Women's Healthcare of Kendall

Pablo E. Delgado, M.D., F.A.C.O.G.
Obstetrics & Gynecology
10700 North Kendall Drive, Suite 200
Miami, FL 33176
Phone: (305) 270-7999 Fax: (305)270-6788

CONSENT TO OPERATION OR OTHER PROCEDURE

Patient ____________________________________ Date of Birth: ________________________
(Patient)

1. I hereby request and authorize Pablo E. Delgado, M.D. and or such physician associate(s) as may be selected by him or her, to perform on the patient the following: (this consists of a physical exam of by body including my breasts and genital organs) and/or surgical operation(s), the nature to the extent of which has been explained to me by the physician in lay terms completely understandable to me.

____
____
____
____

DO YOU ACCEPT BLOOD TRANSFUSIONS, in case of an emergency? YES or NO ______
Initials

2. I have been fully informed by the physician in lay terms understandable to me all medical acceptable alternative treatment.
3. I have been fully informed by the physician in lay terms understandable to me the risk and consequences, which are associated with the surgical procedure(s) described below.
4. I was told that I have the option of refusing the operation or procedure.
5. I have been fully informed that Dr. Delgado does circumcisions in his office. I agree that if I request a circumcision for my baby, it will be done at Dr. Delgado's office rather than in the hospital.
6. I consent to the administration of such anesthetic agents as shall be selected by those responsible for performing the procedure.
7. If any unforeseen condition arise during the course of the operation, I do hereby authorize and request the physician and/or his physician associates to take whatever procedure(s) they deem advisable, which may be in addition to or different from those now planned.
8. I have also been informed there are other risks including but no limited to, severe loss of blood, infection, cardiac arrest that are attendant to the performance of any surgical procedure.
9. I consent to the appropriate disposal by the hospital of any tissues and other body materials, which may be removed during the course of the procedure(s).
10. I have been made aware and acknowledge that the practice of medicine and surgery are not exact sciences and that no guarantees or assurances have been made to me as to any of the results or risks.
11. I further consent to my surgeon (or his designee) making a photographic, videotape or similar records of the operation (which shall remain in my surgeon's custody) fir the purposes my surgeon deems desirable.

I HAVE READ THE ABOVE PARAGRAPHS AND THEY HAVE BEEN EXPLAINED TO MY SATISFACTION.

______________________________	______________________________
Witness (to signature only)	**Signature of patient (or parent or legal guardian is unable to sign this consent**
Date of signature obtained	**Time signed**

PHYSCIAN'S CERTIFICATION

I, PABLO E. Delgado, M.D., hereby certify that the patient, or one authorized to act on his/her behalf: (1) has been fully informed by me or by one of my physician associate(s), in lay terms understandable to the patient, of the mature of the surgical procedure, the alternatives as to treatment, and the consequences of and risks to the patient inherent or associated with the procedure; and (2) has authorized the performance of the procedure.

______________________________	______________________________
Physician	**Date**

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Women's Healthcare of Kendall, LLC provides you this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- ❑ Protected health information may be disclosed or used for treatment, payment or health care operations
- ❑ Women's Healthcare of Kendall, LLC, has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- ❑ Women's Healthcare of Kendall, LLC reserves the right to change the Notice of Privacy Policies
- ❑ The patient has the right to restrict the uses of their information but Women's Healthcare of Kendall, LLC does not have to agree to those restrictions
- ❑ The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- ❑ Women's Healthcare of Kendall, LLC may condition treatment upon the execution of this Consent

This Consent was signed by: ____

____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient): ___________________________________

Date: ________________/____/_____

In front of ____________________________________
Printed name – Practice representative

Women's Healthcare of Kendall, LLC

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative mean, such as sending correspondence to the individual's office instead of the home.

I wish to be contacted in the following manner (check all that apply):
(Quisiera que me contacten de esta manera (marque todo lo que appliqué**)**

[ ] Home Telephone____________________
(Al telefono de casa)

[ ] O.K to leave message with detailed information
(Se puede dejar mensajes con detalle)
[ ] Leave message with call back number

[ ] Leave message with call-back number only
(Dejar mensaje con numero de telefono solamente)

[ ] Written communication
(Communicaciones por excrito)

[ ]O.K. to mail to my home
(Se puede mandar correspondencia
[ ] O.K. to mail to my work address
(Se puede mandar correspondencia a trabajo)
[ ] O.K. to fax to this number ________

(Se puede mandar fax a trabajo)

[ ] Cellular ___________________________
[ ] Work Telephone_____________________
(Telefono de trabajo)
[ ] O.K. to leave message with detailed information
____
(Se puede dejar mensajes con detalle)
[ ] Leave message with call-back number only
(dejar mensaje con numbero solamente)

[ ] Other (otra situacion)

Please explain (favor de explicar)

____

____
PATIENT SIGNATURE (Firma de paciente)

____
Date (Fecha)

____
PRINT NAME (Escriba su nombre)

____
Date of Birth (Fecha de nacimiento)

MAY WE LEAVE A MESSAGE IN YOUR VOICEMAIL OR ON YOUR ANSWERING MACHINE? (PODREMOS DEJARLE UN MENSAJE EN SU MAQUINA TELEFONICA O CORRE ELECTRONICO?)
Yes [ ] NO[ ] N/A [ ]

MAY WE CONTACT YOU AT WORK? (PODEMOS LLAMERLE AL TRABAJO?)
Yes [ ] NO [ ] N/A [ ]

MAY WE DISCUSS MEDICAL INFORMATION ABOUT YOU WITH YOUR SPOUSE OR FAMILY MEMBER?
Yes [ ] NO [ ] N/A [ ]
(NOS AUTORIZA DISCUTIR INFORMACION MEDICA CON SU ESPOSO(A) O ALGUN FAMILIAR?)

OTHER OR SPECIAL NOTIFICATIONS, PLEASE EXPLAIN: (NOTIFICACIONES ESPECIALES – FAVOR DE EXPLICAR):

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to Women's Healthcare of Kendall, LLC. for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fee should assistance become necessary. The undersigned agrees, whether she/he signs as parent, spouse, guarantor, guardian, or patient that in consideration of the services to be rendered to the patient, she/he hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

El/La suscrito(a) autoriza que, toda la informacion medica accesaria para procesar cualquiera de mis reclamos a mi compania de seguro ea puesta a disposicion de esta. Asi mismo autorizo el pago de mis beneficios directamente a Women's Healthcare of Kendall, LLC. Entiendo y accepto que, independiente de mi condicion de asegurado(a), soy totalmente responsible de mi cuenta por los servicios recibidos en esta oficina. Si acaso esta cuenca fuese enviada a un servicio de cobranza, todos los gastos que se irigen de este recurso legal son tambien de mi responsabilidad. El/la suscrito(a) consiente que al firmar como padre, esposo(a), fiador, guardian o paciente, assume la responsabilidad y obligacion por cualquier balance pendiente que derive a causa de tratamiento medico a dicho paciente. En caso de que la cuenta fuese referida a un bogado(a), el/la suscrito(a) pagara dichas cuentas legales y asumira costos de coleccion.

SIGNATURE (FIRMA)____________________________ **DATE (Fecha)**_________________________

NAME (NOMBRE)____

NOTICE OF OBSTETRIC PATIENT

I have been furnished information by Women's Healthcare of Kendall, LLC prepared by the Florida Birth Related Neurological Compensation Association, and have been advised that Women's Healthcare of Kendall, LLC may be a participating physician in that program, wherein certain limited compensation us available in the event certain neurological injury may occur during labor, delivery, or resuscitation. For specifics on the program, I understand I can contract the Florida Birth Related Neurological Injury Compensation Association (NICA),

PO Box 14567, Tallahassee, Florida 32317-4567, (800)398-2129.

I further acknowledge that I have received a copy of the brochure prepared by NICA.

Dated this _____ day of ______________, 200__.

____
Signature of PATIENT

____
(Printed Name of Patient)

Social Security No. ______________

Attest:

Physician or Nurse: _______________
Date: ____________

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HIV Test Informed Consent

I consent to a human immunodeficiency (HIV) test, which is to determine if an individual is infected with the virus, which causes AIDS. I understand:

1. The blood test for HIV is not 100% accurate and sometimes produces false positive or false negative results.

2. More than one blood test may be necessary to confirm positive results.

3. That information identifying me and test results will be confidential and only those required or permitted by lay will know the results and my identity.

4. That my HIV test results can be released to those whom I give written permission to see or to copy my medical record.

5. I will be provided the test results and the opportunity to receive post-test counseling from my physician.

I acknowledge that I have received information regarding measures for the prevention of, exposure of, and transmission of HIV.

______________________________ ____________________________________
Date Time Signature, Patient/Legal authorized Person

______________________________ ____________________________________
Date Time Witness

PHYSICIAN ACKNOWLEDGEMENT

I have provided pre-test counseling, including measures for the prevention of, exposure to, and transmission of HIV, and the right to confidential treatment of the test results and the patient's identity as provided by law. After I explain the rest results, I will give the patient the opportunity to receive post-test counseling.

______________________________ ____________________________________
Date Time Physician Signature