FemCare Ob-Gyn, LLC *Geoffrey N. James, MD, Jason S. James, MD, Jila Senemar, MD, Pamela K. Graham, NP*

PATIENT REGISTRATION

PATIENT INFORMATION

Social Security # _____ Home Address _____

First Name _____ City _____ State _____ Zip _____

Last Name _____ Email address _____

Sex _____ Date of Birth _____ Home Phone (_____) _____

(Check One) ❒Employed ❒Retired ❒Full-Time Student Cell Phone (_____) _____

❒Other _____ Work Phone (_____) _____

Occupation _____ Fax Number (_____) _____

Employer _____ Primary Physician _____

Marital Status: ❒Married ❒Single ❒Divorced ❒Widowed Referred By _____

Spouse's Name _____ Primary Language _____

INSURANCE INFORMATION – *Please provide your insurance card and Driver's License to the receptionist*

Primary Insurance _____ Secondary Insurance _____

Name of Subscriber _____ Relationship _____ DOB _____

Policy # _____ Group # _____ Phone (_____) _____

EMERGENCY CONTACT

Name _____ Relationship _____ Sex _____

Home Phone (_____) _____ Work Phone (_____) _____

I allow Doctor/Staff to leave messages/fax results at: ❒Home ❒Work ❒Cell ❒Fax ❒None

I authorize FemCare Ob-Gyn, LLC to disclose certain protected health information (PHI) about me to the parties listed below:

1._____ 2._____

Fees and Insurance Information

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency, I authorize said attorney to obtain my credit report and I understand that I will be liable for any charges incurred, including reasonable attorney's fees, court costs and collection expenses.

Malpractice Insurance Notification

We have elected not to carry Medical Malpractice Insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to S.458.320(5)(g). 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.

Physician's Release and Assignment

I hereby authorize payment directly to FemCare Ob-Gyn, LLC ("Physician") of all benefits applicable and otherwise payable to me from my insurance carrier or other third party payor, for services rendered by the Physician. I understand that I am financially responsible to the Physician for any and all charges that the carrier declines to pay. I hereby authorize release of my medical records as deemed necessary for payment of benefits.

HIPAA Acknowledgement

By signing below, I acknowledge that I have read and understand the Notice of Privacy Practices of the Federal HIPAA Privacy Rule.

Patient's/Guarantor's Signature _____ Date _____