DAVID I. LUBETKIN, MD, FACOG
COURTNEY McMILLIAN, CNM, MSN, ARNP
POLINA GOLDENBERG, CNM, MSN, ARNP
Obstetrics · Gynecology · Infertility

Patient Name: ______________________________ DOB ______________

Address ____

City ________________ State ____________ Zip Code ______________

Phone # (   ) ________________ Alt # (   ) ________________

Primary Language ____________ Race ______________ Ethnicity ____________

Pharmacy Name, Location & Phone #: ______________________________

____

Referred by ____

Email Address ____

Financial Statement

I certify that the above information is correct and further authorize any holder of medical information to be released to any insurance carrier for any claim. I request payment of authorized benefits for physician services to the physician furnishing the service or authorize such a physician to submit a claim for me. I also agree that should this account be referred to any agency or attorney for collection that I will be responsible for all collection fees, attorney fees and court costs. I am also aware that payment is expected when services are rendered unless other arrangements have been made in advance.

The office will bill your insurance. The insurance plan will determine benefits once the claim is received. I understand that if my insurance is accepted that it will be billed and I will be responsible for any deductible, copay, and coinsurance. I will also be responsible for any fees that are not covered by my insurance. I understand that it is my responsibility to provide valid insurance at the time of my visit, or I will be responsible for the full amount of the services rendered.

Signature ______________________________ Date ______________

1001 NW 13th Street, Suite 101A
Boca Raton, FL 33486
Phone (561) 300-0600 · Fax (561) 300-0601

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Notice of Privacy Acknowledgement

I understand that under Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your notice Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices. I authorize the following people to speak to the office regarding my health information:

Name ______________________________________ Relationship________________________

Name ______________________________________ Relationship________________________

Signature ____ Date:______________

Malpractice Statement

Under Florida Law, physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **Dr. Lubetkin has met these requirements and has decided to become self-insured and not carry commercial medical malpractice insurance**. This is permitted under Florida Law subject to certain conditions. Florida law imposes penalties against non insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice.. This notice is provided pursuant to Florida law title XXXII Chapter 458.320. The undersigned patient, spouse and/or legal guardian or parents acknowledges that she/he has received a copy, read and understands this Medical Malpractice Insurance notice. Furthermore, the undersigned acknowledges this notice was not signed under duress and that all of the patient's questions relating heretofore have been answered to the patient's satisfaction.

Patient name____ Date: ________________

Signature____

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Notice of Privacy Practices
David L. Lubetkin, MD. LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

David L. Lubetkin, MD. LLC
1001 NW 13th St. Suite 101A. Boca Raton, Fl 33486

Office Phone: 561-300-0600
Fax: xxx-xxx-xxxx

Attn: Compliance Contact

Please sign the accompanying "Acknowledgement" form

David Lubetkin, MD

Courtney McMillian, CNM

Polina Goldenberg, CNM

1001 NW 13th Street, Suite 101A

Boca Raton, FL 33486

Consent for Pelvic Examination

Patient Name ____

DOB ____________________

I hereby request and authorize David Lubetkin, MD; Courtney McMillian, CNM; and/or Polina Goldenberg, CNM to perform a PELVIC EXAMINATION. I understand a pelvic exam may be performed as part of my routine or wellness checkup to monitor for possible signs of ovarian cysts, sexually transmitted infections, uterine fibroids or early-stage cancer and are routinely done during pregnancy checkups. Pelvic exams are also performed to investigate symptoms such as abnormal bleeding, unusual vaginal discharge, or pain.

I further understand the pelvic exam includes an external and internal assessment of my genitourinary system including the vulva, vagina, uterus, ovaries, and fallopian tubes; the bladder and rectum. This involves visual examination of the external genitalia and an internal visual exam of the vaginal walls and cervix using a metal speculum (device to open the vaginal canal). A small sample of the cells of the cervix may be taken for a Pap test. To complete the exam, bimanual palpation or touching of the size and shape of the pelvic organs is conducted by inserting two fingers into the vagina and pressing with the other hand on the abdomen followed with a rectal exam (over 40 years old or if there is an issue). While there may be some minor discomfort, a pelvic exam should not be painful.

By signing the document below, the patient or responsible party listed above consent to a **medically indicated examination including but not limited to a pelvic examination.** This consent will remain on file and will not expire.

Patient Signature: ______________________________ **Date:** ________________

Boca Midwifery
New Patient Questionnaire

Boca Midwifery welcomes you to the practice. Kindly fill out the enclosed personal medical history. The responses to the questions that follow will become part of your permanent office record and will remain strictly confidential. The purpose of gathering this information is to maximize the efficiency of your visit today.

Name:______________________________Age:________D.O.B.___________

Social Security Number:______________________ Marital Status:____________

What is the purpose of today's visit?

____

____

____

____

General Medical Information

Do you currently have or have had any of the following medical problems (check all that apply):

_____Asthma

_____Diabetes

_____Thyroid Condition

_____Sinusitis

_____Hay Fever/Allergies

_____Migraines

_____Seizures/Epilepsy

_____High Blood Pressure

_____Stroke

____Mitral Valve Prolapse

____Cardiac Arrhythmias

____Heart Attack

____Pneumonia

____Crohn's Disease

____Ulcerative Colitis

____Kidney Stones

____Hysterectomy

____Fibroid Uterus

_____Ovarian Cysts

_____Arthritis

_____Cancer

_____Hepatitis

_____Breast Masses

_____Fibrocystic Breast Conditions

_____Liver Disease

_____History of Blood Clots

Please List Any Medical Problem Not Listed Above :

____

____

Have You Smoked in the Past NO YES If yes, number of packs per day_____ for how many years? _____

Do you Smoke Now? NO YES If yes, number of packs per day_____ for how many years? _____

Do you Drink Alcohol? NO YES If yes, How many drinks per day?___________

Review of Systems

Please Circle any of the following that pertain to you:

General:	Weight Loss	Weight Gain	fever	Fatigue	
Ear Nose Throat	Sinusitis	ringing in ears	headaches		
Cardiovascular	chest pain	swelling	palpitations	Shortness of breath with exercise	
Respiratory:	Coughing	Wheezing	Coughing up Blood	Shortness of breath	
Gastrointestinal:	Diarrhea	Constipation	Bloody stools	abdominal pain	
Genitourinary:	Blood in urine	Pain with urination	urgency	loss of urine	
	Frequency of urination	Incontinence	Pain with intercourse	Change in Menstrual period	
Breast:	Breast pain	Nipple discharge	Breast lump		
Neurological:	fainting	seizures	numbness	trouble walking	
Psychological:	depression	anxiety			
Endocrinology:	Diabetes	Fatigue	Thyroid problems		
Hematology:	Easy Bruising	Unexpected bleeding	Swollen lymph nodes		
Menopausal symptoms:	hot flashes	Night sweats	Insomnia		

Please list all medications, prescriptions, and over the counter medications you currently take

____

____

____

Allergies to Medications: ______________________________

SURGICAL HISTORY - Please list ANY surgeries you have had and dates of surgery

____

____

____

____

GYNECOLOGIC/MENSTRUAL HISTORY

Last menstrual Period______________

At what age did you first begin to menstruate?______________

How long does your period last?______________

How many days between menstrual cycles? ______________

Are your Periods REGULAR or IRREGULAR Amount: LIGHT MODERATE HEAVY Pain: YES NO

Date of Last GYN exam ____________________

Date of Last Pap smear?____________________

Have you ever had an abnormal pap smear? ____________ If yes, please give details ________________

____

Have you ever had a bone density exam? _________ If yes, when and what were the results________________

Are you sexually active?________________ What is your current form of birth control? ________________

Have you ever been exposed to Gonorrhea, Chlamydia, Syphillis, Herpes or Genital warts (HPV)? ____________

Last mammogram? ________________________ Results? __________________________

If menopausal, are you on hormone replacement therapy? ____________ If Yes, what type? _________________

If no, were you ever on hormone replacement therapy? ____

Do you have any other gynecologic history that the doctor needs to know about? ___________________________

____

OBSTETRICAL HISTORY

Have You Ever Been Pregnant? ____________________

If yes, how many: Live Births_______ Miscarriages?________ Terminations?________ Ectopics?___________

Month	Year	Gest Age	Type of Delivery	Sex	Weight	Complications?

FAMILY HISTORY

Mother: Alive or Deceased Any significant Medical Problems? ____________________________________

Father: Alive or Deceased Any significant Medical Problems?____________________________________

Siblings: Alive or Deceased Any significant Medical Problems? ____________________________________

Any other significant family medical problems? ____

PRINT NAME________________________ **SIGNATURE** ________________________ **DATE** __________

David I. Lubetkin, MD FACOG

Courtney McMillian, CNM, ARNP

Bladder Health Questionnaire

Name ______________________________

1. Over the past month, have you **leaked** urine (even a few drops) or wet yourself when you: Cough, Sneeze, Laugh, Walk quickly, or change position?

Not at All	1-2 Times per month	1 time a week	3-4 times a week	5-6 days a week	Every day	Your score
0	1	2	3	4	5	

2. Over the past month, have you experienced a sudden strong **urge** to urinate causing you to rush to the bathroom?

Not at All	1-2 Times per month	1 time a week	3-4 times a week	5-6 days a week	Every day	Your score
0	1	2	3	4	5	

3. How many times do you wake at night to urinate? ____________

4. Would you be interested in learning more about a treatment for leaking **WITHOUT** medicine or surgery? ________ YES ________ NO

MYRIAD myRisk® Hereditary Cancer

Cancer Family History Questionnaire

Personal Information

Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know. **The following relatives should be considered:** Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

If you can answer YES to ANY of the questions below, please text 'CRA' to 99150 to watch a short educational video prior to seeing your provider today.

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, ovarian, or **pancreatic cancer** at any age	☐Y ☐N		
Colorectal or **uterine cancer** at 64 or younger	☐Y ☐N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐Y ☐N		☐M ☐P	
Two **breast cancers** (bilateral) in one relative at any age	☐Y ☐N		☐M ☐P	
Three **breast cancers** in relatives on the same side of the family at any age	☐Y ☐N		☐M ☐P	
Ovarian cancer at any age	☐Y ☐N		☐M ☐P	
Pancreatic cancer at any age	☐Y ☐N		☐M ☐P	
Male breast cancer at any age	☐Y ☐N		☐M ☐P	
Metastatic prostate cancer at any age	☐Y ☐N		☐M ☐P	
Colon cancer at 49 or younger	☐Y ☐N		☐M ☐P	
Uterine cancer at 49 or younger	☐Y ☐N		☐M ☐P	
Ashkenazi Jewish ancestry with **breast cancer** at any age	☐Y ☐N		☐M ☐P	
If you have a family history of any **other cancers**, list them here:				
Have you or anyone in your family had genetic testing for hereditary cancer?	☐Y ☐N	Who?	What gene(s)?	What was the result?

Cancer Risk Assessment Review (to be completed after discussion with your healthcare provider)

Patient Signature ______________________ Date __________

Healthcare Provider Signature ______________________ Date __________

Office Use Only Patient offered hereditary cancer genetic testing? ☐Yes ☐No ☐Accepted ☐Declined

If yes, which test? ☐BRAC*Analysis*® with Myriad myRisk® ☐Multisite 3 BRAC*Analysis*® REFLEX to BRAC*Analysis*® with Myriad myRisk® ☐COLARIS®PLUS with Myriad myRisk® ☐COLARIS AP®PLUS with Myriad myRisk® ☐Single Site Testing ☐Myriad myRisk® Update ☐Other: ______________________

Follow-up appointment scheduled? ☐Yes ☐No Date of next appointment: ______________________