problems, which require immediate attention, hospital calls, physician calls, etc…, and/or emergencies. These issues are unforeseen and are handled appropriately. I do not leave this office until all of the patients are seen and all medical problems are addressed, regardless of whatever time is necessary.

After the patient is seen, a full report is sent to the referring physician in a timely fashion. I have well-trained staff members available to assist you with any difficulties that may arise before, during or after your visit.

We encourage your comments and suggestions.

Thank You,
Jaime Rodriguez, M.D., F.A.C.O.G
Cesar Rosa, M.D., F.A.C.O.G
Adolfo Gonzalez Garcia, M.D., F.A.C.O.G
Jerry Gilles M.D., F.A.C.O.G
Marcela Rodriguez, DO
Jamie Lenis, APRN

I acknowledge and understand the above-stated Office Philosophy

Name: _____

Date: _____

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Marcella Rodriguez, D.O.
Jamie Lenis, APRN

Name of patient: _____

Date of Birth: _____

CONSENT FOR PELVIC EXAMINATION / TRANSVAGINAL SONOGRAM

Your perinatologist has recommended an endovaginal sonogram to evaluate better your cervix, fetus, uterus, and/or ovaries. For the procedure, a sonogram instrument is inserted in the vagina by one of our sonographers or physicians.

The examination is safe for your baby and will not lead to labor, contractions, or vaginal bleeding. The results of the examination will help us guide your medical care.

With your signature, you consent to the above examination and indicate that all your questions about the examination have been answered.

☐ I DO CONSENT to endovaginal sonogram: _____
Patient Signature / Date

☐ I DO **NOT** CONSENT to endovaginal sonogram: _____
Patient Signature / Date

_____
Witness Signature / Date

PINES - 601 N FLAMINGO RD., Suite 211 Pembroke Pines, FL 33028 T: (954) 389-2700 F: (954) 349-7772
PLANTATION - 220 SW 84th Ave., Suite 104 Plantation, FL 33324 T: (954) 476-6229 F: (954) 476-4679
MIRAMAR - 1951 S.W 172nd Ave., Suite 411 Miramar, FL 33029 T: (954) 431-7372 F: (954) 431-8485

Patient Name:
Patient ID# Date of Birth:

List of Current Medications:

List all prescription, over-the counter, herbal, vitamins, and diet supplement products.

Medications:	Dose:	How often do you take the Medication:	Route of Administration (oral, topical, infection):	Stopped:	Date Stopped:
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	
				☐ YES	

Southeast Perinatal Associates
Maternal - Fetal Medicine
Health Information Form

Name:_____ DOB:_____ Age:_____ Today's Date:_____

Referred by:_____ Reason for Visit:_____

First day of last menstrual period:_____ Estimated due date:_____

Pregnancy History including MISCARRIAGES, STILLBIRTHS, ECTOPICS & TERMINATIONS)

Year	Weeks pregnant at delivery	Birth Weight	Boy / Girl	Vaginal Delivery	Cesarean Section	Reason for C-Section	ALLERGIES TO MEDICATIONS / Complications

Family and genetic history: **Ethnic background (for example, Irish, Italian, African American, etc.):**

Describe your ethnic background: Baby's father's ethnic background:

Check all that apply to you:

❑ You will be 35 or older when the baby is born ❑ Exposed to medication during pregnancy

❑ Baby's father will be 50 or older ❑ Exposure to X-Ray during pregnancy

Do you, the baby's father or any other family member have any of the following:

Intellectual Disability	Yes	No	Mediterranean anemia	Yes	No	Autism	Yes	No
Down syndrome	Yes	No	Sickle cell disease	Yes	No	Neural tube defect	Yes	No
Fragile X	Yes	No	Cystic fibrosis	Yes	No	Heart defect	Yes	No
Tay sachs	Yes	No	Muscular dystrophy	Yes	No	Birth defect	Yes	No
						Other:		

Gynecological History - Have you had any of the following?

Infertility	Yes	No	Previous cervical surgery	Yes	No	Abnormal pap smear	Yes	No
Conceived by IVF or assisted reproduction?	Yes	No	Incompetent cervix	Yes	No	History of any sexually transmitted disease	Yes	No
Donor Egg/Sperm	Yes	No	Fibroids	Yes	No			
			Abnormal uterus	Yes	No			

Medical History - Have you had any of the following:

High blood pressure	Yes	No	Seizures/epilepsy	Yes	No	Anemia/blood transfusions	Yes	No
Diabetes	Yes	No	Hepatitis	Yes	No	Kidney infections	Yes	No
Asthma	Yes	No	Ulcers	Yes	No	Arthritis / joint pain	Yes	No
Heart trouble / murmur	Yes	No	Thyroid disease	Yes	No	HIV	Yes	No
Rheumatic fever	Yes	No	Cancer	Yes	No	Lupus	Yes	No
Depression	Yes	No	Migraines	Yes	No	Other:		

List of current medication(s): including prenatals -

Surgical History:

Social History:

Smoking	Yes	No	Number smoked per day:
Alcohol	Yes	No	Number consumed per day:
Drug use	Yes	No	Type of drug(s):
Seat belt use	Yes	No	
Regular exercise	Yes	No	

Please check if any of the following apply to you now or in the past: ❑ **None of the below problems apply**

❑ Severe fatigue	❑ Mouth sores	❑ Abnormal thirst	❑ Numbness
❑ Double vision	❑ Dental problems	❑ Bloody stool	❑ Depression
❑ Spots before eyes	❑ Chest pain	❑ Constipation	❑ Anxiety
❑ Vision changes	❑ Swelling of legs	❑ Diarrhea	❑ Blood in urine
❑ Ear aches	❑ Palpitations	❑ Nausea / vomiting	❑ Urgency
❑ Ringing in ears	❑ Wheezing	❑ Dizziness	❑ Sinus problems
❑ Shortness of breath	❑ Seizures		

Completed by: ❑ **Patient** ❑ **Office Staff** ❑ **Physician**

Signature of patient:_____

Physician signature:_____ **Date reviewed with patient:**_____

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PATIENT PORTAL ANNOUNCEMENT

Access Your Own Personal Patient Portal Online

We are pleased to offer our new secured web-based Patient Portal through eClinicalWorks, are electronic records management system. The "Sheridan" Patient Portal feature uses Leading Edge technology to promote health care and allow convenient access to your medical information from the comfort and privacy of your home or office.

Participating patients are given secure user IDs and passwords, enabling them to access the portal to view certain portions of the electronic health record such as personal documents, visit summary and personal health record which may include allergies, problem list, medications, procedures, Vital Signs, immunizations, laboratory results, social and family history as well as other health information. You will be able to contact our office through the patient portal's email system.

HEALOW APP

A recent enhancement to this capability is the ability to access your health records remotely using your mobile device through the Healow mobile app. The Healow app is a secure app that helps you to manage your health information when you are on the go. This health and wellness online platform is available through the App Store and Google Play using this link https://www.healow.com/ you can access information as well as download to your device

You will receive an email invitation from Sheridan Healthcare to sign up for patient portal access, please follow the instructions to register. You will then receive an email confirmation of activation which will include your automatically generated sign-on information. Direct any questions regarding the patient portal to SEPA@envisionhealth.com. This e-mail will be monitored Monday through Friday; please allow 24 to 48 hours for a response.

We are very excited about offering you this addition to your patient care. We believe the patient portal will provide you with easier and more efficient access to your medical records while providing you with a more enjoyable healthcare experience.

Note: The patient portal is not intended for use in emergencies. If you require Immediate Medical Care, call 911.