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## LABORATORY TESTING

### Attention All Patients:

It has been advised by your health care provider that as a result of your appointment today, we will be sending lab work to an outside lab for interpretation. If the labs ordered are subject to your deductible, co-pay, co-insurance, and in some cases not covered by insurance you will receive a separate lab bill for any/or all tests that were ordered by the practitioner.

**We currently send all in house specimen collections to Florida Woman Care Laboratory, LLC. If they are not contracted with your insurance, they will forward to correct Lab facility.**

All outside lab orders will be submitted to the lab of your choice.  
Please specify as to which lab to send orders for outside of office testing to:

- \_\_\_\_\_ LabCorp of America
- \_\_\_\_\_ Quest Diagnostics
- \_\_\_\_\_ Other  
(Please specify name of other lab) \_\_\_\_\_

If your insurance is not contracted with any of the above lab facilities, please advise the nurse **PRIOR to seeing the practitioner.**

It is the **patient's responsibility** to know what laboratory your insurance is contracted with, please check your provider directory for the participating laboratory on your plan. Please be advised if you choose to have your labs drawn at any other facility or doctor's office there may be a delay in our office receiving the results.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**This authorization is in effect indefinitely from the date signed above unless revoked sooner.**

[www.obgynwc.com](http://www.obgynwc.com)

Phone: (941) 907-3008 • Fax: (941) 907-3036

8340 Lakewood Ranch Blvd. • Suite 240 • Lakewood Ranch, FL 34202



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### **Patient Consent for E-Prescribing (Electronic Prescribing)**

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

**This authorization is in effect indefinitely from the date signed below unless revoked sooner.**

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Parent, Patient's Signature or Authorized Representative	Date	Time
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Relationship to Patient	Interpreter, if utilized
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Witness Signature



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#### ACKNOWLEDGMENT OF POLICIES

Name of Patient: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

#### PLEASE READ AND SIGN

##### Labs

You have been advised by the health care provider that as a result of your appointment today, they will need to send lab work to an outside lab for interpretation, (ex: pap smear, biopsy, etc), if the labs ordered are not covered by your insurance, **you will receive a separate bill for any/or all tests that were ordered by the provider.** This bill will come to you from the lab directly.

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##### **Pharmacy**

It is your responsibility to provide our office with your preferred pharmacy name and phone number. Please make sure that you provided the correct information to the front desk and/or nurse.

##### **Authorizations/referrals:**

If your insurance requires and authorization or referral from your Primary Care Physician, it is your responsibility to make sure we have this prior to being seen in our office.

##### **Returned Check Charge:**

If we receive a returned check from your bank due to non-sufficient funds, closed account, etc. you will be charged an administrative fee of \$35.00. Future services will require payment by cash, money order, or credit/debit card.

##### **Co-Pays/co-insurance/deductibles:**

Co-pays, co-insurance/deductibles are due at the time of service. Patients will be asked to reschedule their appointment if the appropriate funds are not collected.

##### **Completion of Forms:**

There is a \$25.00 charge per form for all FMLA, short term and long term disability forms. Payment will be collected at the time the paperwork is received in our office. Paperwork will be completed as quickly as possible (up to 2 weeks). Our office will contact you when it is completed.

##### **Patient Responsibilities**

As a patient, it is **your** responsibility to know if you plan is contracted and in network with our group and to understand your insurance plan benefits. Policies and coverage may vary from year to year.

**I have read, understand and acknowledge I have received the financial policy.**

Signature of Patient or Guardian \_\_\_\_\_ Date: \_\_\_\_\_

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## Consent for Pelvic Examination

According to The American College of Obstetricians and Gynecologists, the pelvic examination is part of the evaluation of women presenting with many common conditions, including pelvic pain, abnormal bleeding, vaginal discharge, and sexual problems. Pelvic exams—both in the office and while under anesthesia — are also an important part of evaluation for gynecologic procedures to ensure safe completion of the planned procedure. Often, a pelvic examination is performed for women without symptoms while looking for gynecologic cancer, infection, and pelvic inflammatory disease.

A pelvic examination is an assessment of the external genitalia; internal speculum examination of the vagina and cervix; bimanual palpation of the adnexa, uterus, and bladder; and sometimes rectovaginal examination.

Reasons for a pelvic exam can include (but are not limited to) health screening, abnormal bleeding, pelvic pain, sexual problems, vaginal bulge, urinary issues, or inability to insert a tampon. Other indications include patients undergoing a pelvic procedure (e.g., endometrial biopsy or intrauterine device placement). Also, pelvic examination is indicated in women with current or a history of abnormal pap results, gynecologic cancers, or toxic exposures.

The potential benefits of a pelvic examination include the detection of vulvar, vaginal, cervical, uterine and ovarian cancers and precancers, yeast and bacterial vaginosis, trichomoniasis, and genital herpes, early detection of treatable gynecologic conditions before symptoms begin occurring (e.g. vulvar or vaginal cancer), as well as incidental findings such as dermatologic changes and foreign bodies. Additionally, screening pelvic examinations in the context of a well woman visit may allow gynecologists to explain a patient's anatomy, reassure her of normalcy, and answer your specific questions.

The potential risks of a pelvic exam may include (but are not limited to) fear, anxiety, embarrassment (reports ranged from 10% to 80% of women) or pain and discomfort (from 11% to 60%).

There are few alternatives to pelvic examination, the alternatives are not as effective for providing diagnostic or evaluative information and carry their own set of potential risks. If you have concerns, you should discuss with your healthcare provider.

I \_\_\_\_\_ understand that this Patient Consent Form is required by law. I understand that I need to sign this form to show that I am making an informed decision to have pelvic examinations and I have read and understand the above.

The provider or their delegate has explained to me the nature, purpose, and possible consequences of each procedure as well as risks involved, possible complications, and possible alternative methods of treatment. I also know that the information given to me does not list every possible risk and that other, less likely problems could occur. I was not given any guarantee from anyone about the final results of this procedure.

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date

I understand that my provider is involved in educating tomorrow's medical professionals and that familiarizing students with the female anatomy and instilling a physician workforce with confidence in pelvic examination skills is essential. I consent to pelvic examination by the medical professional student under the supervision of my medical provider.

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date



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