OBGYN WESTSIDE

Your Partner for a Lifetime of Care

Rev. 6/1/2018

Welcome and thank you for choosing OBGYN Westside as your specialist. All new patients are asked to complete the medical history and patient registration forms. It is preferable that you bring the completed forms with you the day of your appointment. You will be receiving an automated reminder call prior to your appointment.

In order to care for you efficiently and avoid delays in evaluating your condition, it is essential that you complete the accompanying forms accurately and entirely. Please also bring the following with you to your visit:

1) Your insurance card

2) Your Copay, should one be required

3) Applicable Medical Records

It may be necessary for you to contact your primary or referring physician prior to your visit in order to obtain the above information. If your insurance carrier requires a referral, please make sure to contact your primary physician and have his/her office fax it to us.

We are one hundred percent dedicated to your care, however, it is important that you are aware of the following OBGYN Westside policies:

- We do not typically call patients back regarding clinical results if the results are normal. However, we are there if you need clarification.
- Refill prescriptions cannot be filled if you have not had an office visit in over a year.
- The on call doctor is the physician who communicates patient requests, however, if you would prefer to speak to another physician for a non urgent matter, please let the front desk know.

Thank you. If you have any additional questions, please email Myndie Friedman, mfriedman@obgynwestside.com

Patient Registration Form

Today's Date:_____

Patient's Last Name:_____ First Name: _____

SS #: _____ Date of Birth: _____

[ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Domestic Partner

Patient's Address: _____ APT #: _____

City:_____ State: _____ Zip: _____

PHARMACY: _____ Phone: _____

Please circle the best phone number/email to communicate a confidential message.

Cell: _____ Home: _____ ****Email:_____

Patient Employer: _____ Work: _____

Employer Address: _____ Occupation:_____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

Name: _____Relationship:_____Cell Phone:_____

****Insurance Information**

Name of Primary Insurance Company: _____

Policy/ID: _____ Group #: _____

Name of Policy Holder: _____ Effective Date: _____

Date of Birth: _____ Do you have Out-of-Network Benefits? _____

Name of Secondary Insurance Company: _____

Policy/ID: _____ Group #: _____

PLEASE NOTE, there is a $75.00 cancellation fee, without 24 hours' notice.

Patient Signature: _____**** Required Information**

Patient's Last Name:_____ First Name:_____

Intake Report

Date Completed _____

Gynecological History

Age period began:_____

Are you using contraception? Y N

If yes, what method?_____

Length of periods: _____ Length of Menstrual cycle: _____

Date of last Pap smear: _____

Have you ever had an abnormal pap? _____

Are you covered for preventative/well visits? _____

Do you have a primary care physician (please indicate name)?

_____

Past Medical History

Have you ever had: ***check Y or N*** ***REQUIRED INFORMATION**

Blood transfusions	**Y N**	Bone Fracture	Y N
Heart disease /Murmurs	**Y N**	Urinary/Bowel Problems	Y N
High Blood Pressure	Y N	Sexual Problems	Y N
Strokes	Y N	Past Steroid Use (i.e. Prednisone, etc.)	Y N
Migraines	Y N	Heparin/Coumadin use	Y N
Epilepsy/Seizures	Y N		
Depression	Y N	**Allergies:**	**Y N**
Bipolar Disorder	Y N	**Specify medication allergy &type of reaction**	
Tuberculosis	Y N		
Asthma	Y N		
Kidney Disease	Y N		
Pulmonary Embolism	Y N		
Deep Vein Thrombosis	Y N		
Thyroid Disease	Y N		
Diabetes	Y N		
Hepatitis/Liver Disease	Y N		
Gallbladder Disease	Y N	**Family History**	
Eating Disorder	Y N	Cancer of the Breast	Y N
Vegetarian	Y N	Cancer of the Ovary	Y N
Lactose Intolerant	Y N	Other Cancer	
Anemia/Blood Disorder	Y N		
Bleeding Problem	Y N	Diabetes	Y N
Lupus	Y N	Heart Disease	Y N
Arthritis/Back problem	Y N		
Multiple Sclerosis	Y N	***Is a blood transfusion acceptable in an emergency situation? Y N**	

Patient's Last Name:_____ First Name:_____

Financial Agreement

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Agreement is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL REQUEST TO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- COPAYMENTS – By law we must collect your carrier designated copay. This payment is expected at the time of service.
- OUT OF NETWORK PLANS – If we do not 'participate' with your plan, payments will be expected at the time of service unless prior arrangements have been made with our administrator. This might include coinsurance, deductible and non-covered amounts. We will send a courtesy bill to the carrier on your behalf and send you an invoice for any outstanding monies due.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to OBGYN Westside for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit with the administrator
- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The guarantor is responsible for payment of services rendered. OBGYN Westside cannot be involved with separation or divorce disputes. You are responsible for the timely payment of your account. Our financial staff will work closely with you and your carrier to avoid sending any account to an outside agency to collect payment. We reserve to send delinquent accounts to an outside collection agency.

We accept CASH, AMERICAN EXPRESS , MASTERCARD, or VISA. *

Checks will only be accepted for payments of $50 or more, with the approval of the administrator.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient Name/ Date of Birth: _____

Patient Signature: _____ Date:_____

Patient's Last Name:_____ First Name:_____

Consent for Communication via Email

(Provider / Office-Patient)

I, (Patient's name): _____,

Email Address: _____, hereby consent to have my physician or members of her staff, other physicians, nurse practitioners and pharmacists communicate with me, where appropriate, via e-mail, regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that email is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my physician and me or members of my physician's office staff or between my physician and other physicians, nurse practitioners and pharmacists regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between my physician and me or members of her office staff or between my physician and other physicians, nurse practitioners or pharmacists regarding my medical care and treatment will be printed out and made a part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on email.

Patient Name: _____

Patient Signature: _____

Today's Date: _____

Patient's Last Name:_____ First Name:_____

SUMMARY – NOTICE OF PRIVACY PRACTICES

THIS IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. WE HAVE ALSO MADE A FULL VERSION OF THE NOTICE AVAILABLE TO YOU ON **WWW.OBGYNWESTSIDE.COM.**

Our Pledge to Protect Your Privacy:

OBGYN Westside are committed to protecting the privacy of your medical information. So that we can best meet your needs, we share your medical information with all the healthcare providers involved in your care. Only to the extent necessary, we also use and share your information to conduct our business operation, to collect payment for the services we provide to you, and to comply with the laws that govern healthcare. We will not use or disclose your information for any other purpose without your permission.

You have the following rights to access and control your health information:

•To inspect and obtain a copy of your medical and billing records, subject to some special requirements for substance and alcohol abuse, genetic, mental health, and HIV-related data;

• To request restrictions on certain uses of disclosures of your medical information;

• To request an accounting of OBGYN Westside disclosures of your medical information;

• To add an addendum to your medical record;

• To request that we communicate with you in a certain way or at a certain location; and

• To receive a copy of the full version of our Notice of Privacy Practices.

Examples of how we may use and disclose your health information:

• To provide you with medical treatment and services;

• To bill and receive payment for the treatment and services you receive;

• For functions necessary to run OBGYN Westside and to assure that our patients receive quality care;

• For workers' compensation or similar programs;

• For required public health activities (e.g., reporting abuse or adverse reactions to medications);

• For healthcare oversight (e.g., to the New York State Department of Health); and

• For law enforcement in certain limited circumstances.

• To a coroner, medical examiner or funeral director as required by law;

• For organ procurement or transplantation, if you are a potential donor.

ACKNOWLEDGEMENT of RECEIPT of NOTICE of PRIVACY PRACTICES (NOPP)

By signing below, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the OBGYN Westside and its affiliates, and how I may obtain access to and control of this information.

Signature of Patient Please PRINT Your Name

_____ _____