FLORIDA BLADDER INSTITUTE
Especially FOR WOMEN

Joseph Gauta, MD, FACOG | Amanda Schultz, PA-C
Specialized Diagnostic, Treatment and Rehabilitative Care for Women with Incontinence, Pelvic & Bladder Disorders
1890 SW Health Parkway, Suite 205, Naples, FL 34109 | 239-449-7979 | fax 239-593-3356 | www.FloridaBladderInstitute.com

INFORMATION UPDATE

Patient Name:_____

Address:_____

City, State, Zip:_____

Home Phone #:_____ Work Phone #:_____ Cell Phone #:_____

Consent to receive automated calls Y or N? Consent to receive text messages Y or N?

Race: _____ Preferred Language: _____ Ethnicity: Hispanic ____ Non-Hispanic ____ I prefer not to disclose ____

Date of Birth: _____ Social Security #_____ Religion _____

Spouse's Work # :_____ Spouse's Cell Phone # :_____

E-Mail Address:_____
May we send you medical information via your e-mail Y or N?

Preferred Pharmacy:_____ Pharmacy Phone #:_____

PLEASE HAVE YOUR INSURANCE CARD AND A PHOTO ID (DRIVER'S LICENSE, ETC.) AVAILABLE

Primary Insurance:_____

Insurance ID #:_____ Group# or Enrollment Code: _____

Insured Party Name:_____

Insured Date of Birth: _____ ( ) Female ( ) Male

Secondary Insurance: _____

PATIENT'S EMPLOYER INFORMATION

Employer:_____

Employer Phone Number:_____

Employer Address:_____

Employer City, State, Zip:_____

PLEASE READ AND SIGN BELOW

The patient understands that he/she or responsible party is financially responsible for all fees not paid by insurance or third party coverage. In addition, the patient authorizes his/her insurance company to pay Especially for Women directly for services rendered. In the event that an outside collection agency is necessary to enforce payment of the account, the patient agrees to pay for all collection fees deemed reasonable. This form will also give authorization for Especially for Women to release any medical information necessary to process any insurance claims.

_____ _____
Signature of Patient or Responsible Party Date

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Financial Information

As a courtesy to you, we will be happy to bill your insurance company for services rendered. If for any reason your insurance company denies the claim, you will be personally responsible for the charges. A credit card is required to be kept on file for any charges not covered by insurance. Due to the thousands of insurance plans available it is impossible for us to know the coverage details of all of the policies. It is your responsibility to know what type of coverage, benefits, deductibles and co-payments you have with your insurance plan.

Well Woman Exam: Most insurance companies do not cover more than one routine well woman exam per 365 day period. If you have had this service provided by another provider within the last 365 days you will be responsible for paying for todays visit.

Pathology Notice: Certain tests that you have done in the office will be sent to a pathologist for diagnostic evaluation. The pathologist will submit a bill to your insurance company and bill you directly if there is a balance due.

Phone Calls: We encourage you to use the patient portal* to communicate with your provider concerning health questions. Communication through the patient portal is more efficient and does *not* incur a charge to you. Phone calls regarding health concerns *will* incur a charge. The charge will vary from $30 to $90 depending on the length of the call.

Surgery Cancellation Policy: A fee of $250.00 will be charged if you cancel a scheduled surgical procedure with less than a 48 hrs notice.

Office Visit Cancellation & No Show Policy: A fee of $50.00 will be charged if you cancel a scheduled office visit less than 24 hours from the appointment time. Scheduled in-office surgical procedures will incur a fee of $100 to you if cancelled less than 24 hours in advance.

Assignment to Pay for Services: I agree to pay the Florida Bladder Institute & Especially for Women for all charges for services rendered today, or any future date of service, in this office. I understand that any unpaid charges will be billed to my credit card. I further understand, in the event this account is referred to an agency or attorney for collection, I will be responsible for all collection fees, attorney's fees and/or court costs.

I Agree with all of the statements above.

_____ _____

Signature of Patient or Responsible Party Date

***Make Appointments, Send Messages, Access Your Health Records & See Your Billing Statements 24 Hours A Day On The Patient Portal Found On Our Website WWW.FLORIDABLADDERINSTITUTE.COM**