Patient Information Sheet

Patient _____ Date_____
Address_____
City _____ State & Zip_____
Phone (home) _____ (work)_____
(cell/pager)_____ Email_____
Date of Birth _____ Age_____ SSN#_____
Drivers License # and State _____
Marital Status- (circle one) S M D W Partnered
Occupation_____
Employer_____
Work Address_____
Referred to this office by _____
Primary Care Physician_____ Phone_____
Spouse/ Partner name_____ Social Security #_____
Spouse Date of Birth _____Occupation_____
Work Address_____
Work Phone_____Cell/ Pager_____
Other nearest relative (name)_____
(phone)_____(relationship)_____

Patient's Primary Health Insurance company_____
Certificate #_____ Group#_____
Name of insured_____Relationship to patient_____
Secondary Health Insurance Company_____
Certificate #_____ Group#_____
Name of insured_____
Relationship to patient_____

ASSIGNMENT OF BENEFITS

I hereby directly assign to Dr._____ all benefits payable from my insurance carriers for medical services rendered now and in the future, and that these payments will be credited to my account. I further authorize the release of all information, which is required by the insurance carrier for processing of my claims. A photocopy of this authorization will be as valid as the original signature.

Patient/ Insured signature_____ Date_____
Witness_____ Date_____

Patient Financial Statement

1) All charges for office visits are payable in full at the time of service (except Medicare).
2) The lab gives us a discounted rate of 30-70% less than their regular charges. We charge you exactly what the lab charges us. This provides you with significant savings if paid in our office.
3) PAP smears are required by law to be billed directly by the laboratory, and you will receive a separate bill from them. A small fee for our office processing these lab tests is included in your office billing for all tests, which are sent to an outside clinical laboratory.
4) Office visit charges will be given to you on a form, which can be sent to your insurance carrier for reimbursement. In order to minimize our clerical costs we do not complete or submit claim forms for routine office visits (except Medicare).
5) Surgical procedures performed either in the office or in the hospital require a 25% deposit prior to the procedure, and the balance is payable within 45 days. If you have medical insurance, we will gladly submit to your carrier all necessary forms and obtain appropriate authorizations; however, you are ultimately responsible for full payment on your account. A signed insurance form with "assignment of benefits" payable to this office is required prior to any surgical procedure.
6) I understand that I am responsible to pay for all services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if payment becomes 30 days past due, delinquent charges of 18% per year or a minimum of $5 per month will be applied to any unpaid balances.

I, _____ have read all the above statement and agree to observe these policies.

_____ _____ _____

Patient Witness Date

ADDENDUM TO FINANCIAL STATEMENT for HMO/ PPO PATIENTS

I, _____ hereby certify that I am currently covered by _____ health insurance, that I am in good standing, and have no pre-existing conditions excluded from my coverage related to Gynecological or Obstetrical problems. I will notify this office immediately in the event that my insurance coverage changes or terminates.

I understand that my doctor is a participating physician or locum tenens for this insurance plan, and that he will therefore accept those benefits paid by the plan to him for my medical care, according to the conditions of my health insurance policy, and that I am not directly responsible for the payment of medical fees as defined in the Patient Financial Statement.

According to my insurance plan, my only financial responsibilities to the doctor are 1) COPAYMENT of $_____ per visit, and 2) the payment of any DEDUCTIBLE attached to my policy. I am however fully responsible for any services which are not included in my benefits (such as infertility treatment, newborn circumcision, etc.)

If I am also covered under a health insurance policy through my spouse, then this secondary insurance carrier my also be billed.

In the event that I am no longer a subscriber to this HMO/ PPO health plan, I will become fully responsible for any and all new charges for my medical care, as of the date of termination for this insurance coverage, and I will be subject to the terms as set forth in the Patient Financial Statement and or Obstetrical Information/ Financial Statement which accompanies this addendum.

I have read the above statement and agree to observe these policies.

_____ _____ _____

Patient Witness Date

SUMMARY NOTICE OF PRIVACY PRACTICES

We are required by federal law to provide you with a Notice of Privacy Practices that describes how medical information that we maintain about you may be used or disclosed. The Notice describes how, when, and why we use and disclose medical information about you, and provides a description of your rights and our obligations under federal and state privacy laws.

Uses and Disclosures: We are permitted to use and disclose your health information under a variety of circumstances. Sometimes we must obtain your authorization before we use or disclose that information, but in other circumstances we may use your information without your authorization and without informing you of the use or disclosure. Some of the reasons that we may use or disclose your information include:

To provide information about your health condition to other health care providers;

To provide information to your health plan;

To report a communicable disease, or other legal reporting requirements; or

To comply with a court order requiring the disclosure of your medical record.

Your Rights: While the records that we main about you belong to us, under the federal privacy law you have a variety of rights with respect to the information maintained in those records. For instance, you have the right to access and receive a copy of the medical information we maintain about you and to request that we amend any of the information that you believe is incomplete or incorrect. Also, you may request that we provide you with a list of disclosures that we have made of your medical information. All of these rights are subject to some exceptions that are described in full in the Notice.

Acknowledgement: You will be asked to sign an acknowledgement of your receipt of this Notice of Privacy Practices. However, your receipt of care and treatment is not conditioned upon your signing the acknowledgement form.

Our Obligations: We are required to provide you with our Notice of Privacy Practices and to abide by its terms. We may change the Notice from time to time. All amendments apply retroactively.

Our full Notice of Privacy Practices is attached. Please read it carefully. If you have any questions or require additional information, please contact contact our Privacy Officer, Ilyse Frieder at 310.857.6146.

I acknowledge that I have had the opportunity to review the full Notice of Privacy Practices.

Name:_____ Birth Date_____

Signature:_____ Date:_____

MEDICAL HISTORY

Name:_____ **Date:**_____

Circle any conditions you have ever had:

HEART MURMUR	GALL BLADDER PROBLEMS	THROMBOPHLEBITIS
RHEUMATIC FEVER	JUANDICE	GERMAN MEASLES
HEART ATTACK	HEPATITIS	SEIZURES
HIGH BLOOD PRESSURE	BLOOD TRANSFUSIONS, CLOTS	NERVE PROBLEMS
ASTHMA	KIDNEY PROBLEMS	PELVIC PAIN
LUNG PROBLEMS	BLADDER INFECTIONS	MENSTRUAL IRREGULARITY
EMPHYSEMA	KIDNEY INFECTIONS	ABNORMAL PAP SMEAR
MIGRAINES	ANEMIA	VAGINAL INFECTIONS
BLOOD CLOTTING DISORDER	DIABETES	UTERINE INFECTIONS
STOMACHE ULCERS	THYROID PROBLEMS	TUBAL INFECTIONS
SEXUAL PROBLEMS	DRUG USE	GENITAL HERPES
EXPOSURE TO AIDS	INFERTILITY PROBLEMS	GENITAL WARTS
ENDOMETROSIS	GONORRHEA	CHLAMYDIA
TAY SACHS TESTING (JEWISH HERITAGE)		

Operations: _____

Did your mother take DES while she was pregnant with you? YES NO Don't know

Who in your family has had the following: DIABETES _____

STROKE_____ HIGH BLOOD PRESSURE_____

HEART ATTACK_____ BIRTH DEFECTS_____

BLEEDING DISORDER_____ STILLBIRTH_____

BREAST CANCER _____ CANCER OF THE UTERUS_____

CANCER OF THE CERVIX _____ CANCER OF THE OVARY _____

Mother alive? YES _____ NO_____ Father alive? YES_____ NO_____

OBSTETRICAL HISTORY

Number or pregnancies _____ #Full Term _____ #Premature (before 36 weeks) ____

Miscarriages _____ #Elective Abortions _____ #Living Children _____

Complications of abortions or pregnancies _____

Age at first menstruation: _____ Periods Usually: Regular _____ Irregular ____

Dates of flow _____ Days between periods _____ Spotting _____ Clots _____

Contraception Past: (circle) Pill IUD Diaphragm Sponge Foam or Condoms
Tubal Ligation Partner Vasectomy

Present form of contraception: _____

Any medications you are now taking? _____

Any allergies or reactions to medications?_____

Do you smoke? _____ How much? _____

Drink coffee? _____ How much?_____

Drink alcohol? _____ How much? _____

PRESENT INFORMATION

Age _____ Marital Status: S M D Sep. W

Date of last pap smear _____ Normal_____ Abnormal_____

Last menstrual period _____

Who is your family doctor or internist?_____

Phone:_____