

# ANNUAL



## PATIENT INFORMATION SHEET

New Patient  Update

Today's Date \_\_\_\_\_ Please fill out ALL sections completely and legibly.

Your Name \_\_\_\_\_ Your Age \_\_\_\_\_ Your Birth Date Month | Day | Year

Patient's Social Security Number \_\_\_\_\_ Referring Physician \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
How long have you lived in the area? Years | Months  Single  Married  Divorced  Widowed  Separated  
Employer \_\_\_\_\_ Occupation OR STUDENT How Long Employed Years | Months  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse/Parent's Name \_\_\_\_\_ Spouse/Parent's Birth Date Month | Day | Year  
Spouse/Parent's Social Security Number \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation OR STUDENT How Long Employed Years | Months  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF HOSPITALIZATION IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION.**

### THIS SECTION MUST BE FILLED OUT COMPLETELY OR INSURANCE CANNOT BE BILLED.

Primary Policy Holder's Name \_\_\_\_\_ Policy Holder's Birth Date Month | Day | Year  
Policy Holder's Social Security Number \_\_\_\_\_  Self  Spouse  Parent  Other  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Primary Insurance Company \_\_\_\_\_ ID No. \_\_\_\_\_  
Policy Holder's Employer \_\_\_\_\_ Group No. \_\_\_\_\_  
Claim's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Secondary Policy Holder's Name \_\_\_\_\_ Policy Holder's Birth Date Month | Day | Year  
Policy Holder's Social Security Number \_\_\_\_\_  Self  Spouse  Parent  Other  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Secondary Insurance Company \_\_\_\_\_ ID No. \_\_\_\_\_  
Policy Holder's Employer \_\_\_\_\_ Group No. \_\_\_\_\_  
Claim's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Emergency Contact \_\_\_\_\_  Spouse  Parent  Other  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT:** I hereby authorize OB-GYN Associates to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Email: \_\_\_\_\_



## CONSENT TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

(In compliance with the federal HIPAA Guidelines)

Today's Date \_\_\_\_\_

Your Name \_\_\_\_\_ Your Age \_\_\_\_\_ Your Birth Date Month | Day | Year

### **How we may use and disclose your health information.**

Your protected health information will be used by OB/GYN Associates or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

### **The notice of privacy practices.**

OB/GYN Associates is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. Please review it carefully.

### **You may place restrictions on the use or disclosure of your health information.**

You may request a restriction on the use or disclosure of our protected information. However, OB/GYN Associates may or may not agree to your request to restrict the use or to activate this request. Please consult with a practice representative or the Privacy Official if you would like additional information or clarification.

It is a violation of the federal privacy standards if OB/GYN Associates agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information prior to the date of your request. If you still have questions after reviewing the Notice of Privacy Brochure, please consult with a practice representative or the Privacy Official at the location and contact information listed on the back of the brochure.

### **You may revoke this consent at anytime.**

You may revoke this consent at anytime; however, OB/GYN Associates requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect the use and disclosure prior to the date of your request.

### **Changes to privacy practices.**

OB/GYN Associates reserves the right to change or modify the privacy practices outlined in the *Notice of Privacy* brochure. OB/GYN Associates will notify you of any changes of privacy practices either my mail, at your next appointment, or an other pre-approved method that you request.

### **Signature.**

I have reviewed this consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to OB/GYN Associates to use and disclose my health information in accordance with this consent and the notice provided.

Patient's Name \_\_\_\_\_ Please Print

Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Representative \_\_\_\_\_ Please Print

Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



HEALTH HISTORY UPDATE

Today's Date \_\_\_\_\_ Please fill out ALL sections completely and legibly.

Your Name \_\_\_\_\_ Your Age \_\_\_\_\_ Your Birth Date Month | Day | Year

Primary Care Physician Other than OB/GYN Preferred Lab Preferred Hospital

Total # Pregnancies Total # Births Last Period Mo. | Day | Yr. Hysterectomy Month | Year Have you had any of the following Health Screening Tests? Mammogram Month | Year Colonoscopy Month | Year Bone Density Month | Year Lipid/Cholesterol Month | Year

Are you Allergic to any Medications? No Yes If Yes, please list. Are you Taking any Medications? No Yes If Yes, please list. ALL PRESCRIPTION AND NON-PRESCRIPTIONS DRUGS AND VITAMINS

What is the Reason for your Visit today? Annual Exam Vaginal Discharge or Infection Abnormal Bleeding Contraception Pelvic Pain Urinary Problems Possible Pregnancy Hormone Problems Infertility Consultation Other

What is your Method of Contraception? Sterilization (male female) Birth Control Pills Condoms IUD Depo Provera Natural Family Planning Diaphragm Rhythm Other

Since your last visit, have there been ANY CHANGES in your MEDICAL OR SURGICAL HISTORY? No Yes Cancer (type) Hypertension Asthma Surgeries Stroke Heart Disease Diabetes Migraine Diabetes Other

Since your last visit, have there been ANY CHANGES in your FAMILY HISTORY? No Yes Cancer (type) Asthma Diabetes Hypertension Stroke Heart Disease Blood Clots Other

Social History Married Single Separated Do you smoke tobacco? No Yes If Yes, packs per day? Are You Sexually Active? No Yes Do you drink alcohol? No Yes If Yes, drinks per week?

Review of Systems Constitutional: fatigue, weight change Breasts: change in skin, discharge, lumps, pain Cardiovascular: chest pain/discomfort, palpitations Respiratory: cough, shortness of breath Gastrointestinal: abdominal pain, bloating, blood in stools, constipation, diarrhea, nausea, vomiting Genitourinary: urinary frequency, urinary incontinence, pain with urination, urinary urgency, problems with sex Integument: change in existing skin lesions, rash Neurologic: headaches Psychiatric: anxiety, depression, difficulty sleeping Heme-Lymph: easy bruising or bleeding Other



## FINANCIAL POLICIES

- ✓ OB/GYN Associates strives to provide the very best level of care and service to our patients. This includes working with many insurance companies and plans. In order to facilitate insurance billing, we require the most up-to-date insurance information so that we may bill all services in a correct and efficient manner. We do bill the insurance for services; however the patient is responsible for knowing her coverage and benefits. OB-Gyn Associates has a foremost relationship with our patients, and the patient is ultimately responsible for payment of services. We will honor accurate contractual adjustments (discounts) from your health plan; however the patient may be billed up to the correct contractual allowance. The patient responsibility for payment supersedes any agreement OB-Gyn Associates may have with any insurance network, plan or carrier. Additionally, each plan has varying requirements for prior authorization for services that are subject to change. OB-Gyn Associates will help with medical information to obtain prior authorization, but it is the patient that is ultimately responsible for understanding the authorization requirements for her plan and obtaining the same. All copays/deductibles/co-insurance or other patient financial responsibilities are due at the time of the appointment.
- ✓ A current copy of the insurance card is required at every service, and is vital in ensuring that services are billed correctly. If a patient does not have a current copy of her insurance card, she has the option of paying in full for that day, and we will promptly refund the patient once the service has been paid by the insurance company.
- ✓ In order to ensure that all of our patients are seen in a timely manner, we ask that you please cancel or reschedule your appointments at least 24 hours prior to your appointment time. If an appointment is missed or cancelled without prior notification, the patient may incur a fee for the missed appointment.
- ✓ Part of our service to you is to complete FMLA/disability paperwork and we will have it returned to you within 3 business days. In order to maintain this level of service, we charge a fee of \$20, which is due upon our receipt of the paperwork.
- ✓ We accept personal checks; however should any checks come back to us as non-sufficient funds, we will charge a \$20 fee to cover the bank charges, and we will ask for all subsequent payments to be made by cash or credit card. We can not hold checks for a later deposit date, so please make sure there are sufficient funds in your account prior to writing us a check.

### **Authorization for Treatment & Financial Agreement**

I authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct, unless notification is received in writing within 30 days of statement issue date. I agree to pay all charges within 15 days of statement issue date. I agree to assign my insurance benefits to OB/GYN Associates, if applicable, for today's service, and any subsequent services with OB/GYN Associates. I am aware that if I fail to pay any overdue balances and/or fail to commit to a pre-arranged payment plan, my account may be forwarded for further collection action, which may include, but is not limited to, late fees, attorney fees, and possibly third party collection agencies. In the event amounts become overdue, I agree and understand that credit reports and/or credit history may be obtained from credit reporting agencies. All costs associated to this action will be the responsibility of the patient or financially responsible guardian.

### **Authorization for Release of Medical Information**

I authorize any holder of medical information about me to release said information requested by insurance companies with whom I have coverage or any public agents for the purpose of payment, treatment, or operations for services provided. Release of information for any other purposes will require written consent from the patient/guardian/parent.

***I have read and understand these policies and hereby acknowledge receipt of a copy of this form, and agree to it's terms***

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (if different)

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