
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.

COMPREHENSIVE OBGYN CARE

A Division of Southern New England Care for Women, LLC

A. Michael Coppa, M.D.

Jeiny Zapata, APRN

Board Certified Obstetrics & Gynecology

725 Reservoir Avenue Suite 203
Cranston, RI 02910
Tel. (401) 946-4022 Fax (401) 946-4077

14 Cedar Swamp Road
Smithfield, RI 02917
Tel. (401) 231-1450 Fax (401) 946-4077

Dear Patient:

You are receiving this paperwork because you have an upcoming appointment with us on

*******PLEASE ARRIVE 15-20 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT TIME*******

We would greatly appreciate your cooperation by completing the enclosed packet and bringing it back to us on your scheduled appointment. Also please bring your insurance cards with you on the day of your appointment.

I want to thank you in advance and we look forward to seeing you at your visit.

Sincerely,

Jeiny Zapata APRN and Staff.

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 _____

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, (circle one) Men Women Both _____

Current Birth Control Method _____

If Post-Menopausal, age at Menopause _____

Are you currently taking any Hormone Therapy medications? Yes No _____

Have you ever used Hormone Therapy medications in the Past? 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: _____

PAST MEDICAL HISTORY

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	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 surgeries you may have had in the past.

TYPE OF SURGERY	DATE OF SURGERY

FAMILY HISTORY

Mother: Living Deceased –Cause of Death: _____

Father: Living Deceased – Cause of Death: _____

Number of Siblings: ____ Living: ____ Deceased: ____ If so, what was the cause? _____

Have any of your blood relatives had the following? If so, please specify the age and relationship. Also state if maternal (M) or paternal (P).

	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: _____

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

How many children? _____

Exercise level: (Circle one) None Occasional Moderate Heavy _____

Smoking Status: (Circle one) Never a Smoker Former Smoker Smoker, for how many years? _____

Alcohol Intake: (Circle one) None Occasional Moderate Heavy _____

Do you use any illicit drugs? No Yes If yes, please state what drug(s) _____

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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

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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