Lisa R Hearing MD PA

“No Show” & “Late Cancellation” Policy

Description

"No Show " shall mean any patient who fails to arrive for a scheduled appointment.

"Same Day Cancellation,” or “Late Cancellation,” shall mean any patient who cancels an appointment less than 24 hrs before their scheduled appointment.

Policy

Lisa R Hearing MD PA’s goal is to provide excellent care to each patient in a timely manner.

If it is necessary to cancel an appointment, patients are required to notify the office at least 24 hours before their appointment time.

Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

Procedure

I. A patient is notified of the appointment "No Show" & “Late Cancellation” Policy at the time of scheduling. This policy can and will be provided in writing to patients at their request.

II. Established / New Patients: Appointments must be canceled at least 24 hours prior to the scheduled appointment time

III. In the event of "No-Show” & “Late Cancellation” less than 24 hours prior to the scheduled appointment time, **a $55 fee will be charged to patient.**

Patient Legal Representative Signature Print Name and Date

CONSENT FOR PELVIC EXAMINATION

A Pelvic Examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs. This procedure is used to diagnose and/or treat conditions that involve the pelvis. It may be performed using any combination of modalities, which may include the health care provider's gloved hand or instrumentation. For purposes of this consent, vaginal sonography is included.

By signing this consent, I _____ authorize and direct
[Print Patient's Name]

_____Lisa R. Hearing MD_____

And any treating health care provider, the employed and/or contracted medical personnel of _____Lisa R. Hearing MD_____ as deemed necessary by my treating physician and the medical students and/or students receiving training as a health care provider who may be involved in my care to perform a pelvic examination may be needed while receiving medical care from _____Lisa R. Hearing MD_____ in the future, and I hereby agree and acknowledge that this written consent applies to any and all pelvic examinations conducted today, or in the future, by a health care provider, medical student, or student receiving training as a health care provider employed by and/or contracted with _____Lisa R. Hearing MD_____.

Unless I revoke this consent in writing by hand delivering a copy of the revocation to _____Lisa R. Hearing MD, PA_____. By my signature below I acknowledge that I have read or have read to me and understand the contents of this form.

_____

Patient/Legal Representative Signature Printed Name and Date

_____

Witness Signature Printed Name and Date

_____

Provider Signature Printed Name and Date

Lisa R Hearing, MD, PA
Obstetrics Gynecology

CONFIDENTIAL COMMUNICATIONS

By signing below you give our practice permission to communicate test results by leaving a message on your voice mail, answering machine, cell phone, home phone.

SIGNATURE DATE WITNESS

Lisa R Hearing, MD, FACOG
3893 Military Trail, Suite 1
Jupiter, FL 33458

"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 MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

_____ _____

Patient/Responsible Party Date

Lisa R. Hearing M.D., P.A.

Obstetrics and Gynecology

Information Sheet

LAST NAME _____ FIRST _____ MIDDLE _____ PREFER TO BE CALLED _____

SOCIAL SECURITY # _____ BRITHDATE _____ DRIVERS LICENSE # _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE NUMBER _____ WORK PHONE NUMBER _____ CELL PHONE NUMBER _____ MARITAL STATUS _____

EMAIL ADDRESS _____ RACE / ETHNICITY _____

REFERRING PHYSICIAN _____ REFERRED BY _____ PRIMARY LANGUAGE _____

SPOUSE OR EMERGENCY CONTACT NAME _____ RELATION _____ PHONE NUMBER _____

PHARMACY NAME _____ PHARMACY PHONE NUMBER _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ EMPLOYER PHONE NUMBER _____

INSURANCE _____ PT RELATION TO INSURED _____

POLICY HOLDER NAME _____ ID NUMBER / GROUP _____

HOLDER'S DATE OF BIRTH _____ PLAN TYPE (PPO, POS, HMO) _____

GUARANTOR (RESPONSIBLE FOR BILL): SELF / SPOUSE/ PARENT GUARANTOR ADDRESS _____

GUARANTOR NAME _____ CELL NUMBER _____

GUARANTOR DATE OF BIRTH _____ GUARANTOR EMPLOYER _____

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION: I hereby assign all medical and/or surgical benefits including Medicare, Medicaid, Private Insurance and other health plans to Lisa R. Hearing, M.D., P.A.

I also hereby authorize assignee to release all information, including HIV test results to secure payment. I understand that I am financially responsible for all charges whether or not paid by insurance and will be held responsible for all collection costs and associated legal fees should it become necessary to secure payment for services rendered. I am aware that finance charges will accrue on balances older than 30 days once they have been transferred to the patient's responsibility.

I acknowledge that there will be a $35 fee for any check returned for insufficient funds, closed account, etc.

A photocopy of this assignment is considered as valid as an original and this assignment and release will remain in effect until revoked by me in writing and delivered to Lisa R. Hearing, M.D., P.A.

SIGNATURE OF PATIENT _____ DATE _____ SIGNATURE OF GUARANTOR _____ DATE _____

Lisa R. Hearing M.D., P.A.
Obstetrics and Gynecology
Medical History

LAST NAME FIRST MIDDLE AGE BIRTHDATE

DRUG ALLERGIES: _____

MEDICATIONS LIST: SURGERIES LIST:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

CHECK IF YOU HAVE A PERSONAL HISTORY OF:

- ☐ ABNORMAL MAMMOGRAM
- ☐ ABUSE - SEXUAL/PHYSICAL
- ☐ ACNE
- ☐ ALCOHOLISM
- ☐ ALLERGIES
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ANEMIA
- ☐ DVT or PULMONARY EMBOLISM
- ☐ BLOOD TRANSFUSIONS
- ☐ BREAST DISEASE
- ☐ CANCER _____
- ☐ HIGH CHOLESTEROL
- ☐ COLITIS
- ☐ DEPRESSION
- ☐ DIABETES/LOW BLOOD SUGAR
- ☐ DIVERTICULOSIS
- ☐ DRUG DEPENDENCY
- ☐ EMOTIONAL PROBLEMS
- ☐ EPILEPSY/SEIZURES
- ☐ EYE PROBLEMS
- ☐ GLAUCOMA
- ☐ GALLBLADDER PROBLEMS
- ☐ HEADACHES
- ☐ HEART PROBLEMS
- ☐ GENETIC DISORDER
- ☐ HEPATITIS
- ☐ HERNIA
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV TESTING
- ☐ INTESTINAL PROBLEMS
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ MITRAL VALVE PROLAPSE
- ☐ NEUROLOGIC PROBLEMS
- ☐ OSTEOPOROSIS
- ☐ LUNG DISEASE
- ☐ RHEUMATIC/SCARLET FEVER
- ☐ AUTISM
- ☐ STROKE
- ☐ SICKLE CELL ANEMIA
- ☐ ADHD or ADD
- ☐ THYROID DISEASE
- ☐ TUBERCULOSIS
- ☐ ULCERS
- ☐ DISABILITY
- ☐ URINARY INCONTINENCE
- ☐ ANXIETY DISORDER
- ☐ OTHER:

OBSTETRICAL HSTORY:

TOTAL PREG	FULL TERM	PREMATURE	MISCARRIAGE	ABORTION	ECTOPICS	MULTIPLE BIRTHS	LIVING

PAST PREGNANCIES:

DATE	SEX	WEIGHT	VAGINAL OR C/S	COMPLICATIONS

GYNECOLOGIC HISTORY:

ANY INFECTIONS: HERPES CHLAMYDIA GONORRHEA SYPHILIS HPV / WARTS OTHER:

ANY ABNORMAL PAPS? _____ TREATMENT: _____ DATE OF LAST PAP: _____

DATE LAST MAMMOGRAM: _____ BONE DENSITY: _____ COLONOSCOPY: _____

PERIODS BEGAN AGE: _____ MENOPAUSE: _____ HORMONE THERAPY: _____

SEXUALLY ACTIVE: YES / NO TYPE OF CONTRACEPTION USED, IF ANY: _____

MENSES OCCUR EVERY _____ DAYS, LAST ABOUT _____ DAYS, WITH HEAVY / MODERATE / LIGHT FLOW

LIST ANY GYNECOLOGIC / MENSTRUAL / SEXUAL PROBLEMS: _____

LIST MEDICAL ILLNESSES IN FAMILY MEMBERS:

PARENTS: GRANDPARENTS:

SIBLINGS: CHILDREN:

PATIENT SOCIAL HISTORY:

YOUR HIGHEST LEVEL OF EDUCATION: _____

YOUR OCCUPATION: _____ RETIRED

SINGLE / MARRIED / DIVORCED / WIDOWED / IN A RELATIONSHIP

CIGARETTE SMOKER: FORMER / CURRENT / NEVER

ALCOHOL USE: YES / NO DAILY / WEEKLY / OCCASIONALLY

DRUG USE: FORMER / CURRENT / NEVER

YOUR PRIMARY PHYSICIAN'S NAME: _____