PATIENT INFORMATION

DATE: ____________

PATIENT'S NAME: ____
FIRST MIDDLE LAST MAIDEN NAME

BIRTH DATE: ______________ **AGE:**______ **MARITAL STATUS:** ____________ **SS#:** ______________

CONTACT PHONE NUMBER: ______________________ **EMAIL:** ______________________

CURRENT ADDRESS: ____
STREET APT# CITY STATE ZIPCODE

SPOUSE NAME: ______________________________ **SPOUSE PHONE:** ______________

RACE: CAUCASIAN, HISPANIC, ASIAN, AFRICAN AMERICAN, OTHER

RESPONSIBLE FOR BILL: ____

PREFERRED LANGUAGE: ENGLISH, SPANISH, VIETNAMESE, OTHER ____________

PATIENT'S EMPLOYER: ____
COMPANY NAME PHONE NUMBER

SPOUSE'S EMPLOYER: ____
COMPANY NAME PHONE NUMBER

PERSON TO NOTIFY IN CASE OF EMERGENCY: ______________________________
(OTHER THAN SPOUSE)

HOW RELATED: ____
PHONE NUMBER

PRIMARY CARE PHYSICIAN: ______________ **MEDICAL INFORMATION SHARED WITH:** ______________
NAME

IN ORDER FOR INSURANCE CLAIMS TO BE FILED CORRECTLY, PLEASE FILL OUT INSURANCE INFORMATION COMPLETLY

PRIMARY INSURANCE: ____
NAME OF INSURANCE EMPLOYER

____
CLAIM MAILING ADDRESS POLICY HOLDER

____
IDENTIFICATION NUMBER GROUP NUMBER POLICY HOLDER SS NUMBER

POLICY HOLDER BIRTH DATE: ______________ **GENDER**: MALE or FEMALE
MONTH DAY YEAR

SECONDARY INSURANCE: ____
NAME OF INSURANCE EMPLOYER

____
CLAIM MAILING ADDRESS POLICY HOLDER

____
IDENTIFICATION NUMBER GROUP NUMBER POLICY HOLDER SS NUMBER

POLICY HOLDER BIRTH DATE: ______________ **GENDER**: MALE or FEMALE
MONTH DAY YEAR

I hereby authorize College Hill staff to release any records/information needed to process medical/surgical health insurance claims. I authorize medical/surgical benefits for services performed by the College Hill OB/GYN Physicians. I also understand that regardless of insurance coverage, I am responsible for payment of all services provided by the Physicians at College Hill OB/GYN. A copy of this authorization is as valid as the original.

____
SIGNATURE **DATE**

2020

FINANCIAL POLICIES AND PROCEDURES

We are pleased to participate in your health care and look forward to establishing a lasting relationship as your health care providers. These policies and procedures will establish the expectations you will receive from our providers and what we expect from you as our patient. To create mutual understanding, we request that you carefully read and sign the financial policies and procedures of College Hill Obstetrics and Gynecology.

1. **Please arrive 10-15 minutes prior to your appointment** to complete the registration process. Please bring a photo ID, current insurance card, relevant medical records and a form of payment.
2. **Insurance:** Our practice participates with most major insurance plans. It is the patient's responsibility to be well-informed of their insurance benefits and the requirements therein, i.e. copays, deductibles, coinsurance, pre-existing clauses and any benefit exclusions. Medicare patients having surgery may be asked to sign an ABN.
3. **Insurance:** It is the patient's responsibility to provide our office with a current insurance identification card at each visit. If our office is not notified of updates or changes to your policy, you will be financially responsible for the entire amount due for that date of service.
4. **Copayments:** All COPAYS are due at the time of service.
5. **Procedures / Surgeries:** In the event of a scheduled surgery or procedure, during your pre-op visit our office will collect any co pays, deductibles and co-insurance determined by your insurance company. Out of pocket expense must be paid 3 weeks before surgery.
6. **Deductibles for OB Patients:** Prior to your first OB visit, we will meet with you to sign the Pregnancy Financial Policy to pay your deductible via monthly payments. You must pay a portion of your deductible prior to your first visit.
7. **Self-Pay:** Should you not have health insurance coverage, you will be responsible for paying your scheduled procedure balance prior to services. Any services that occur during that visit will be billed to the patient. Pathology and or lab charges that arise during the visit will also be the patients' responsibility. All Self-Pay OB patients are required to pay $400 to cover the cost of the exam and lab and will sign the Pregnancy Financial Policy and pay their balance via monthly payments.
8. **Forms of payment:** We accept cash, checks, Visa, MasterCard, Discover and Care Credit. A fee of $35 will be charged to the patient in the event of a returned check fee.
9. **Referrals / Preauthorization:** It is the responsibility of the patient to obtain any referrals and/or pre-certifications required by your insurance company prior to your visit. In the event a referral is required and not obtained, payment for services rendered will be the patient's responsibility at the time of service.
10. **Lab:** Based on the terms of your insurance policy, our office is required to utilize a contracted laboratory for your test results. In the event you receive a bill from that lab and have questions, please contact their office directly as we do not have access to the statement that the laboratory has sent you.
11. **Account balances / collections:** Accounts with a balance over 45 days old will be considered delinquent. Our office will attempt to collect this balance through statements and collection calls. Therefore, if for any reason, you are unable to settle your account within 45 day, it is imperative that you contact our business office to establish payment arrangements.
    a. It is important to note that any balance over 90 days old may be placed with a collection agency and/or credit bureau. If it becomes necessary to utilize an outside collection agency, you will be charged the amount for the collection fees, attorney fees, and allowable court fees. If you disregard our collection attempts, we can only assume that you do not intend to pay for the medical services that were provided to you in good faith, thus our professional relationship could be dissolved.
12. **Prescription refills / after hour calls:** For non-emergent routine issues, i.e. prescriptions refills, test results, medication questions, we ask that you please contact our office between the hours of 9 a.m. to 4:30 p.m., Monday thru Thursday and 9 a.m. to 11:30 on Friday. Regarding prescriptions refills, you must contact your pharmacy to request any refills and they will in turn contact our office via fax or electronic prescriptions for authorization. Refills will not be processed after hours.
13. **Medical Record Request:** Due to HIPPA compliance, all request for copies of medical records must be in written form and signed by the patient. A fee will be assessed.
14. **FMLA / Disability Forms:** A fee of $10 if paying cash or a fee of $12.50 if paying via credit card will be charged to the patient for completion of FMLA, short term disability and creditor forms please be sure you have completed your portion of any form. Please allow 10-14 days for medical records request and disability forms.
15. **Effective January 1, 2019** any patient who fails to show or cancels an appointment with less than a 24 hours may be charged $50. This will be billed to the patient and not insurance and is due at the time of the patient's next office visit prior to the visit. A patient may be terminated from the practice after 3 of these last minute cancels or no shows.
16. **Effective January 1, 2019** any patient who no shows or cancels a surgery with less than 24 hours may be charged $150. This is billed to the patient and not insurance and is due prior to rescheduling surgery.
17. **Refunds:** Patient refunds of $25 or greater will automatically be processed back to the credit card or mailed to the address on file. Amounts less than $25 will remain on the patients account as a credit, unless a refund is requested.

Our practice believes that a good physician-patient relationship is based upon understanding and good communication. Questions regarding College Hill OB/GYN policies and procedures should be directed to our practice administrator. Please sign that you have read and agree to the financial policies and procedures.

____________________________ Patient Signature

____________________ Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of College Hill OB/GYN, P.A.'s Notice of Privacy Practices.

______________________________	______________________________
Signature of Patient/Personal Representative	Date
______________________________	______________________________
Relationship to Patient	Patient's Name

For College Hill OB/GYN, P.A. Use Only

The above named Patient Personal Representative was provided with a copy of College Hill OB/GYN, P.A.'s Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of his/her receipt the Notice, but such acknowledgement could not be obtained because:

_____ Patient/Personal Representative refused to sign.

_____ Patient/Personal Representative was unable to sign.

_____ The patient had a medical emergency and an attempt to obtain the acknowledgement will be made at the next available opportunity.

_____ Other reason (please specify): ______________________________

____

____

Signature of workforce member completing form:

______________________________ ______________________________

Date

Original to be maintained in Patient's medical record

Date: ________ **Patient Name:** ____________________________ **DOB:** ________

PAIN MANAGEMENT AGREEMENT

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Medication Refill Information:

1. Prescription pain medications are allowed by the physicians at College Hill OB/GYN, P.A. for a maximum of six weeks after surgery or delivery.

2. Advance notice of 5-7 business days is required for all **narcotic prescription refills**.

3. Request for scheduled refills for **narcotics** must be telephoned to our office, only during regular office hours Monday-Thursday (8:30am- 4:00pm), Friday (8:30 – 12:00). Refills will not be made at night, on holidays, or on weekends.

4. Controlled substance cannot be telephoned in to the pharmacy.

5. All hard copies of the **narcotics** prescriptions must be hand delivered to the pharmacy by myself.

6. If College Hill OB/GYN, P.A. finds out you are receiving **narcotic prescriptions** from multiple physicians during the timeframe you are under our physicians' care, we have the right to fire you as a patient.

This agreement will supersede all other agreements.

By signing below I indicate that I understand AND agree to ALL the terms of the above agreement. I have received a Copy of this for my own records.

Patient Signature ________________________________ Date ______________________

COLLEGE HILL
Obstetrics & Gynecology

PATIENT HISTORY

DOCTORS REQUIRE THIS FORM TO BE COMPLETELY FILLED OUT EVERY 3 YEARS

NAME:	**DATE:**

Welcome:
Your accurate completion of this health history is greatly appreciated. This will allow us to more accurately address your health problems and make recommendations. This information enables us to spend more quality time evaluating your present concerns and less time on the collection process of your previous health history. Please let us know if you have any questions and thank you for your assistance.

DATE OF BIRTH:__________________ AGE:________________

PRIMARY CARE PROVIDER: ____

PREFERRED PHARMACY:____

MEDICATIONS: PLEASE LIST ANY CURRENT MEDICATIONS THAT YOU ARE TAKING (INCLUDING HERBAL & OVER THE COUNTER)____

VACCINES: PLEASE LIST ALL RECENT VACCINATIONS THAT YOU HAVE RECEIVED

____

ALLERGIES: PLEASE LIST ANY ALLERGIES TO MEDICATIONS/FOOD (LATEX OR IODINE)

____

PROBLEMS: PLEASE CHECK ALL THAT APPLY

- ❑ STD
- ❑ BREAST LUMP
- ❑ VAGINAL DISCHARGE
- ❑ PAINFUL PERIODS
- ❑ LACK OF PERIODS
- ❑ IRREGULAR PERIODS
- ❑ ABNORMAL UTERINE BLEEDING
- ❑ PREGNANCY
- ❑ VAGINAL ITCHING
- ❑ ABNORMAL CERVICAL PAP SMEAR
- ❑ INFERTILITY
- ❑ BIRTH CONTROL
- ❑ SURGERY CONSULTATION
- ❑ PELVIC/ABDOMINAL PAIN
- ❑ CYST/FIBROIDS
- ❑ MENOPAUSE/ HORMONES
- ❑ OTHER ____________________________

GYNECOLOGY HISTORY:

DATE OF LAST PAP SMEAR:

________RESULT________?

HPV VACCINE:______________

SEXUALLY ACTIVE?____________

SEXUAL PROBLEMS?___________

STIs/STDs:_______________

DATE OF MOST RECENT MAMMOGRAM:_________

AGE AT FIRST CHILD:___________

CURRENT BIRTH CONTROL METHOD:___________________

DESIRED BIRTH CONTROL METHOD:

____

ABNORMAL PAP: YES / NO

LAST MENSTRUAL PERIOD:________

HOW MANY DAYS DO YOU FLOW?

____

ARE YOUR FLOWS LIGHT OR HEAVY?___________________

FREQUENCY OF CYCLE:_________

AGE THAT YOU STARTED YOUR MENSTRUAL CYCLE:____________

IF POST MENOPAUSAL, AGE AT MENOPAUSE:_______________

PRENATAL HISTORY:

TOTAL PREGNANCIES:___TOTAL MISCARRIAGES:____TOTAL ABORTIONS:_____CHILDREN LIVING____ECTOPIC PREG:____

BIRTH DATE	SEX	WEIGHT	TYPE OF DELIVERY	COMPLICATION	LOCATION

FAMILY HISTORY: PLEASE LIST ANY FAMILY MEMBERS WITH THE FOLLOWING ILLNESSES (PARENTS, GRANDPARENTS, AUNTS OR UNCLES) ****PLEASE SPECIFY**** PATERNAL / MATERNAL (?)

HEART DISEASE:____________________ TUBERCULOSIS:______________ STROKE:___________________

HIGH BLOOD PRESSURE:______________ BREAST CANCER:_____________ KIDNEY DISEASE:______________

DIABETES:_______________________ COLON CANCER:______________ OSTEOPOROSIS:_______________

CANCER:__________________ OVARIAN CANCER:____________ THYROID DISORDER:__________

SOCIAL HISTORY:

a. CIGARETTE SMOKING: YES / NO AMOUNT:____

b. TOBACCO YEARS OF USE____

c. FREQUENCY OF ALCOHOL USE:____

d. HISTORY OF ANY DRUG USE:____

e. OCCUPATION OR TYPE OF EMPLOYMENT:____

SURGICAL HISTORY: PLEASE LIST ALL SURGERY YOU HAVE HAD AND APPROXIMATE DATES:

a. ______________________________

b. ______________________________

c. ______________________________

d. ______________________________

PAST MEDICAL HISTORY: PLEASE CHECK ALL THAT APPLY

DOMESTIC VIOLENCE ____________
ACID REFLUX ____________
ANEMIA ____________
ANESTHESIA
COMPLICATIONS ____________
ARTHRITIS ____________
ASTHMA ____________
BIRTH DEFECTS OR INHERITED
DISEASE ____________
BLOOD TRANSFUSION ____________
BREAST CANCER ____________
BREAST PROBLEM ____________
CANCER ____________
DEPRESSION ____________
DIABETES ____________
EATING DISORDER ____________
ECZEMA ____________
ENDOMETRIOSIS ____________
FIBROMYALGIA ____________
GI PROBLEMS ____________

HEADACHES ____________
HEART DISEASE ____________
HEART PROBLEMS ____________
HEPATITIS ____________
HIGH CHOLESTEROL ____________
HYPERTENSION ____________
INFERTILITY ____________
KIDNEY DISEASE ____________
KIDNEY OR BLADDER
PROBLEMS ____________
LUNG DISEASE ____________
OSTEOPOROSIS ____________
OTHER ____________
OVARIAN CANCER ____________
POLYPS ____________
PRE-ECLAMPSIA ____________
PSYCHIATRIC ILLNESS ____________
STROKE ____________
THROMBOPHILIAS ____________
THYROID PROBLEMS ____________
VARICOSTIES ____________

Any history of MRSA? If yes, when? Have you tested negative since your positive test of MRSA?

____

____

REVIEW OF SYMPTOMS: ARE YOU PRESENTLY HAVING ANY OF THESE PROBLEMS?

CHEST PAIN, SHORTNESS OF BREATH, IRREGULAR HEART RATE
COUGHING UP OF SPUTUM, BLOOD OR WHEEZING
BREAST PAIN, NIPPLE DISCHARGE OR BLEEDING
ABDOMINAL PAIN
BLACK, TARRY STOOLS, BLOOD OR MUCUS IN STOOLS
PERSISTENT DIARRHEA OR CONSTIPATION
PAIN OR SWELLING OF JOINTS
BURNING WITH URINATION, BLOOD IN URINE OR UNUSUAL URINARY FREQUENCY
INVOLUNTARY LOSS OF URINE
VAGINAL DISCHARGE, BURNING OR ITCHING
PAINFUL INTERCOURSE
PELVIC PAIN

QUESTIONS? ______________________________

____

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.

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	
Do you have a family history of **other cancers**?	☐ Y ☐ N	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: ______________________