FIRST
I.V.F
Florida Institute for Reproductive Sciences and Technologies
Minna Ruth Selub, M.D., F.A.C.O.G., Medical Director

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

ATTENTION:

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE AND MAIL MY COMPLETE MEDICAL RECORD IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT, TO:

DR. MINNA R. SELUB
AT THE ADDRESS APPEARING AT THE BOTTOM OF THIS PAGE

Name:_____

Date of Birth:_____

Address:_____

_____

_____

Signature_____

2300 North Commerce Parkway | Suite 319 | Weston, Florida 33326
t: 954. 217. 3456 | f: 954.217.3470 | FIRSTivf@aol.com | www.FIRSTivf.net

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You must have your medical records forwarded to us prior to your appointment. You can fax them to (954) 217-3470 OR email them to office@firstivf.net, or mail them to the address below

Broward Health Weston

Dr. Minna R. Selub

2300 N Commerce Parkway #319

Weston, FL 33326

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Consent for financial responsibility

1. **CONSENT FOR MEDICAL CARE:** I authorize Dr. Minna Selub to determine what kind of tests must be done in order to learn more about my condition and what treatment is to be given. Tests may include x-rays, urinanalysis, blood pressure tests, ultrasound examinations, semen analysis or other routine tests. I understand that if Dr. Selub advises a more complex test or treatment, or one which has special risks, it will be explained to me. Furthermore, I authorize the personnel of Florida Institute for Reproductive Sciences and Technologies (F.I.R.S.T) to assist in giving, or to give, the test or treatment which I might receive. I acknowledge that my doctor is available to answer any questions I might have. I understand that medicine is not an exact science, and acknowledge that no guarantee or assurance had been made to me as to the results of treatments, tests, or examinations.

2. **ASSIGNMENT OF BENEFITS:** I hereby irrevocably assign payment to F.I.R.S.T., and the physicians accepting this assignment, of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to F.I.R.S.T. and Dr. Selub for charges that the carrier declines to pay. It is further agreed that any credit balance resulting from payment by my insurance or other sources may be applied to any other accounts owed to F.I.R.S.T. and Dr. Selub by the insured or immediate family.

3. **RELEASE OF MEDICAL RECORDS:** I hereby authorize F.I.R.S.T. and Dr. Selub to disclose all or part of my records to any person or corporation which is required to pay for all or part of F.I.R.S.T.'s or Dr. Selub's charges, including but not limited to, insurance companies. This authorization includes, without limitation, release of medical records, present or future psychiatric, HIV (Human Immunodeficiency Virus which causes AIDS) tests and/or substance abuse records.

4. **PAYMENT:** I hereby assume responsibility to pay the costs of all services provided by F.I.R.S.T and Dr. Selub to me. F.I.R.S.T. will make every effort to obtain payment/pre-authorization for all managed care patients, but I do understand that is it my responsibility to secure authorization for an elective procedure and to report an emergency within 24 hours. In the event that I fail to fulfill any of the obligations in this section, I agree to pay any and all attorney fees and/or collection costs incurred by F.I.R.S.T. in the enforcement of this agreement.

5. I understand that if I am an insured patient, and F.I.R.S.T. and Dr. Selub are contracted with my insurance, I am responsible to pay my co-payment and any charges that may be applied to my deductible. I completely understand that if any charges/services are billed to my insurance and they are denied for **any** reason, I am 100% responsible for payment in full.

If you choose to receive services at our facility without authorization from you insurance company, you will be responsible for payment of your bill at, before, or after the time service is rendered. You may contact your managed care plan to appeal their decision not to authorize services. If payment has been denied, however, you will be responsible for payment in full at the time of denial.

_____ _____

Print Patient's Name: Date:

Patient's signature_____

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PLEASE FILL OUT COMPLETELY

Name:_____

Home Phone:_____ **Work Phone:**_____

Cell Phone:_____ **EMAIL:**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Date of Birth:_____ **Place of Birth:**_____

Partner: Male: ____ **or Female:**_____ **Social Security #**_____

Occupation:_____ **Employer:**_____

Employer Address:_____

Partner's Name:_____ **Date of Birth:**_____

Social Security #_____ **Contact:**_____

Emergency Contact _____

Relationship:_____ **Phone:**_____

Mother's Name:_____ **Father's Name:**_____

ReferringPhysician:_____ **Phone:**_____

Address:_____

Insurance Company:_____

Address:_____

Phone#:_____

Policy #_____ **Group #**_____

Policy Holder:_____

Name:_____Age:____Occupation:_____

Family History:	LIVING Age:	Health:	Deceased Age:	Cause:	HAS ANY RELATIVE EVERY HAD:	No:	Yes:	Who:
Father:					Cancer			
Mother:					Tuberculosis			
Brother/Sister					Diabetes			
1					Heart Trouble			
2					High blood pressure			
3					Stroke			
4					Epilepsy			
					Suicide			
Partner:					Mental Illness			
Son/Daughter					Hysterectomy			
1					Kidney Trouble			
2					Other			
3								
4								

Weight: Now:_____lbs 1 year ago:_____lbs Highest:_____lbs When:_____

Have you ever had:	No:	Yes:	Do you have or have you ever had:	No:	Yes:
German Measles			Any eye diseases, injury or impaired vision		
Mumps			Any ear disease, injury or impaired hearing		
Chicken Pox			Any trouble with nose, sinuses, mouth, throat		
Scarlet Fever			Any head injury, fainting spells, convulsions		
Diphtheria			Frequent or severe headaches		
Pneumonia			Skin Disease		
Rheumatic Fever			Chronic or frequent cough		
Heart Disease			Chest pain or spitting up blood		
Heart Murmur			Night sweats		
Polio or Meningitis			Shortness of breath		
Kidney Infections			Swelling of hands, feet or ankles		
Gonorrhea or Chlamydia			Varicose vein		
Anemia			Kidney or bladder disease		
Jaundice			Indigestion, stomach trouble or ulcers		
Gallbladder Disease			Rectal bleeding, constipation or diarrhea		
Epilepsy			Loss of urine with cough or sneeze		
Migraine Headaches			Alcoholic Beverages: ___Never or _____Moderate		
Tuberculosis			Allergies		
Cancer			Cigarettes ___ packs per day		
High or low blood pressure			Transfusions		
Nervous Breakdown			Recreational Drugs		
Others			What medications are you on now:		

Menstrual History:

Age at on set: _____

Regular: ____Yes _____No

Cycle: _____Days (from start to start)

Usual Duration: _____Days

Flow: _____Light _____Moderate _____Heavy

Pains or cramps: _____Yes _____No

Last menstrual period: _____

List Pregnancies including Miscarriages:

Year	Weight	Sex	Labor/Hours	Anesthesia	Complications

List surgeries including out-patient procedures:

Year	Procedure	Year	Procedure

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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 **Dr. Minna Selub** of **Florida Institute for Reproductive Sciences and Technologies (FIRST)** to perform a pelvic examination, including vaginal sonography, as described above.

I understand that a pelvic examination may be needed while receiving medical care from **FIRST** 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 Dr. Minna Selub or a health care provider employed by and/or contracted with **FIRST**, unless I revoke this consent in writing by hand delivering a copy of the revocation to **FIRST**.

By my signature below I acknowledge that I have read or have had this consent form 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

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Cancellation/No Show Policy

For Appointments

1. Cancellation/No Show Policy

We understand that there are times when you must miss an appointment because of emergencies or obligations to work or family. However, when you do not call to cancel and appointment, you may be preventing another patient from getting a consultation, diagnosis, or treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit at a desirable time because of a seemingly full appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a $50.00 fee; this will not be covered by your insurance company. A no show fee of $75.00 will be charged for failing to call and failing to show up for a scheduled appointment.

2. Scheduled Appointments

We understand that delays can happen, however we must try to keep other patients and the doctor on time. If a patient arrives 15 minutes past their scheduled time, we may have to reschedule the appointment.

3. Account balances

We require that patients with self-pay balances pay their account balances to zero (0) before receiving further services by our practice. Patients who have questions about bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over $100.00 must make payment arrangements prior to scheduling an appointment.

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4. CONFIRMATION OF A NEW PATIENT APPOINTMENT

I understand that my new patient appointment will not be confirmed until I have returned this completed form. Once it has been sent back, I understand I will be sent new patient forms to complete and my appointment will be confirmed.

5. Credit card Authorization

I, _____, understand the importance of notifying the physician's office at least 24 hours prior to cancelling my scheduled appointment. I am giving my consent to the Florida Institute for Reproductive Sciences and Technologies to charge my credit card $50.00 for each missed appointment (where, at least, a 24-hour notice is not given) and $75.00 for each missed appointment where I fail to call and show up for the appointment.

I understand that I may revoke this agreement at any time by providing a request in writing. I am also aware that when medical services rendered by Dr. Minna Selub have been completed this form shall be shredded and my treatment will be terminated.

Name on card:_____

Card number:_____

Expiration date:_____Security code:_____

Street address:_____Zip code_____

Email address for receipt:_____

Patient /Card Holder Signature:

_____Date:_____

Please check this box if you would like us to use the same card towards your new patient consult or co-payment.

*New Patient Consult without insurance or insurance we do not take is $200.00

*Co-payment amount varies depending on the Insurance you have (that we accept)