Blessings OB/GYN and Women's Health

REGISTRATION FORMS

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First: [First Name]	Middle:	Marital status: Single / Married / Divorced / Separated / Widow

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ◯ M ◯ F

Complete Address:

Social Security no:	Home phone no:	Cell phone no:
Pharmacy:	Pharmacy major cross streets:	Pharmacy Phone number:

Email:

INSURANCE INFORMATION

(Please provide your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	◯ Yes ◉ No	Is this patient covered by insurance?	◯ Yes ◯ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: Other: [Other insurance]

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: | Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: | Other:

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Blessings OB/GYN and women's health or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Blessings OB/GYN and Women's Health

HIPPA AUTHORIZATION FORM

Patient's Full Name	Patient Social Security Number
____	______________________________
Address	Patient's Date of Birth
____	______________________________
City, State, Zip Code	Patient's Telephone Number
____	______________________________

I authorize the following person (s):

____

To receive the following health information regarding my care (please select):

- ○ All medical information
- ○ Billing related information
- ○ My health information related to the following treatment or condition only:
  ____
- ○ Other:
  ____

DO YOU ALLOW INFORMATION REGARDING ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH BE DISCLOSED:

- ○ YES, DISCLOSE THIS INFORMATION *
- ○ NO, DO NOT DISCLOSE THIS INFORMATION *

*I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization anytime by notifying Blessings OB/GYN and Women's Health in writing. I understand that any revocation request will not be effective for any action taken prior to the request. Those actions cannot be reversed and this request will not affect those actions.

____ ____________________________

Patient Signature Date

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copy of medical records. This facility may apply a printing fee of $25.

Blessings OB/GYN and Women's Health

Financial Agreement

1. **Insurance-** We participate in most major insurance plans; however, please be aware that we may not participate in all of their individual plans. It is your responsibility to know your own insurance benefit, including whether or not we are an in-network provider with your plans network. It is also your responsibility to know your covered benefits and any exclusions in your insurance policy. ****If you choose to receive care prior to verifying this you understand you will be responsible for any out of network benefits which may include but are not limited to higher copays, deductibles, and co-insurance.**

2. **Non-payment**-If your account is over 90 days past due, you will receive a final notice letter stating that you have 10 days to pay your account in full. Partial payment will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid we will refer your account to an outside collection agency. An additional 30% will be added to any outstanding balance. You will be responsible for any collection fees, legal fees, or court costs incurred in the collection process.

3. All copays and deductibles must be paid in full at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. There may an instance where your insurance makes payment directly to you. You understand it is your responsibility to make payment to our office towards any balance due.

4. **Non-covered services-** Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by your insurance. You understand you will be responsible for payment of any denied charges. These must be paid in full at the time of your visit.

5. **Proof of insurance**- We must obtain a copy of your driver's license or passport and valid insurance card prior to your visit. If you fail to provide us with the correct insurance information you will be held responsible for the balance of the claim.

6. **Claim submission**- We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information to them directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claims. Your insurance benefit is a contract between you and your insurance company for payment of services.

7. **Coverage changes**- If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your claim is not paid within 45 days the balance will be automatically billed to you. It is then your responsibility to work with your insurance company for payment of services.

8. We have an on-site lab for patient convenience. They are not part of Blessings OB/GYN and Women's Care. Any bill related questions must be discussed with labs billing department.

9. **Release of Information**: I assign benefits of my medical insurance to Blessings OB/GYN and Women's Health and authorize payment directly to Blessings OB/GYN and Women's Health. I authorize Blessings OB/GYN and Women's Health to release medical information to payer as required for payment of claims for medical services.

We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

I have read and understand this Patient Financial Agreement. Any questions have been answered to me.

____ __________________________

Patient / Guardian Signature Date

Blessings OB/GYN and Women's Health

Medical Treatment agreement

Patient or the patients' legal representative agree to the following terms of encounter s with Blessings OB/GYN and Women's Health and its providers.

1. **Medical Treatment**: The patient consents to the treatment, services and procedures which may include but are not limited to laboratory procedures (including routine urine drug screens), X- ray examinations, telemedicine services, medical and surgical treatments or procedures or anesthesia.
2. **Release of Information**: The patient acknowledges and agrees that medical and/or financial records (including information regarding alcohol or drug abuse, HIV/AIDS related and/or to other communicable disease related information) may be release to the following:
   - **A.** Healthcare providers or their agent who are providing or have provided healthcare care to the patient
   - **B.** Any individual or entity responsible for payment as specified by patient on HIPPA authorization form
   - **C.** Provider and/or originations conducting review, quality assurance or peer review.
   - **D.** Blessings OB/GYN and Women's Health legal representatives and professional liability carriers.
   - **E.** Individuals and/or originations engaged in medical education and/or research provided that information may only be released without patient identifying information.
   - **F.** Individuals and entities as specified by federal and state law.
   - **G.** Patient records of services provided at any facility included outpatient surgery centers, hospitals, etc. may be exchanged among facilities to provide appropriate patient care
3. **Contraband**: Drugs, alcohol, weapons and other articles specified as contraband by Blessings OB/GYN and Women's Health may not be brought onto Blessings OB/GYN premises. Any illegal substance will be confiscated and turned over to law enforcement authorities.
4. **Dismissal from physician services:** Patient may be dismissed from Blessings OB/GYN and Women's Health for:
   - **A.** Excessive no-shows
   - **B.** Inappropriate or disruptive behavior towards other patients or staff
   - **C.** Failure to follow treatment recommendations
   - **D.** Providing false or inaccurate medical information in regards to previous medical care or medications
   - **E.** Failure to meet financial obligations
   - **F.** Failing to authorize the release of record to Blessings OB/GYN and Women's health.
5. **Photographs /Taped Sessions**: I understand and agree that a photograph may be take of me for identification purposes or for other treatment purposes. I further agree that therapy sessions may be taped (audio and or videotaping) and that all photographs and tapes will remain the property of Blessings OB/GYN and women's health. I will not audiotape, videotape or take pictures of Blessings OB/GYN and women's care staff without their permission/consent.

This agreement shall remain in effect as long as I am seeking services Blessings OB/GYN and women's health. I will be asked to sign a new agreement every year. This release shall continue for so long as the medical and /or financial records are needed for payment, treatment or healthcare operations.

____ _____________________________

Patient / Guardian Signature Date

Blessings OB/GYN and Women's Health

<u>Only AHCCCS patients</u>

AHCCCS Non-Covered Services Waiver

Date: ____ AHCCCS ID: _______________________________________

Name: ____

Any procedures and/or surgeries ordered by the physician will be verified with AHCCCS in advance and discussed with the patient. Should the procedure not be covered and you decide to follow through, you understand you will be held responsible for all costs. By signing below you are agreeing in advance to accept full responsibility for all costs as

____ ______________________________

Patient name Date

____

Patient Signature

Blessings OB/GYN and Women's Health

NOTICE!!!

FOR SHORT TERM DISABILITY AND FAMILY LEAVE OF ABSENCE FORMS

Please be aware there is a $25.00 charge per document (due at time of request) for all FMLA or short-term disability requests forms which typically take 5 – 7 business days to process.

You may have documents rushed (within 48 hours) for a $50.00 charge per document.

By signing below, you acknowledge that you have been notified of our price and turnaround time for processing documents.

____ ____

Signature Date

GYNECOLOGIC HISTORY QUESTIONNAIRE (please complete front and back)

Name: ____ DOB: _____________________ Date: _______________

Chief reason for today's visit: ____

First day of last menstrual period: ____

Date of last pap smear_____________________________ Results: ____

Type of birth control currently using____
(Including vasectomy, tubal ligation, condoms, abstinence, or natural family planning methods)

Are you happy with this type of birth control? ____

OBSTETRICAL HISTORY

Are you currently pregnant: Yes_______ No_______ If so, on what date what the first positive pregnancy test: _________________

Total number of times pregnant: (including miscarriages and abortions): ____

Total number of live births (include dates and types of deliveries): ____

____

Total number of miscarriages: ____________________________ Total number of abortions: _________________________________

Any complications during pregnancies? If so, please explain: ____

____

Did you have a Cesarean Section: If so, when: ____

Any family history of inherited disorders (i.e. Tay-Sachs, Spina Bifida, Down Syndrome, other genetic disorder):

____

GYNECOLOGICAL HISTORY

Age at first period: ___________________ how many days do your periods last: ____

How often do your periods come: Every 28-30 days _________ More frequently __________ Less frequently __________

How heavy is your menstrual flow: Light _______ Moderate_______ Heavy________ Extremely heavy___________

Do you have bad cramps: Yes ________ No ________ do you have PMS symptoms: Yes_______ No________

Any bleeding between periods: Yes _______ No _______ any bleeding after intercourse: Yes________ No_________

Any problems with urination (loss of urine when coughing, sneezing, etc.): Yes _______ No _______

Check any of the following that you have had either in the past or currently:

_________ Pelvic Inflammatory Disease (PID) _________Vaginal Infections ________IUD Related Problems

_________Abnormal Pap Smears (what abnormality and when):____

Sexually transmitted disease: ________ Gonorrhea __________Chlamydia _________Herpes _________ other

MEDICAL HISTORY

How is your overall health: Excellent______ Good______ Fair______ Poor ______

Do you smoke: Yes______ No______ If yes, how much: _______packs per day how many years have you smoked_________

Are you a past smoker: Yes______ No_______ when did you quit: _____________

Do you drink alcohol: Yes______ No______ How many alcoholic beverages do you have in a week? ___________

Social drug use? Yes______ No______ If so, what type of drugs do you use: ____

Have you ever been diagnosed with a MEDICAL or PSYCHOLOGICAL condition: If so, what was the diagnosis and when:

____

Have you ever been hospitalized for a medical illness? If so please explain: ____

____

What surgeries have you had? (Please provide the year including cosmetic)____

____

Do you have allergies to any medications: Yes______ No______ Do you have any other allergies: Yes______ No______

Please list: ____ Please list: ____

____ ____

____ ____

Do you have any history of a bleeding disorder: Yes______ No_______ had a blood transfusion: Yes______ No______

Do you use medication on a regular basis? Please list the name and dosages: ____

____

Have you had a mammogram: Yes______ No______ Date and result of last mammogram: ____________________________

Do you have any problems with your breasts: (lumps, discharge, or pain) ____

FAMILY HISTORY (Please check if anyone in your family has had any of these conditions and their relationship to you)

Breast Cancer ______________ Uterine Cancer________________ Ovarian Cancer________________ Colon Cancer_____________

Diabetes_____________ Heart Disease_____________ High Blood Pressure_____________ Stroke_____________

Osteoporosis_____________ Thyroid Disease _____________ Autoimmune Disease_____________ Other_____________

SOCIAL HISTORY

Marital Status ___________________________ Occupation ____