Center for Pediatric Adolescent Gynecology

Lawrence Amesse, MD, PA

INSURANCE INFORMATION/PATIENT AGREEMENT

Patient Name: ____Date of Birth: _____________
Last name, First Name

Address: ____
Street, City, State, Zip

Email: ______________________________________ Cell Phone: _______________________

Home Phone: __________________________ Work Phone: ____________________________

Other Guarantor: ____
(Mother/Father/Guardian) Last Name, First Name

Address: ____

Cell Phone: ______________________________Home Phone: ___________________________

Insurance Company: __________________ID#: _________________ Group#: _____________

Insurance Phone: __________________________ Driver's License #: ______________________

I authorize Dr. Amesse and staff to provide medical treatment to me. I also authorize any physician, hospital, or medical facilities to provide information on my medical history. I understand that the practice of medicine is not an exact science and expected or desirable outcomes cannot be guaranteed. Treatments have risks and they may result in complications with short term and /or long-term consequences.

Signature: ____ Date: _____________________
Patient

Signature: ____ Date: _____________________
Other Guarantor

In order for Dr. Lawrence S. Amesse to provide medical treatment, it will be necessary for him to be reimbursed for his services.

Prior to your visit we will attempt to verify your insurance coverage. If the services provided by Dr. Amesse are covered by your insurance policy, the insurance company will be billed directly. Payment from you insurance company will then go directly to Dr. Amesse MD, PA. In the event the insurance company does not pay for those services or you do not have insurance, you will be financially responsible. All charges are due in full within 30 days from the date the amount was billed to you.

Signature: ____ Date: ____________________
Patient

Signature: ____ Date: ___________________
Other Guarantor

Center for Pediatric Adolescent Gynecology

Lawrence Amesse, MD, PA

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I authorize Lawrence Amesse, MD, PA to use and disclose all health and medical information relevant to my diagnosis and treatment ____
Name of Patient

to the following: ____For the purpose of diagnosis and
Name of Recipient

treatment of my medical condition. I also Authorize Lawrence Amesse, MD, PA and his representatives to leave messages including laboratory results on my voicemail/ answering machine even if confidential information might be overheard by others than myself.

Home Yes __________ No ___________
Work Yes __________ No ___________
Cell Yes __________ No ___________

You have the right to revoke this authorization any time, provided that you do so in writing and accept the extent that we have already used or disclosed the information in reliance on this authorization.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to the Authorization may be subject to redisclosure and no longer protected under federal law.

By: ________________________________ Date: ___________
Patient

Or By: _____________________________ Date: ___________
Patient's Representative

Description of representatives Authority: _______________________________

I, ___________________, authorize Lawrence Amesse MD PA to furnish the above
Patient

information as is requested to the above Health Care Provider.

Signature _____________________________________ Date ______________________

Center for Pediatric Adolescent Gynecology
Lawrence Amesse, MD, PA

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of Lawrence Amesse, MD PA Notice of Privacy Practices and I have been provided the opportunity to review it.

Patient Name: ____

Birth Date: ___________________________________ SS#__________________________

Address: ____

Signature: ______________________________________ Date: ___________________
Patient

Center for Pediatric Adolescent Gynecology
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FINANCIAL RESPONSIBILITY

I understand and agree to all of the following:

1. The printed fees and payments policies that I have been given are approximate, and is based on the number and nature of services used by the typical patient. The actual total cost may vary depending on the services required in the course of my own treatment.

2. In case Lawrence Amesse, MD PA has contacted my insurance company and believes that benefits are expected to be paid, Dr. Amesse cannot guarantee insurance payment.

3. If the insurance company payment is sent to me instead of Lawrence Amesse, MD PA, I agree not to cash the check, but to endorse it and forward it to the practice.

4. If my insurance company has not paid the claim within ninety days after it was filed, or if they deny the claim for any reason, I will be responsible for payment.

5. Payment of any bill sent to me is due in full by the 30th of the month in which it was sent. There is a 1.5% monthly late charge added to any past due balance. A charge applies to any check that is returned by the bank. Patients whose accounts are sent to an outside collection agency is responsible for collection cost.

_____________________________________ ________________________
Patient Signature Date

_____________________________________ __________________________
Reviewed by Date

Center for Pediatric Adolescent Gynecology
Lawrence Amesse, MD, PA

CONSENT/RELEASE OF RECORD

Date: ____________________________

Patient Name: ____

CONSENT FOR MEDICAL TREATMENT- I hereby authorize The Center for Pediatric and Adolescent Gynecology and Dr. Amesse to administer any medical treatments and medications and to perform laboratory tests (including blood tests for any disease or condition) and diagnostic procedures as deemed necessary or advisable in my diagnoses and treatments. I understand that physician(s) will receive results of the tests and services ordered. I am aware that the practice of medicine, surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations.

I authorize the release of any medical information necessary to process claims for payments, and for the purpose of obtaining authorization from insurance companies for further tests or treatment with any right to privacy waived including any treatment for mental illness, alcohol abuse, drug abuse or HIV.

I, the undersigned, certify that I have read the foregoing and am the patient, the patient's legal representative or duly authorized by the patient as the patient's general agent to execute the above and accept its terms. The undersigned also fully understand the contents of this form and voluntarily executes it.

Patient Signature ______________________________________ Date ______________
(If other than patient, sign & state relationship)

Witness Signature _____________________________________ Date ______________

Center for Pediatric and Adolescent Gynecology

Lawrence Amesse, MD, PA

HEALTH HISTORY QUESTIONNAIRE

Welcome to Fertility Florida and the *Center for Pediatric and Adolescent Gynecology*. The enclosed questionaire that will help us facilitate you visit, and to provide more effective medical care.

Answer each question to the best of your ability by filling in the information or by marking the appropriate space. Don't worry if you are uncertain of the answer to some of the questions. You will have a chance to review them with the doctor. Please print legibly using a ballpoint pen as these forms will become a part of your permanent medical record.

Your answers will be treated confidentially, as are all aspects of your medical care.

Thanks and we look forward to working with you.

Center for Pediatric and Adolescent Gynecology
Lawrence Amesse, MD, PA

Date: ___________________________

Name: ____ DOB: ________________ Age: _________

Address: _______________________________________ Home phone: _____-________________________

_______________________________________ FAX: (if available)_____-______________________

_______________________________________ Email:_____________________________________

School/Grade: N/A ____________________________ Employer: N/A ___________________________

DRUG ALLERGIES: NONE; LIST____

REASON FOR YOUR VISIT

Pelvic Pain

Sexually Transmitted Diseases

Polycystic Ovary Syndrome

Abnormal Menstrual Periods

Lack of Menstrual Periods

Endometriosis

Ovarian Cysts/Dermoid etc

Excess Facial or Body Hair

Vaginal Discharge

Labial Adhesions

Contraception

Other____

Please describe your present problem. Include all symptoms, how long you have experienced them and the patterns. Also indicate whether they have changed in severity over time:

____

____

____

____

PREVIOUS EVALUATION FOR PRESENT PROBLEM

Year Doctor's Name Tests & Results Treatments / Medications

____

____

____

MENSTRUAL HISTORY

Not Applicable (N/A)

Age at onset: _________ What were the dates of your last two periods: _______________________________

Are your cycles regular: Y / N Periods come every _________ days. # of days periods last: ___________

Amount of bleeding and change during the period: ____

Painful periods (describe) ?____

Bleeding between periods (describe) ?____

Pain between periods ? If yes, explain ____

Have you ever received treatment to bring on or to regulate your periods? Y / N If yes, explain: _____________

____

GYNECOLOGIC HISTORY

Prior examinations: N/A

Date of last exam _________ Reason: ____

Date of last PAP smear ____________ N/A _____________________

History of abnormal PAP Y / N Dates _______________ Treatments ___________________________

Have you had a history of (if yes, please give dates and type of treatments)

Milky breast discharge ____

Chlamydia ____

Pelvic infection ____

Other gynecologic problem ____

____

____

Birth control history: N/A

Method	Dates	Problems
IUD		
Pills		
Diaphragm		
Patch		
Condoms		
Nexplanon		
Depo-Provera		
Other		

PREGNANCY HISTORY: N/A

List all the pregnancies you have had, in chronological order, including miscarriages if applicable

___

GENERAL HEALTH

List current medical problems: None

Date	Illness	Treatments

List surgeries you had: None

Date	Illness	Surgery

Medications you are currently on and medications you have taken regularly in the past: None

___

___

SOCIAL:

Alcohol consumption N/A ___________________________ Cigarettes per day N/A ______________________
Caffeine (how much) N/A __________________________

FAMILY HISTORY:

List below the ages of your immediate living relatives, or their age at death if deceased, and their medical problems, if any, including medical problems and age at menopause.

Mother ____

Father ____

Brother(s)____

Sister(s) ____

Grand parents ____

ADDITIONAL PATIENT COMMENTS: None

Please add any pertinent medical information not previously mentioned:

____

____

____

Who referred you to our office?____

If an other physician please indicate name and address below:

Referring physician: ____________________________________

Address: ____

____

Office phone ____-___________

Patient's signature ________________________________

Date ________________________________