Ivonne M. Reynolds, DO, FACOOG
Jessica White-Videa, DO, FACOG

Comprehensive Gynecological and Obstetrical Care
Minimally Invasive Gynecologic and Robotic Surgery
Bio-Identical Hormone Replacement Therapy

2964 North State Road 7, Suite 310, Margate, FL 33063 | office 954.917.4997 | fax 954.917.5404 | www.ireynoldsobgyn.com
9970 Central Park Blvd., Suite 206, Boca Raton, FL 33428 | office 561.509.5424 | fax 561-287-4751

Name _____ Today's Date _____
Last First Middle Initial

Date of Birth _____ Age _____ Social Security # _____

Mailing Address _____
Street City State Zip

Phone Number _____ Cell Phone _____

Email Address _____ Driver's License No: _____

Employer _____ Employer Phone _____

How Did you Hear about us? ☐ Physician _____ ☐ Friend/ Family _____

Primary Care Physician _____ Physician Phone _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Insurance

Ins. Co Name _____ Phone _____

Address _____
Street City State Zip

I.D. No _____ Group No _____

PRIMARY POLICY HOLDER /SUBSCRIBER _____ Relationship to Patient _____

Policy Holder Date of Birth _____ Social Security No _____

Secondary Insurance
Ins. Co Name _____ Phone _____

I.D. No: _____ Group No _____

In Case of Emergency

Who Should We Contact? _____ Relationship _____

Phone _____ Work Phone _____ Cell Phone _____

Fees and Insurance Information Dr. Ivonne M. Reynolds, DO, LLC will assist its patients in making every effort to collect payments from the patient's or guarantor' s insurance company through courtesy filing of insurance claims and other required documentation. Since most carriers have time limits for filing correct information, it is imperative that we receive complete and correct insurance information. Though assistance will be provided, it is the patient's responsibility to make sure his/her insurance carrier pays his/her claim. Patients, or their guarantors, are responsible for payment in full of financial obligations whether or not their insurer makes a payment. 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 of all charges is the patient's responsibility and should it be necessary for this account to be turned over to either a collection agency for collection, I understand that I will be liable for any charges incurred, including collection agency's fee, attorney's fee and or court costs. In accordance with Florida law, 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 noninsured physicians who fail to satisfy adverse judgment arising from claims of medical malpractice; this notice is pursuant to Florida law. **Physicians Release and Assignment:** I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier/HMO/TPP for services rendered by the physician. I understand that I am financially responsible to the physician for any and all co-insurance, deductibles, copays and/or non-covered service charges that the carrier declines to pay. I hereby authorize the release of my medical records to my insurance provider as deemed necessary for payment of insurance benefits.

Signature _____ Date _____