PATIENT REGISTRATION FORM

North Springs OB/GYN

Today's Date: ______________________

Patient Name: ______________________
Last First MI Nickname

Date of Birth: ______________ SSN: ______________ Gender: (circle) F / M

Address: ______________________
Street Apt/Ste City State Zip

E-Mail for the Patient Portal: ______________________

Patient Home Phone ( ) ______________ May we call / leave a message? (circle) YES / NO

Patient Cell Phone ( ) ______________ May we call / leave a message? (circle) YES / NO May we text message you? (circle) YES / NO

Patient's Employer ______________ Work Phone ( ) ______________ OK to call work? (circle) YES / NO

RACE: (circle one) American Indian or Alaskan Native Asian Black or African American Black Hispanic or Latino
Native Hawaiian / Other Pacific Islander White Hispanic or Latino Decline to answer

Ethnicity: (circle one) Hispanic or Latino Not Hispanic or Latino Decline to answer

Language Preference: (circle one) English Other: ______________

Marital Status: (circle one) Single Engaged Married Divorced Widowed Other: ______________

Primary reason for today's visit: ______________________

Primary Care Physician: ______________ Referring Physician: ______________

*Current insurance card(s) and photo identification are **required for scanning**. Please complete the following:*

Primary Health Plan: ______________ Policy #/ID: ______________ Group#: ______________

Name of Policy Holder: ______________ SSN: ______________ Date of Birth: ______________ Gender (circle) F M

Relationship to Patient: ______________ Employer: ______________ Employer Phone: ( ) ______________

Secondary Health Plan: ______________ Policy #/ID: ______________ Group # ______________

Name of Policy Holder: ______________ SSN: ______________ Date of Birth: ______________ Gender (circle) F M

Relationship to Patient: ______________ Employer: ______________ Employer Phone: ( ) ______________

If you have a secondary Health Plan, Have you coordinated your benefits? (circle one) YES NO If no, this will need to be done, please ask us how.

If patient is a minor, name of Custodial Parent: ______________________

Custodial Parent's Primary Phone: ( ) ______________ Secondary Phone: ( ) ______________

Custodial Parent's SSN: ______________ Date of Birth: ______________

Emergency Contact – Close friend / relative not living with you that we can contact in an emergency: ______________

Phone: ( ) ______________ Relationship: ______________

Name of person we may speak with other than yourself regarding your medical care?: ______________

Phone: ( ) ______________ Relationship: ______________

North Springs Ob/Gyn
4110 Briargate Parkway, Suite 405
719-327-2229
Fax: 719-282-2983

Christian York, M.D.

Name: ______________________ Date of Birth:__________ Age:______ Date: __________
Husband/Partner's Name:______________________ Did someone refer you? ______________________
Reason for visit: ____

Preferred Pharmacy:______________________ Preferred Lab: ______________________
Care Team (other doctor's involved in your care): ______________________

Medications (List dose and purpose)	**Medication Allergies** (list reaction)
	Latex allergy: Yes No Reaction:

Personal Gynecological History

First day of last period: __________ Period every ______ days. How many days do you have your period?__________
Age of first period: __________ HPV Vaccine: YES NO If Yes, year received: __________
Date of last pap test: __________ Abnormal pap? YES NO If Yes, any treatment: __________
History of any of the following: (circle one) Colposcopy Cryotherapy LEEP Unsure, but had something done
Date of last mammogram: __________ Any abnormal mammograms? YES NO If yes, what year? __________
History of Menopause? YES NO If yes, what year? __________, If yes, using HRT? YES NO
History of Colonoscopy? YES NO If yes, what year? __________
Have you had any sexual transmitted infections? YES NO If yes, what and when: __________
Are you currently sexually active? YES NO

Personal Obstetrical History

Total number of pregnancies: __________ Total number of births:__________ Total number of living children:__________
Number of spontaneous miscarriages:__________ Elective terminations: __________ Ectopic/Tubal Pregnancies: __________
List pregnancy/deliveries below. If you need additional paper, please write on the back.

Birth Date:__________ Baby's name:__________ Hours in labor: ______ Epidural: YES NO
BOY/GIRL/Multiples: __________ How much did baby weigh at birth? __________
Birth Type: Vaginal VBAC Cesarean Section, why? __________
How many weeks were you at delivery: ______
Any other pregnancy complications? __________

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Christian York, M.D.

Family History

Family Member- Diagnosis	Family Member-Diagnosis	Family Member-Diagnosis
EX: Maternal Grandmother- Breast Cancer		

Personal Social History

Highest level of education: ____________ Occupation: ____________ Employer: ____________
Home State: ____________ Pets: ____________ Feel safe at home: YES NO
Sexual Orientation: (circle one) Heterosexual Homosexual Bisexual Other: ______ Decline
Marital Status: Single Engaged Married Divorced Widowed Other: ____________
Spouse's Name: ____________ Occupation: ____________
Smoking Status: please circle which type: Cigarettes Smokeless Tobacco Vaping
(circle one) Never Former (How many smoking years _______) Current (packs per day _______)
Alcohol Intake: (circle one) None Occasional Moderate Heavy Other: ____________
THC/ Medical THC/ Other Drugs: YES NO Average use: ____________ Last Use: ____________
Chronic Pain/ Pain Contract: YES NO Who is the doctor prescribing?: ____________
Exercise Level: None Occasional Moderate Heavy Other: ____________
Performs monthly self breast exams: YES NO Advanced Directive? YES NO If yes, please provide a copy.

Personal Surgical/ Hospital Admission History

Surgery/ Hospitalization	Date	Surgery/Hospitalization	Date

Personal Medical History (please circle if you have any of the following diagnosis or concerns)

Please circle if you have any of the diagnosis listed below:	Please circle if you have any of the diagnosis listed below:	Please circle if you have any of the diagnosis listed below:	Please circle if you have any of the diagnosis listed below:
Accident/Trauma	Diabetes (during pregnancy?)	Ear, eyes, nose, or throat symptoms	Passing blood clots
Anxiety/Depression, Other	Gastrointestinal/IBS/Stomach/Bowels	Chest Pain	Pelvic Pain
Anemia	Headaches/Migraines	Irregular heart beat	Constipation
Arthritis/Lupus	High blood pressure/Heart	Shortness of breath	Diarrhea
Asthma/ other lung problems	Hepatitis/ Liver	Easy Bruising	Leaking bladder
Cancer- Breast	Infertility/Trouble getting pregnant	Skin rash or skin changes	Hot flashes
Cancer- Other	Kidney/Kidney stones	Breast lump or pain	Decreased libido
Chronic Pain/pa pain contract	Neurological/Epilepsy	Painful joints	Feelings of depression
Bladder control	Pelvic pain/Endometriosis	Bleeding after intercourse	Abnormal hair growth
Blood clots (PE/DVT)	Thyroid	Irregular periods	Difficulty period
Blood clotting disorder	Other:	Absent Periods	Vaginal discharge
Blood transfusion	Other:	Heavy periods (affecting lifestyle?)	Other:

FINANCIAL POLICY

North Springs OB/GYN

Today's Date: ______________________

Patient Name: ____
Last First MI

Date of Birth: ______________________ SSN: ______________________

We are committed to providing you with the best possible medical care. If you have medical insurance, we would like to help you receive the maximum allowable benefits. In order to achieve this goal, we will need your assistance and understanding of our financial policies. Please carefully review this information and sign/initial where indicated.

Current insurance cards must be presented to the office at each visit. Any changes to personal information must be given to the office immediately.

ASSIGNMENT: I request that payment of authorized insurance, Medicare, and Medicaid benefits be made payable to North Springs OB/GYN on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to an outside collection agency, I agree to pay all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency fees and understand that I may no longer be a patient at this office.

____________ ***(Initial) I have read and agree to the above statement.***

CO-PAY/COINSURANCE/DEDUCTIBLE: I understand that my primary insurance will be billed; billing secondary insurance is a courtesy only and I am ultimately responsible for assigned co-payments, coinsurance and deductible amounts by primary and/or secondary insurance. Tertiary insurance billing remains my responsibility.

____________ ***(Initial) I have read and agree to the above statement.***

RELEASE OF INFORMATION: I authorize the holder of medical information about me to release any and all information to Centers for Medicare and Medicaid Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize North Springs OB/GYN to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

____________ ***(Initial) I have read and agree to the above statement.***

REQUESTS FOR INFORMATION: Should I receive any requests from my insurance company in regards to my services at this office, I must respond to that correspondence immediately, in order to have the claim processed and paid.

____________ ***(Initial) I have read and agree to the above statement.***

SELF-PAY: Self-pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided.

____________ ***(Initial) I have read and agree to the above statement.***

NO-SHOW FOR APPOINTMENTS: In the interest in offering all of our patients prompt appointments, if you do not notify us 24 hours in advance, a No-Show fee of $50 may be charged for that appointment slot and / or you may be discharged from the practice.

____________ ***(Initial) I have read and agree to the above statement.***

RETURNED CHECKS: I understand and agree to pay a returned check charge of $35.00 for each check that is returned for any reason. I agree to pay the amount of the check plus the service charge within 30 days of receipt of notification.

____________ ***(Initial) I have read and agree to the above statement.***

SOCIAL MEDIA/PUBLIC WEBSITE: I give permission for North Springs OB/GYN to respond to posts on social media / public websites only if the original post is generated by the patient. This may include responding to information about protected health information but only if originated by the patient.

____________ ***(Initial) I have read and agree to the above statement.***

PRIVACY POLICY: I have been made aware of the privacy policy of North Springs OB/GYN and have received (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

I have read and agree to the above information and I, the undersigned/patient, am ultimately responsible for the fees. By signing below, I consent to be contacted by regular mail, by email or by telephone (including a cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages.

PRINT NAME ____

SIGNATURE ______________________________ DATE ______________

NORTH SPRINGS OB / GYN

NOTICE OF PRIVACY PRACTICES

USE AND DISCLOSURE OF PROTECTED HEATLH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your health facts and to provide you with the notice of our legal duties and privacy practices. We must follow the terms of the notice in effect right now, but we reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As a client of ours, facts about you must be used and disclosed to other parties for treatment, payment and health care operations. These uses and disclosures require your consent, and include, but are not limited to the following information:

- A release of information contained in financial and or medical records;
- Diseases spread person to person, such as Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS);
- Drug and or alcohol abuse;
- Psychiatric diagnosis and treatment records;
- Laboratory test results;
- Medical history;
- Treatment progress;
- Data from the OASIS data set (home health);
- Any other related facts.

We may release the above to:

1. Your insurance company, Medicare, Medicaid, or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment;
2. Any person from a program or an insurance company, who performs billing, quality and risk management tasks, such as insurance auditors and state Risk Management;
3. Any hospital, nursing home, or other health care facility where you may have testing done or to which you may be admitted;
4. Any assisted living or personal care facility where you live;
5. Any doctor providing your care;
6. Family members and other people who are part of your plan for service, in such programs as CSHP, EPSDT, home health, hospice, etc.;
7. State and or Federal agencies acting on behalf of programs, Medicare and or Medicaid, including state surveyors or auditors for programs such as CSHP, EPSDT, PCS, WIC, STD/HIV, home health, hospice, etc.;
8. Other health care people to start treatment.

We may contact you to:

1. Provide appointment reminders or news about other health programs we provide;
2. Raise funds or donate items for our business.

We are allowed to use or disclose facts about you without consent in the following situations:

1. In emergency treatment situations, if we try to obtain consent as soon as possible after treatment;
2. Where significant barriers to communicating with you exist and we determine that the consent is clearly inferred from the situation;
3. Where we are required by law to provide treatment and we are unable to obtain consent;
4. Where the use or disclosure is required by law;
5. For certain public health activities, such as reporting births, deaths, injuries, diseases, etc.;
6. Where we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency authorized to receive abuse, neglect or domestic violence reports;
7. Health care oversight activities;
8. Certain legal administrative proceedings;
9. Certain law enforcement purposes;
10. To coroners, medical examiners and funeral directors in certain situations (home health, hospice, etc);
11. For organ, eye or tissue donation purposes (home health, hospice, etc.);
12. For certain research purposes;
13. To avoid a serious threat to health and safety;

NORTH SPRINGS OB / GYN

NOTICE OF PRIVACY PRACTICES

14. For specialized government functions, including military and veterans' activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institution and custodial situations;
15. For Workers' Compensation purposes.

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict or forbid the disclosure in the following situations:

1. The use of a directory of people served by us (clinic schedules, patient schedules);
2. To a family member, friend or other person you choose, who may assist in your care or payment for care.

Other uses and disclosures will be made only with your written approval. That approval may be withdrawn in writing at any time, except in limited situations.

YOUR RIGHTS

You have the right, subject to certain conditions, to:

1. Request restrictions on certain uses and disclosures of facts about you by filling out our Request form. However, we are not required to agree to the requested restrictions.
2. Receive confidential communication of protected health data by giving us another address or means of receiving health data.
3. Inspect and copy protected health data by filling out our request form.
4. Amend protected health data by filling out our form.
5. Receive a list of disclosures made of your protected health data by filling out our request form.
6. Obtain a paper copy of this notice upon request, if you agreed to receive this notice by e-mail, fax, or website.

COMPLAINTS

You may complain to us and the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation against you for filing a complaint. The complaint must be filed in writing with us and must state the specific incident(s) including the date, what happened and details of the incident.

For details about filing a complaint with us, contact: Office Manager at 719.327-2229.

ACKNOWLEDGMENT

I have read this Notice or have had it explained to me. I understand this Notice and have had the chance to ask questions about any matters I don't understand.

-- ------------------------------
Signature Date

For Staff Use Only

The following good faith efforts were made to obtain acknowledgement: --

----

However, acknowledgement was not obtained because: --

-- Signature: ------------------------------ Date: --------------

North Springs Ob | Gyn

Needing a note or forms filled out?

Patients / Family members may require forms to be completed by one of our providers (FMLA, Return to Duty, Disability, etc). Completion of these forms requires administrative time to gather information and complete the forms, physician time to review and verify information. To expedite processing these requests in a timely manner, we have developed the following policy.

Forms - (one or more pages or letter requiring letterhead) to be signed by a provider:

- For example; FMLA, Return to Duty, *Disability, etc.
- You must have been seen by one of our providers for this condition within the last 30 days.
- Do not give the paperwork directly to a provider whether it's in the office or the hospital. Giving your paperwork to a provider will not get them done faster.
- Processing fee of $20.00 (cash or credit card) will be collected at the time the paperwork is turned in to a staff member, this will get the paperwork started.
- Staff will need to discuss the details needed on the forms (example, the time you are requesting off).
- A staff member will notify you within 3-5 business days that your paperwork is ready and may be picked up during normal business hours. We do not fax this paperwork.

Notes – (hand written) to be signed by a Registered Nurse:

- For example: excuse from work / school for appointment or sickness, jury duty, other simple requests.
- You must have been seen by one of our providers for this condition within the last 10 days.
- After speaking with a staff member about the details of your requested note, a processing fee of $10.00 (cash or credit card) will be collected.
- These can be done on the same day as your request.

Disability Forms

- Disability forms are completed if you have a **pregnancy related problem**, are **post partum**, or had **surgery** with us, and *our provider* has recommended that you not work. We cannot complete disability forms for any other reasons.

Patient Signature: ______________________________ Date: ____________________

03/08/2018 elfy

North Springs Ob | Gyn

Patient Portal

The Importance of the Patient Portal

The patient portal is a secure way (HIPAA Compliant) for us to communicate with you about your health and also for you to communicate with us! This is a wonderful benefit to you as our patient and to us as your provider! Other things the portal can do:

*General, non-urgent medical questions (not asking if you need to be seen for a concern).

*Appointment requests (again, non urgent).

*Medication refill requests. Please allow 48-72 hours for refill requests to be processed and completed.

*View and pay your bill securely on line.

*Send a question regarding your bill or your health plan.

*Review your medical history including current medications, allergies and recent test results.

*Review your health plan information and pre-check in for appointments.

Patient Portal Don'ts

*Please do not send urgent medical questions or urgent requests for appointments through the patient portal. If you have an urgent medical question or concern, please call the office at 719-327-2229, Option 1 for assistance.

*Please do not give your log in and password to anyone, including family members. You can sign up a friend or family member to be able to have access to your account. This is done through the portal under the My Profile tab on the left, labeled Family Access.

Please Note: All patient portal messages will be checked during our normal business hours. If a portal message is sent after hours, over the weekend or on a holiday, it will be reviewed by staff on the next business day and respond to all portal messages within 24 hours once received during business hours.