WELCOME TO OUR OFFICE

We are delighted to have you as our new patient and look forward to providing you with the highest quality healthcare.

Please take a moment to review and complete the attached paperwork. Please bring the completed forms to your upcoming visit and **plan to arrive at least 15 minutes** prior to your appointment time. If you plan to fill out your forms at our office, **please arrive at least 20 minutes** before your scheduled appointment time. We realize that your time is important, and we strive to keep your wait to a minimum. We do our best to stay on schedule**. IF YOU ARE MORE THAN 15 MINUTES LATE, OR YOU DO NOT HAVE THE REQUIRED DOCUMENTS: PHOTO IDENTIFICATION, INSURANCE CARD, CO-PAYMENT AND REFERRAL (IF REQUIRED BY YOUR INSURANCE) YOU WILL NEED TO RESCHEDULE YOUR APPOINTMENT.**

Since we value your time and do not overbook our schedule, we require 24- hour notice to cancel or reschedule your appointment. A fee of $35.00 will be assessed for all "No Show" appointments or appointments cancelled with less than 24-hour notice to our practice. The fee for Monday evening late cancellation or "No Show" appointment is $100.

You will receive an email from our office requesting that you register for the **Patient Portal**. Click on the "**REGISTER**" button in the email. You will then be asked to verify your identity. You will be sent a temporary access code. After entering the code and choosing your password, please also check the boxes to **accept the terms and conditions** of the portal and **remember computer**. You will now be logged into your portal account. Once in your portal account you can fill in your information including your **Health History Form**. This is the preferred method, as the information you complete online can be automatically downloaded into your chart once you arrive for your appointment. If you would rather fill out the forms for your health history, kindly bring them with you to your appointment.

Thank you for choosing our office for your gynecological needs. If you have any further questions, please feel free to contact our office at **609-448-7800** during our scheduled hours: **Monday 9-7, Tuesday Wednesday and Thursday 9-5, and Friday 8-2**.

We look forward to meeting you at your visit!

PATIENT REGISTRATION INFORMATION

First Name: _____Middle: _____ Last Name: _____

Sex: M F Date of Birth: _____ Marital Status: S M D W Domestic Partner

Address: _____City: _____Zip: _____

Telephone: _____ Cell Phone: _____Email _____

How did you hear about our practice?_____

Primary Care Physician: _____ Preferred Imaging Facility:_____

Pharmacy:

_____

PARENT INFORMATION (FOR ADOLESCENTS UNDER 18)

Name: _____ Date of Birth: _____Sex: M F

Address (if different than above): _____

Telephone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Employer Address/Phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____ Telephone: _____

PRIMARY INSURANCE CARRIER

Carrier: _____ID#: _____ Group#: _____

Claims Address: _____ Telephone: _____

Policy Holder: __SELF __OTHER (Name) _____ DOB: _____Relationship: _____

SECONDARY INSURANCE CARRIER

Carrier: _____ID#: _____ Group#: _____

Claims Address: _____ Telephone: _____

Policy Holder: __SELF __OTHER (Name) _____ DOB: _____Relationship: _____

I hereby grant permission to ANTHEIA GYNECOLOGY (ANTHEIAOBGYN, LLC) to employ such medical, surgical and lab/x-ray procedures as my doctor may consider necessary in my diagnosis and treatment. I authorize the holder of medical or other information to release to my insurance carrier, governmental agency (or its intermediary) any information needed for this or related insurance claim. I agree to pay any charges incurred by me to ANTHEIA GYNECOLOGY (ANTHEIAOBGYN, LLC).

_____ _____

Signature of Patient or Parent if Patient is a Minor Date

Antheia GYNECOLOGY

ASSIGNMENT OF BENEFITS

I hereby request that payment of insurance benefits be made directly to:

I hereby request that payment of insurance benefits be made directly to:

ANTHEIA OBGYN, LLC
Helen Simigiannis, MD

On my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges relating to the service(s) rendered to my dependent or myself. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay my portion promptly.

In the event that my insurance company sends payment by check directly to me, I agree to endorse and forward such a check to ANTHEIA OBGYN, LLC. If I deposit such a check in to my personal account, I agree to send ANTHEIA OBGYN, LLC payment for the equivalent amount promptly.

Patient Name (please print): _____

Patient Signature: _____

Date: _____

FINANCIAL POLICIES AGREEMENT *INITIAL EACH LINE*

_____I understand that I am presenting myself in the office today for medical services to be performed. While many insurance companies cover the services that may be performed such as an annual exam (including pap smear, breast exam, other age appropriate screenings), biopsies, colposcopies and injections, I have been informed that some insurance companies do not. If my insurance company does not pay Antheia Gynecology for the services performed today I understand that any charges incurred during my exam will be my financial responsibility.

_____If an abnormality is encountered or a pre-existing problem is addressed in the process of performing an annual exam I may be billed for an office visit as well as an annual exam. This will be billed to my insurance company as a significant, separately identifiable service that was provided by the same physician on the same day as the preventative or annual exam.

_____I understand that I will also be responsible for any co-payment or coinsurance payment due to Antheia Gynecology at the time of service, per the requirements of my health insurance plan contract. I also understand that I will be responsible for payment for charges in full if I do not have any health insurance coverage on the date of service.

_____I understand that if I require a referral or pre-authorization for Antheia Gynecology's services or any additional services recommended by Antheia Gynecology (including but not limited to lab work and radiology); I am responsible for either obtaining the correct referral.

_____I understand that all co-pays are due at the time of service and are collected prior to the visit.

_____I understand that there is a $35.00 fee for returned checks and a $35.00 fee for appointments cancelled with less than 24- hour notice. The fee for Monday evening appointments cancelled with less than 24-hour notice is $100.

_____I agree to the above financial policy. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release information necessary to secure the payment of benefits.

_____I understand that all laboratory services are billed separately by the reference lab.

_____I understand that if I am a self-pay patient, that the fee paid to the office does not include laboratory fees and that I will be billed separately by the reference lab.

Signature of Patient (Parent if patient is a minor) _____ Date: _____

Antheia
GYNECOLOGY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION & HIPAA

I authorize the release of my protected health information to the following physician(s) or facility(s) upon request of the physician(s)or facility(s) for the purpose of my treatment.

Name of Designated Physician or Facility: _____

Type of Physician or Facility: _____

___ I do NOT wish to designate a physician or facility

I authorize the staff and/or practitioners at Antheia Gynecology to discuss my healthcare, diagnosis, test results, procedures, prognosis, insurance and billing information with the following for the purpose of my treatment or payment of services rendered:

Name of Designated Individual_____ Relationship_____

____ I do NOT wish to designate an individual

I authorize the staff at Antheia Gynecology to leave messages for any reason on my private voicemail:

_____

Phone Number

IF YOU AUTHORIZE THE BELOW CONSENTS, PLEASE INITIAL:

_____ Consent to call _____ Consent to text _____ Consent to access medication records

I understand and have been offered and/or received a copy of the HIPAA Notices of Privacy Practices for Antheia Gynecology.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Antheia
GYNECOLOGY

Name: _____ Date: ____

Medical History

Your medical history helps us prepare for your next visit. If you have any questions or concerns, you can discuss them with your healthcare provider. Your provider will review your information and use it as part of your ongoing medical record.

Allergies

List any medication or food allergies you have and your reactions: _____ No Allergies

Medication	**Reaction**

Current Medications

Include prescriptions, over-the-counter medications, vitamins, supplements, etc:

Medication	Strength	Frequency

Immunization History

Please check all immunizations received and indicate when you last received immunization:

	Date		Date
___Chickenpox		___MMR (Measles, Mumps, Rubella)	
___Flu Vaccine		___Pneumonia Vaccine	
___Gardasil/HPV	/ /	___Tdap Tetanus & Pertussis	
___Hepatitis A		___Tetanus	
___Hepatitis B		___Zostavax (Shingles)	
___Meningococcus			

Name: _____

Disease / Condition History

___ Anemia / Blood Disorder
___ Arthritis
___ Bleeding Disorder
___ Blood Clots or DVT
___ Blood Transfusions
___ Broken Bones
___ Cancer
___ Diabetes
___ Endometriosis
___ Fever
___ Easy Bruising / Bleeding
___ Fibromyalgia
___ Heavy Periods
___ Hepatitis
___ High Cholesterol
___ HIV / Aids
___ Hypertension
___ Kidney Disease
___ Kidney Stones
___ Leaking Urine
___ Leg / Foot Ulcers
___ Liver Disease
___Osteoporosis
___ Pulmonary Embolism
___ Swollen Glands
___ Tuberculosis
___ Vaginal Infections
___ Other

Surgical History

Surgery	Year

Family History:

Alcoholism, Arthritis, Depression, Cancer: Breast Cancer, Cervical Cancer, Colon Cancer, Ovarian Cancer, Uterine Cancer, Other Cancers, Diabetes, Genetic Diseases

Ovarian Cancer, Uterine Cancer, Other Cancers, Diabetes, Genetic Diseases,
Heart Disease, Hypertension, Osteoporosis, Stroke, etc.

Medical Condition	Relationship	Onset Age	Age at Death

Social History

Marital Status	___Single	___Married	___Divorced	
		___Widowed	___Living with Partner	
Are you sexually active?	**Yes / No**	Sexual Orientation _____		
Do you smoke?	**Yes / No**	If yes, how much_____		# of years _____
Do you drink alcoholic beverages?	**Yes / No**	If yes, how much_____		# of years _____
Do you use recreational drugs?	**Yes / No**	If yes, how much_____		# of years _____
Do you drink caffeine?	**Yes / No**	If yes, how much_____		# of years _____
How much do you exercise?	___None	___Occasional	___Moderate	___High

Name: _____

Are you currently experiencing any of the following:

Neurological	Current	History
Dizziness		
Fainting		
Headaches		
Memory Loss		
Migraines		
Numbness		
Restless Legs		
Seizures		
Weakness		

Respiratory	Current	History
Asthma		
COPD		
Cough		
Sleep Apnea		
Ear Pain		
Ringing in Ears		
Wheezing		

Musculoskeletal	Current	History
Back Pain		
Joint Pain		
Muscle Weakness		

Social/Emotional	Current	History
Alcohol Overuse		
Anxiety / Stress		
Bipolar Disease		
Depression		
Feel Unsafe in Relationship		
Mania		
Sleep Problems		

Name: _____

Gynecological History

	Date	Abnormal	Describe
Last Pap Smear		**Yes / No**	
Last Mammogram		**Yes / No**	
DEXA Scan		**Yes / No**	
Colonoscopy		**Yes / No**	

Age of First Menstrual Period _____

First Day of Last Menstrual Period _____

Check off all words that describe your periods:

•Bleeding	___Light	___Moderate	___Heavy
•Length of period	___Short	___Medium	___Long
•Rate pain of your period	___Painless	___Mild	___Painful

Do your periods affect your social life, fitness routine or sexual intimacy **Yes / No**

How many days of bleeding _____

How many days between periods _____

Bleeding between periods **Yes / No**

Number of Pregnancies _____

Number of Births _____

Number of Cesarean Sections _____

Age you delivered first child _____

Number of Abortions _____

Vaginal itching, burning or discharge **Yes / No**

Painful intercourse **Yes / No**

Painful intercourse	**Yes / No**	
Breast lump or nipple discharge	**Yes / No**	
Are you using contraception?	**Yes / No**	

•If yes, what method?	___BC Pills	___Condoms	___NuvaRing	___IUD	___Other

Are you satisfied with this method?	**Yes / No**	
Is your family complete?	**Yes / No**	
Are you Post - Menopausal	**Yes / No**	If yes, what age onset? _____ If yes, how long? _____
Have you used hormones for menopause?	**Yes / No**	

Patient Portal Access Authorization

You can access the Antheia Gynecology Patient Portal on our website: www.antheiagyn.com

You will need an email address, home/cell phone numbers

This is in addition to our current services and allows you 24/7 access to:

- Exchange messages with our practice
- Review billing statements
- Request appointments
- Research health topics
- Preview Personal Health Information
- Complete and update medical forms
- Update your profile and contact information

You will receive an email from our office requesting that you register for the Patient Portal. Click on the **"REGISTER"** button in the email. You will then be asked to verify your identity. You will be sent a temporary access code. After entering the code and choosing your password, please also check the boxes to **accept the terms and conditions** of the portal and **remember computer**. You will now be logged into your portal account. Once in your portal account you can fill in your information including your **Health History Form**. This is the preferred method, as the information you complete online can be automatically downloaded into your chart once you arrive for your appointment. If you would prefer to fill out the forms for your health history, kindly bring them with you to your appointment**.**

Please Note: If you do not respond to reminder calls the automated system will continue to call you.

____ I do not wish to use the Patient Portal. Initials _____.

PATIENT RIGHTS AND RESPONSIBILITIES

As a patient you have certain rights and responsibilities that the staff and physicians respect. We recognize that a respectful relationship between the healthcare provider and the patient is the foundation of proper medical care.

PATIENTS HAVE THE RIGHT TO:

- Receive humane care and treatment with respect and consideration
- Confidentiality of your health records
- Privacy and confidentiality when seeking or receiving care except for life threatening conditions or situations.
- Be informed of and to exercise the option to refuse to participate in any research aspect of your care without compromising access to medical care and treatment
- Receive accurate information concerning diagnosis, treatment, risks involved and prognosis of an illness or health related condition.
- Ask for reasonable alternatives to care
- A second professional opinion regarding one's health care and treatment
- Participate actively in decisions regarding one's healthcare and treatment
- Accessible information regarding the scope and availability of services
- Be informed about any legal reporting requirements regarding any aspect of screening or care
- To file complaints and appeals with impunity
- To encourage family involvement of care

PATIENTS HAVE THE RESPONSIBILITY TO:

- Provide complete information about one's illness/problem to enable proper evaluation and treatment
- Ask questions so that an understanding of the condition or problem is ensured
- Show respect to health personnel and other patients
- Reschedule/Cancel appointments so that another person may be given that time slot
- Pay bills or file health claims in a timely manner
- Use prescription or medical devices for oneself only
- Inform the practitioner(s) if one's condition worsens, or an unexpected reaction occurs from a medication.

Helen Simigiannis, MD, FACOG
375 US Highway 130, Suite 103
East Windsor, NJ 08520

609-448-7800 Phone
609-448-7880 Fax

Use For: Another party

Releasing records **to** AG

Authorization Form for Release of Confidential Health Information

I, _____, hereby authorize:

Name of Patient or Authorized Representative

Name of Health Care Facility, Physician, etc.

Street Address, City, State and Zip Code

To Release to Antheia Gynecology the following information below contained in the patient record of:

_____, DOB_____

Patient's Name *Birthdate*

Residing at _____

Street Address, City, State and Zip Code

PLEASE RELEASE THE FOLLOWING RECORDS:

- COMPLETE RECORDS
- RADIOLOGY REPORTS
- OPERATIVE REPORTS
- PATHOLOGY REPORTS
- LAB REPORTS
- OTHER (SPECIFY) _____

_____ _____

PATIENT SIGNATURE **DATE OF AUTHORIZATION**

If you are not the patient, please specify relationship to the patient: _____

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THIS AUTHORIZATION.

BY SIGNING THIS FORM, I AUTHORIZE YOU TO RELEASE COPIES OF MY MEDICAL RECORDS. I UNDERSTAND THAT THIS MAY INCLUDE INFORMATION REGARDING MEDICAL, SURGICAL, PSYCHIATRIC TREATMENT, DRUG TREATMENT, HIV TESTING, TESTING AND/OR COUNSELING.

Notice of Privacy Practices
Helen Simigiannis, MD

Medical Information About You: The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not all possible uses or disclosures are listed.

For Treatment: We may use your medical information for treatment or services. Example: In treating you for a specific condition, we may need it if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or third party. Example: We may need to send your protected health information such as your name, address, office visit date and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operatives: We may use and disclose medical information about your health care operatives to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff caring for you.

Other Uses or Disclosures That Can be Made Without Your Consent or Authorization: As required during an investigation by law enforcement agencies**,** To avert a serious threat to public safety, As required by military command authorities for their medical records, To workers compensation or similar programs for processing of claims, In response to a legal proceeding, To a coroner or medical examiner for identification of a body, As required by the US Food and Drug Administration, Other healthcare providers' treatment activities, Other covered entities and providers payment activities, Other covered entities healthcare operative activities to the extent permitted by HIPAA, Uses and disclosures required by law, Uses and disclosures in domestic violence or neglect situations, Health oversight activities, Other public health activities. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses and Disclosures Of Information Protected Health Requiring Your Written Consent: Other uses and Disclosures of medical information by this Notice or the laws that apply to us will be made only with your written consent. You may revoke the authorization in writing at any time. We will therefore no longer use or disclose your medical information. We are required to retain our records of previous disclosures.

Disclosures and Changes To Your Medical Information

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operatives, or to someone who is involved in your care or the payment for your care.

about you for treatment, payment, or health care operatives, or to someone who is involved in your care or the payment for your care. We are required to agree to your request. If we do agree, we will comply with your request unless information is needed to provide you with emergency treatment. To request restrictions, you must submit your request to the Privacy Officer at this practice. In your request, you must tell us what information you want us to limit.

Right to an Account on Non-Standard Disclosures: You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this Practice. Your request must state the time period for which you want to receive a list of disclosures, which is no longer than six years and may not include dates earlier than December 12, 2012. Your request should indicate in what form you want this list. The first list within a 12-month period will be free, but additional lists may carry a cost to you.

Right to Amend: If you feel that medical information we have on you is incorrect or incomplete; you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not a part of the medical information kept at this practice, is not a part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for an amendment, you have the right to file a statement of disagreement with us. We will prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Your Access To Medical Information:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records, but does not include psychotherapy notes, information compiled for use in a civil, criminal or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to a Paper Copy of this Notice: You have the right to a paper copy of our current Notice of Privacy Practice any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. To obtain a paper copy please request one from the Privacy Office at this practice.

Right to Request Confidential Communications: You have the right to request how we send communication to you about medical matters and where you would like those communications sent. To request confidential communications, you must make a request to the Privacy Officer at this practice. We will not ask you the reason for this request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Antheia Gynecology, LLC
375 US Highway 130, Suite 103
East Windsor, NJ 08520
Phone: 609-448-7800 Fax: 609-448-7880
Email: info@antheiagyn.com