Comprehensive OBGYN Care

A division of Southern New England Healthcare for Women, LLC

A Michael Coppa M.D. | Jeiny Zapata APRN

725 Reservoir Avenue, Cranston, RI 02910
Office: (401) 946-4022 Fax: (401) 946-4077
Office hours are: Monday 9am-5pm
Tuesday 9am-5pm
Wednesday 9am-2pm
Thursday 9am-5pm
Friday 9am-4pm

14 Cedar Swamp Road, Smithfield, RI 02917
Office: (401) 231-1450 Fax: (401) 946-4077
Monday 1pm-5pm

The Doctor and the staff at Comprehensive OBGYN Care would like to welcome you to our practice. We look forward to providing you quality care and will do our best to make your visit positive and successful. Enclosed you will find information that is important to review, as it states our policies of the office and to protection of your privacy. Thank you for choosing Comprehensive OB/GYN Care.

Our office offers the following Services and Procedures

▪Doctors on call24/7 ▪On-Site Lab ▪Infertility ▪Family planning ▪Non-Stress Testing
▪Fetal Surveillance ▪Complete Pre & Post Natal Testing ▪Normal & High Risk Pregnancies
▪Compassionate Postpartum Care ▪Infertility ▪The Latest in Surgical, Laser & Laparoscopic Procedures
▪Urinary Incontinence ▪Menstrual Problems ▪Management of Menopause
▪Testing & Treatment for STD and HPV ▪Offer variety of Birth Control Contraceptive Options
▪Low libido ▪Hypothyroidism ▪Vitamin B12 and/or D deficiency ▪Obesity

Prescription Refills- Any prescription refill request should be called in to your pharmacy. Refills will not be filled during non-business hours.

Release of Medical Records- For your protection, we allow for the release of medical records only with your written consent. However, there is a fee associated with the release of medical records. Simply contact our office and we will happy to provide you with the medical request form that outlines fees, and necessary information needed to initiate your request.

Missed Appointments- You share responsibility of your medical care and obligated to keep your scheduled appointments. If you are unable to keep your appointment, we require 24 hours notice. If you miss the appointment without notice, you will be charged a No-Show fee of $50.00. Patients who are more than 15 minutes late may have to reschedule.

Insurance Cards- Please be sure to bring your insurance card(s) and a picture ID with you to your appointment. If your insurance requires a referral, please be sure to bring it with you or have the office fax the referral to us. If you have had blood work, mammograms, or any other testing done, please have your doctor forward copies to us prior to your visit or bring a copy with you.

Emergencies-If you have an emergency during office hours, please call our office. If you have an emergency after hours, our answering service will contact the physician on call. If necessary, call 911 or go to the nearest emergency room.

PATIENT REGISTRATION

Last Name: ____________________ First Name: _____________________ Date of Birth: ____________

Maiden Name: _________________ Marital Status: __S __M__D__W Social Security #_______________

Address: ___________________________ Apt. # ______ City:______________ State: ____ Zip: _______

Home Phone: __________________ Work Phone: __________________ Cell Phone: ________________

Email: _____________________ Preferred method of Contact: (Please Circle One) Home# Work# Cell#

Language: ☐ English ☐ Spanish ☐ Other _________ Race: ____________ Ethnicity: ______________

Employer: ______________________ Occupation: ___________________ Phone: __________________

Partner's Name: _______________________ Date of Birth: ___________ Phone: __________________

Primary Care Physician: _______________________________ **PCP Phone**: ________________________

PCP Address: __________________________ City: ____________________ State: _____ Zip: ________

Pharmacy: _________________________________ **Pharmacy Phone**: ___________________________

EMERGENCY CONTACT

Name: _______________________ Relationship: ______________ Phone: ________________________

INSURANCE INFORMATION

Insurance Plan Name:____

Insurance Co. Address: _______________________ City: __________________ State: ____ Zip: _______

Policy Holder Name: _______________________________ Relationship: _________________________

Policy Holder Date of Birth: __________________

Policy #: _________________________________ Group #: ____________________________________

IF YOU HAVE TWO INSURANCES, PLEASE COMPLETE THE FOLLOWING:

Secondary Insurance Plan Name: ____

Insurance Co. Address: _____________________________ City: _____________ State: ____ Zip: _____

Policy Holder Name: __________________________________ Relationship: ______________________

Policy Holder Date of Birth: ____________________

Policy #: ___________________________________ Group #: __________________________________

I hereby authorize release of information necessary to file claim with my insurance company and assign to Southern New England Healthcare for Women (SNEHW). I agree that I will pay any collection or attorney fees and costs incurred in collection of my account by SNEHW. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to provide the practice with current/updated insurance information, obtaining the necessary referral and/or other authorization from my primary care and/or referring physician when required. A copy of this signature is a valid original.

I also acknowledge that the practice had made the Health Insurance Portability and Accountability Act (HIPPA) notice effective April 13, 2003 available to me on the date indicated below.

Patient Signature ____ Date _____________________

HISTORY INTAKE

Today's Date: ________________________

Last Name: __________________________ **First Name:** ________________ **Date of Birth**: ______________

Important: In order to provide the highest quality health care possible, it is important that we have the following information. Please answer all the questions as accurately as possible. If you do not understand the question, please ask for assistance. Thank you.

PHARMACY _______________________________ **PHARMACY PHONE** ________________________________

Address ________________________________ City _________________ State _______ Zip ______________

PRIMARY CARE PHYSICIAN _______________________________ **PCP PHONE:** _________________________

Address ________________________________ City _________________ State _______ Zip ______________

TELLS US ABOUT OTHER PHYSICIANS WHO YOU MAY SEE:

PHYSICIAN _______________________________ **SPECIALTY:** ______________ _________________________

Phone: _________________________ Address ____

PHYSICIAN _______________________________ **SPECIALTY:** ______________ _________________________

Phone: _________________________ Address ____

LIST ANY ALLERGIES: ____

____

LIST ALL MEDICATIONS: PRESCRIBED, OVER THE COUNTER AND HERBAL

May we have your permission to contact your insurance to obtain a list of the medications you have had filled during the last 13 months? YES NO

MEDICATION/DOSE/FREQUENCY	MEDICATION/DOSE/FREQUENCY

Last Name: ___________________________ **First Name:** ________________ **Date of Birth**: ______________

GYN HISTORY

Age your period began:				
Date of Last Pap Smear				
Have you ever had an abnormal pap smear?	Yes	No		
Are you sexually active?	Yes	No	If Yes,	Men Women Both
Current Birth Control Method				
Have you ever been diagnosed with any sexually transmitted infection or disease?				
Have you had an HPV vaccine?				
If Post Menopausal, Age at Menopause				
Are you currently taking any Hormone Replacement Therapy medications?	Yes	No	Have you ever taken any Hormone Replacement Therapy medications?	Yes No
Have you had any post menopausal bleeding?	Yes	No		
Date of Last Mammogram:				
Date of Last Colonoscopy:				
Date of most recent bone density?				

OBSTETRICAL HISTORY

Have you ever been pregnant? (Including termination of pregnancy) YES NO

How many times have you been pregnant? _____________

□ number of full-term delivery(s) _________ □ number of premature delivery(s) _________

□ number of terminations/abortions _________ □ number of miscarriages ____________

□ number of tubal pregnancies _________ □ number of twins/triplets ___________

How many children living? _______________

PAST PREGNANCIES

Last Name: ___________________________ **First Name:** _________________ **Date of Birth**: _______________

	Delivery Date	# of Fetus	Weight	Sex	Delivery Type	Full-term or Pre-mature	Complications during pregnancy or delivery
1							
2							
3							
4							
5							
6							

PAST MEDICAL HISTORY: Circle all that apply.

Arthritis	Yes No	GI Problems (please specify)	Yes No
Acid Reflux(GERD)	Yes No	GYN Cancer(please specify)	Yes No
AIDS/HIV	Yes No	Headaches/Migraines	Yes No
Anemia	Yes No	Heart Problems	Yes No
Anxiety/Depression	Yes No	Hematologic Disorders(please specify)	Yes No
Asthma	Yes No	Hepatitis	Yes No
Bladder Disorder (please specify)	Yes No	High Cholesterol	Yes No
Breast Cancer	Yes No	High Blood Pressure	Yes No
Cancer (please specify)	Yes No	Kidney Disorder(please specify)	Yes No
Coronary Artery Disease	Yes No	Lung Disease(please specify)	Yes No
Diabetes	Yes No	Osteoporosis/Osteopenia	Yes No
DVT/PE	Yes No	Psychiatric Illness	Yes No
Endometriosis	Yes No	Stroke	Yes No
Glaucoma	Yes No	Thrombophilia	Yes No
Fibromyalgia	Yes No	Thyroid Disorder	Yes No
Other			

SURGICAL HISTORY – Please list any surgery you may have had in the past.

Type of Surgery	Date of Surgery

FAMILY HISTORY

Last Name: ___________________________ **First Name:** ________________ **Date of Birth**: ______________

Mother □ Living □ Deceased - Cause and Age at death: ______________________________

Father □ Living □ Deceased - Cause and Age at death: ______________________________

Number of Siblings: _________ Living ___________ Deceased __________ Cause ____________________

Has any of your blood relative(s) had the following, also specify the age and relationship:

	Yes/No	Relative		Yes/No	Relative
Ovarian Cancer			High Blood Pressure		
Uterine Cancer			Kidney Disease		
Colon Cancer			Hyperlipidemia		
Breast Cancer			Diabetes		
Melanoma			Depression		
Prostate Cancer			Bipolar Disorder		
Heart Disease			Stroke		
Thyroid Disease			Osteoporosis		
Other					

SOCIAL HISTORY

Occupation: ____

Level of Education: ____

Marital Status: (circle one) Single Married Divorced Separated Widowed Domestic Partner

Exercise Level: (circle one) None Occasional Moderate Heavy

Smoking Status: (circle one) Never a smoker Former Smoker Smoker Have been smoking since ____years old

Alcohol Intake: (circle one) None Occasional Moderate Heavy

Do you use illicit drugs? No Yes ____

Have you ever had abuse or domestic violence directed at you: No Yes

Do you routinely use a seat belt? No Yes Do you use sunscreen regularly? No Yes

Is a blood transfusion acceptable in an emergency? No Yes

Do you have an advanced directive? No Yes

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Patients’ Financial Policy

Participating Insurance

- Comprehensive OBGYN Care participates with most medical insurance plans in the area.
- We will file a claim on your behalf and accept contracted payments for covered services.
- You are responsible to pay for plan deductibles; co-insurance and co-payments associated with the services rendered (out of pocket expenses).
- You are responsible to pay for services that your medical insurance plan does not cover or that they determine are not medically necessary.
- Co-payments will be collected at the time of service.

Non-Participating Insurances

- If Comprehensive OBGYN Care does not participate with your insurance plan, you are responsible for payment of all charges associated with the services you received.

No Insurance

- Payment is expected at time of service.
- Payment plans are available but must be established before services rendered.

Outstanding Balances

- Patients with an outstanding balanced with Comprehensive OBGYN Care will be expected to pay that balance, or commit to a payment plan before additional services are rendered.
- Outstanding balances may include co-insurance, co-insurance and/or non-covered services from prior visit, etc.
- Outstanding balances may also include amounts due for services provided by Dr. A Michael Coppa M.D. or Women and Infants Hospital.
- We reserve the right to reschedule your appointments if you have a balance that is greater than 60 days, have been sent to collections, and/or no payment arrangements have been made.

We accept Cash, MasterCard, Visa and Discover. We DO NOT accept checks!

Please read and sign below

I hereby authorize release of information necessary to file claim with my insurance company and assign benefits to Comprehensive OBGYN Care. I understand and accept that I am financially responsible for balances not covered by my insurance carrier. A copy of this signature is valid as original.

____ ________________

Signature of Patient or Responsible Party Date

____

Printed name of Patient

Attention All Patients!

No Show Policy

Patient Name: ________________________________ DOB ____________________

By signing this document, you understand and will abide by the policy that Comprehensive OBGYN Care has for missed appointments. The No Show Policy encompasses that if a patient needs to reschedule or cancel a scheduled appointment, the patient is responsible to do so with at least a 24 hour notice. If you, the patient, do not give a 24 hour notice or if you do not show up to your scheduled appointment, you are subject to be charged a $50.00 No Show fee for a missed appointment or procedure.

____ ____________________

Signature of Patient or Responsible Party Date