Beth L. Freedland, DO

Board Certified Obstetrician / Gynecologists

Patient Name: _____
Last First Middle

Date of Birth: _____/_____/_____ Social Security #: _____ Marital Status: S M W D

Home Address: _____

_____

Home Phone: _____ Cell Phone: _____

Email (to be used for patient portal):_____

Spouse Name: _____ Spouse Contact Number: _____

Employer: _____ Employer Phone:_____

Emergency Contact: _____Relationship: _____

Emergency Contact Phone: _____

Primary Care Physician: _____ Phone: _____

I was referred to Dr. Freedland by: _____

Insurance Company: _____ Phone Number: _____

Member ID: _____ Group Number: _____

Subscriber: _____ Subscriber Date of Birth: _____/_____/_____

Pharmacy Name: _____ Phone: _____

Address: _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Beth Freedland, D.O.

I understand that I am financially responsible to all charges whether or not paid by said insurance. I will be responsible for expenses associated with all collection, including reasonable attorney fees and court costs. Co-payments are due at the time of the visit. Self pay patients are responsible for payments at the time of their visit.

I authorize Beth Freedland, D.O. to release all information necessary to secure payment.

Patient Signature: _____ Date: _____

7301 A West Palmetto Park Road, Suite 200C, Boca Raton, FL 33433
Dr. Freedland: Phone **(561) 961-5456** Fax: **(561) 672-7953** Web: **drbethfreedland.com**

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Medical History

Name: _____ Date of Birth: _____/_____/_____ Date: _____/_____/20_____

Medical & Family History:

	Current	Past	Family		Current	Past	Family
Seizures/Epilepsy	_____	_____	_____	High Cholesterol	_____	_____	_____
Stroke	_____	_____	_____	Thyroid problems	_____	_____	_____
Stomach/Duodenal	_____	_____	_____	Blood Clots	_____	_____	_____
Migraine Headaches	_____	_____	_____	Phlebitis	_____	_____	_____
Heart Disease/Murmurs	_____	_____	_____	Bleeding Disorders	_____	_____	_____
Asthma/Lung Disease	_____	_____	_____	Specify Type	_____	_____	_____
High Blood Pressure	_____	_____	_____	Sickle Cell	_____	_____	_____
Diabetes	_____	_____	_____	Cancer	_____	_____	_____
Liver problems	_____	_____	_____	Specify Type	_____	_____	_____
Osteoporosis	_____	_____	_____	Anemia	_____	_____	_____

Other Medical Problems: _____

_____

Medication Allergies: _____

_____

Current medications:

	Medication	Dose	Frequency		Medication	Dose	Frequency
1	_____	_____	_____	5	_____	_____	_____
2	_____	_____	_____	6	_____	_____	_____
3	_____	_____	_____	7	_____	_____	_____
4	_____	_____	_____	8	_____	_____	_____

Surgical History

	Date	Procedure	Complication (if any)
1			
2			
3			
4			

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PAYMENT POLICY

Please read and sign this form as it concerns you, the patient.

YOU ARE RESPONSIBLE FOR YOUR INSURANCE POLICY

Due to many changes in Insurance policies, we cannot be responsible for interpreting each individual policy. It is the patient's responsibility to know your individual coverage and its limitations, as well as who is in an In-Network Provider for your plan.

We urge you to check with your insurance company regarding your benefits. Failure to comply could result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is a contract between you and your insurance company. It is your responsibility to know or find out, whether or not our provider is In-Network for your specific insurance plan.

Referrals

If you need a referral from your insurance company or your Primary Care Provider (PCP) to be seen in this office, the referral must be present and handed to the front office staff at the time of your visit. If it is not available, your appointment will be rescheduled and it will be your responsibility to obtain one. We encourage you to call your PCP and have your referral faxed to us prior to your appointment.

Non-Participating/Out of Network Provider Policy

If we are not a participating provider with your insurance company/plan, we will collect our fee in full at the time of service.

If the physician is considered out-of-network provider with your insurance company/plan, we will collect all out-of-network co-payments and fees at the time of service.

Your Financial Responsibility

You are responsible for paying any co-payments, co-insurance, deductibles, etc. Because we are considered specialists, some diagnostic and invasive procedures are not considered part of your standard office visit co-payment and may be applied toward your deductible and/or co-insurance.

Please call your insurance company and take the time to learn about your specific plan and what services it covers.

Patient Name: _____
Please Print

Patient Signature: _____ Date: _____

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NO SHOW/MISSED APPOINTMENT POLICY

When our office books your appointment, we are setting aside a dedicated time slot for you. We only ask that if you must reschedule your appointment that you please provide us with at least 24 hours' notice. This policy enables us to better utilize our appointment slots for those in need of our medical care.

Effective January 1, 2019 there will be charge of $25.00 for not showing up at any/all scheduled appointments.

If this fee is charged to your account, no future appointments will be scheduled until it is paid.

Printed Name: _____

Signature: _____

Date: _____

MALPRACTICE ACKNOWLEDGEMENT

Due to the current medical malpractice crisis, Dr. Freedland does not carry medical malpractice insurance.

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 has decided not to carry medical malpractice insurance. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

F.S. 458.320(5)(G)(1)

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PROTECTED HEALTH INFORMATION
PATIENT CONSENT

Patient Name: _____ Date of Birth: _____

Patient Address: _____

_____

PATIENT CONTACT

All calls regarding your care, test results and appointments will be made to your cell phone number. If you would like us to contact you at an alternative phone number, please indicate that number below.

Alternative Contact Number: _____

_____ I hereby authorize this practice to contact me by telephone and if I am not present, they may leave a message on my answering machine or with the persons listed below.

OR

_____ I prefer that you ***DO NOT*** leave messages on my answering machine.

I, _____, authorize Beth Freedland, D.O. to release my Protected Health Information (PHI) to the people I have listed below if I am not available. (Please include restrictions, if any, of your PHI to each individual).

Individual/Relationship to Patient	Restrictions (If Applicable)
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature: _____

Date: _____

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name: _____ Date: _____
Please Print

Patient Signature: _____

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CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

I hereby consent to a medically indicated physical examination. This may include, but is not limited to, a female gynecological exam which may include a rectal exam and a pelvic exam and an ultrasound exam which may include a probe placed in the vagina. This will be performed by Beth Freedland, D.O. and any of their licensed ultrasound technicians. This consent will remain active until I withdraw my consent in writing.

Patient Name: _____ Date: _____
Please Print

Patient Signature: _____

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CONSENT FOR VOICE AND TEXT MESSAGING COMMUNICATION

I understand that in order for the office of Beth Freedland, D.O. to leave detailed messages containing specific medical information on my voicemail, answering machine, I need to give my permission to Beth Freedland, D.O.

I further understand that in order for Beth Freedland, D.O. to text detailed messages containing specific medical information to my cell phone, I need to give my written express permission to Beth Freedland, D.O. I also understand that my healthcare information at Beth Freedland, D.O. is protected and a copy of the Notice of Privacy Practices is available upon my request.

In order to receive text messages from Beth Freedland, D.O. I must enable my cell phone to receive text messages from phone numbers that are not in my contacts. The text messages will most likely come from a phone number you are not familiar with.

If I decide to opt out from receiving text message notifications from Beth Freedland, D.O., understand that I must allow two weeks to ensure that my results have arrived. After two weeks, I will have to call the office for results. If I do decide to opt out, it is my responsibility to call the office for results.

Consent for Messages

I give my written express consent to Beth Freedland, D.O. to leave detailed messages on my voicemail/answering machine and/or to text message me about my NORMAL lab results, diagnostic and/or imaging results, prescription information, or appointment reminders. No abnormal results will be communicated via our automated system.

Patient Name: _____ Date: _____
(Please Print)

Patient Signature: _____ Cell #: _____
(# to be used for text message notifications)

It is my responsibility to keep this information up to date, as I recognize that my information may change over time. This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that I must provide written notice in order to revoke this consent.

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EMAIL CONSENT & ACKNOWLEDGMENT FORM

1. Risk of using email to communicate with your provider:

Beth Freedland, D.O. (to be referred to as provider for the remainder of this form) offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before using email communication. These include, but are not limited to, the following risks:

a) Emails can be circulated, forwarded, and stored in numerous paper and electronic files
b) Emails can be immediately broadcast worldwide and be received by unintended recipients
c) Email senders can easily type in the wrong email address
d) Email is easier to falsify handwritten or signed documents
e) Back up copies of email may exist even after the sender or recipient has deleted his or her copy
f) Employers and on-line services have a right to archive and inspect emails transmitted through their system
g) Email can be intercepted, altered, forwarded, or used without authorization or detection
h) Email can be used to introduce viruses into the computer system
i) Email can be used as evidence in court

2. Conditions for the use of email:

Beth Freedland, D.O. will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the provider cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not caused by provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of email includes agreement with the following conditions:

a) All emails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those emails.
b) Provider may forward emails internally to provider staff and agents necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c) The patient is responsible for protecting his/her password or other means of access to email. Provider is not liable for breaches of confidentiality caused by the patient or a third party.
d) Provider shall not engage in email communication that is unlawful, such as unlawfully practicing medicine across state lines.
e) It is the patient's responsibility to follow-up and/or schedule an appointment.

3. Patient responsibility and instructions: to communicate by email, the patient shall:

a) Limit or avoid using his/her employer's computer.
b) Inform provider of changes in his/her email address.
c) Confirm that he/she has received and read the email from the provider.
d) Put the patient's name in the body of the email.
e) Include the category of the communication in the emails subject line for, for routing purposes (e.g. billing and questions).
f) Take precautions to preserve the confidentiality of email, such as using screen savers and safeguarding his/her computer password.

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g) Withdraw consent only by email or written communication to provider.

4. Termination of the email relationship

The provider shall have the right to immediately terminate the email relationship with you if determined in the sole provider discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the provider determine to be unacceptable.

5. Patient acknowledgement and agreement

I have discussed with the provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my provider may impose to communicate with patients by email. Any questions I have had were answered.

6. Hold Harmless

I agree to indemnify and hold harmless the provider and its trustees, officers, directors, employees, agents, information provider and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the provider, and any breach by me of these restrictions and conditions.

Patient Name: _____ Date: _____
Please Print

Patient Signature: _____

Patient Email: _____

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FEMALE HEALTH ASSESSMENT

Patient Name: _____ Date of Birth: _____ Date: _____

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very severe (4)
Hot flashes	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)	☐	☐	☐	☐	☐
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire, sexual activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory	☐	☐	☐	☐	☐
Problems with thinking, concentrating or reasoning	☐	☐	☐	☐	☐
Difficulty learning new things	☐	☐	☐	☐	☐
Trouble thinking of the right word to describe persons, places or things when speaking	☐	☐	☐	☐	☐
Increase in frequency or intensity of headaches or migraines	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
Weight gain or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
Dry or wrinkled skin	☐	☐	☐	☐	☐
Total score	_____				

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