Gynecology Specialists of Philadelphia

Penn Presbyterian Medical Center, 51 North 39th Street, MOB 340
Philadelphia, PA 19104
P: 215-662-9775 * F: 215-243-4668

823 South 9th Street, 1st Floor
Philadelphia, PA 19147
P: 267-239-2725 * F: 267-239-2728

Last Name_____ First Name_____MI___

SS#_____ DOB_____

E-Mail address _____

Address_____

City _____State_____ Zip _____

Best Phone# _____ (home/ work/ cell)

Alternate # _____ (home/ work/ cell)

Race_____ Ethnicity (Hispanic/non-Hispanic)_____DECLINE

Preferred Language _____ Marital Status _____

Preferred Pronoun _____ Gender _____

Employer_____ Occupation_____

Pharmacy Name _____ Pharmacy Phone # _____

Emergency Contact

Name_____ Phone #_____Relationship_____

Address _____

Insurance Information: Please provide a copy of your insurance card

Insurance Subscriber (if not self):_____ Subscriber DOB: _____
Subscriber
Address_____Relationsip_____

May we speak to a friend/family member about your health/results over the phone? If so list their name (s) here; _____
_____

Referral Information

Referred BY (circle) Doctor _____ Website Insurance PENN Referral Line

Primary Care/ Family Doctor_____ Phone #_____

*I hereby authorize the release of medical information necessary for the processing of my medical/ laboratory claims. I authorize payment to Gynecology Specialists of Philadelphia LLC. I take full responsibility for payment for all services rendered. A photocopy of this authorization is as valid as the original.
* I have received a copy of GSP Privacy & Office Policies. I have read and agree to comply with these policies.

Patient Signature _____Date _____

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Name_____ DOB_____

Medical History: Have you had the following?

___ High Blood Pressure	___ Heart Attack	___ Depression
___ High Cholesterol	___ Stroke	___ Anxiety
___ Diabetes	___ Blood Clot (lung)	___ Seizures
___Anemia	___ Blood Clot (leg)	___ Migraines
___ Hyperthyroidism	___ Bowel Obstruction	___ Kidney Failure
___ Hypothyroidism	___ Crohn's Disease	___ Kidney Stones
___ Breast Cancer	___ Ulcerative Colitis	___ Sarcoidosis
___ Cervical Cancer	___ Irritable Bowel (IBS)	___ Sickle Cell Disease
___ Ovarian Cancer	___ GERD (Acid Reflux)	___ Lupus
___ Uterine Cancer	___ Hepatitis B	___ Rheumatoid Arthritis
____ Asthma	___ Hepatitis C	___ Gallstones
___ Sjogren 's syndrome	___ Emphysema	___ Anorexia/ Bulimia

___ Other _____

Surgical History: Please list name and date of procedure if possible

_____

_____

Medications:

Name	Dose	Times per day

Allergies: _____ No Known / Unknown

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Name_____ DOB_____

Chief Complaint/ Reason for Visit:

_____

Gynecologic History:
First day of your last period_____

Date of your last ANNUAL/PAP exam _____ Any abnormal pap tests? Yes/ No

Date of last mammogram _____Any abnormal mammograms? Yes/ No

Have you had 3 Gardasil Vaccines? Yes/ No

List any GYN problems you have or had in the past (i.e. Fibroids, endometriosis, PID, cysts, ETC)
_____
_____
_____

Contraceptive History:

What are you using for birth control? Circle all that apply

None tubal ligation vasectomy pills Nuva Ring condoms IUD Depo

Any problems with contraception now or in the past? _____

Obstetrical History:

How many pregnancies have you had? _____
How many children delivered? _____ Vaginal or C-Section
Miscarriages _____ Abortions_____ Ectopic or Tubal Pregnancies _____

Family History:

Has anyone in your family had cancer? Yes/ No

Please list who has or had cancer, maternal or paternal, the type of cancer, and the age of diagnosis:
_____
_____

Social History:

Do you smoke? **Yes/ No** Drink alcohol? **Yes/ No** Use other drugs? **Yes/ No** Caffeine? **Yes/ No**

Are you sexually active? **Yes/ No** If yes, with **men** **women** **both**

Have you ever had a sexually transmitted disease (STD)? **Yes/ No**
If yes, what did you have? _____ Were you treated? **Yes/ No**

Any history of abuse? Physical? **Yes/No** Emotional? **Yes/No** Sexual? **Yes/No** Verbal? **Yes/No**

Any other health history we should be aware of? _____

_____

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OFFICE POLICIES

There are many practices you could have chosen for your gynecologic care. We would like to take the time to thank you for choosing Gynecology Specialists of Philadelphia. It is our desire to provide personalized, compassionate, top-notch care to all of our patients and understand it is important that play an active role in their health care. To that end, we believe our patients should have a full understanding of our office policies, expectations and procedures so as to optimize your experience with us. Please take time to read the information outlined below.

Our office accepts routine phone calls from 8:30 am – 4:15 pm Monday-Thursday and 8:30 am – 2:30 pm on Friday. Please make non-emergency calls during these hours so that we have access to your medical records and can better serve you.

INSURANCE: There are numerous insurance plans available therefore, it's impossible for our staff to know the covered benefits of each plan. It is YOUR responsibility to know and understand the policies and benefits of your plan including referrals, authorizations, co-payments, deductibles, covered hospitals, labs and x-ray (radiology) facilities.

APPOINTMENTS: We will make every effort to schedule your appointment in an appropriate time frame. **YEARLY WELL-WOMAN EXAMS** will be scheduled within **ONE TO THREE MONTHS** of calling. Scheduling these routine exams in that time frame is important in order to allow patients with urgent medical needs to be seen in a shorter time frame. If you are due for your well-woman exam and have an urgent problem, we will make **two** appointments for you – an **earlier** appointment for the **problem** and a **later** appointment for the **well-woman exam**.

Due to the nature of our practice, we occasionally need to reschedule an appointment you have made and appreciate your understanding should this be the case. We ask that you give 24 hours notice if you need to reschedule.

FIRST TIME OFFICE VISITS: Please arrive 15 minutes early for your appointment to allow enough time to complete your registration forms. Please bring a list of all current medications. If this is a consult, please be sure your referral has been sent (if required) and bring any appropriate reports and lab results.

LABORATORY: All lab tests performed in the office (pap smears, cultures, biopsies) are processed and billed to you by outside laboratories. We do not draw blood at our office. We will provide you a lab slip and bloodwork should be done at Quest or LabCorp according to your insurance coverage.

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TEST RESULTS: Some test results may be reviewed with you over the phone. Others may require a follow up appointment to discuss. **This decision is made at the discretion of your provider**.

> ****Most results take approximately 2-3 weeks to return to our office – this includes pap smears, cultures, blood work, biopsies and most radiology studies including routine mammograms. If you have not heard from our office within that time frame, please contact the office.**

TELEPHONE: One of our providers is on-call every evening, including weekends, for **emergencies**. The answering service takes all calls after hours. Routine prescriptions (ie: birth control), appointment scheduling/confirmation/cancellations and reviewing of test results will not be handled after hours.

We cannot treat patients over the telephone. If you feel you have a true medical emergency, please call 911 or go to the nearest emergency room.

PRESCRIPTION REFILLS: If you contact our office for a prescription refill, please have the medication name and your pharmacy phone number ready. There is a 24 hour turnaround for refill requests. If you need a prescription refilled before the weekend, please call ahead to allow time to process your request. **We cannot refill medications after hours or on weekends**.

OFFICE VISIT PUNCTUALITY: We value all of our patients and we appreciate that your time is precious. Our goal is that we are as punctual as possible and see you for your appointment in a timely manner. However, circumstances arise **on a daily basis** which compromise our ability to be punctual. It is our hope that you will be as understanding as possible with the demands on our staff, especially due to surgical emergencies which require the providers to attend to patients in the hospital or emergency room throughout the day. Our intention is to provide all of our patients with the utmost in medical care. We hope that you will be understanding of these dynamics as they are an inherent part of any gynecology practice which affect our punctuality.

Thank you!

Gynecology Specialists of Philadelphia

I HAVE READ AND AGREE TO COMPLY WITH GYNECOLOGY SPECIALISTS OF PHILADELPHIA OFFICE POLICIES

_____ _____
Printed Name of Patient or Personal Representative Relationship

_____ _____
Signature of Patient or Personal Representative Date

The undersigned certifies that she has received a copy of *Notice of Privacy Practices (NPP)* AKA *Health Insurance Portability and Accountability Act* (HIPAA) and is the patient, or is the patient's personal representative,

_____ _____
Printed Name of Patient or Personal Representative Relationship

_____ _____
Signature of Patient or Personal Representative Date

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize Gynecology Specialists of Philadelphia and its providers to view my external prescription history via eClinical Works EHR system. I understand that this includes but is not limited to prescription history from other unaffiliated medical providers, insurance companies, and/or pharmacy benefit managers may be viewable by provider and staff at Comprehensive Primary Care. This also may include prescriptions dating back several years.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTOOD THE CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

_____ _____
Printed Name of Patient or Personal Representative Relationship

_____ _____
Signature of Patient or Personal Representative Date

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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I_____,

DOB _____ voluntarily consent to authorize my health care provider (complete provider's name, telephone # and fax # below)

_____to use or disclose my health information during the term of this authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: _____

Address: _____

Purpose: I authorize the release of my health information for the following specific purpose: _____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]
- ❑ Only the following records or types of health information: _____.

Term: I understand that this Authorization will remain in effect:
- ❑ From the date of this Authorization until the _____ day of _____, 20___.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs:_____

Redisclosure: **I understand that my health care provider cannot guarantee that the recipient will not disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.**

_____ _____
SIGNATURE OF PATIENT DATE

[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**

Sonya Lee, MD
Linda Romano, PA-C
Alyssa Davis, PA-C
Jessica Azad. PA-C

PAYMENT POLICY

Patients are responsible for charges including co-pays, deductibles, co-insurance or services that are not covered by their health insurance plans. Services may not be covered if there is a pre-existing condition clause, or if your plan does not cover preventative services. Student plans and basic plans often have limitations of coverage. All patients must provide a valid credit/debit card upon establishing care to be used ONLY if charges are not covered by your insurance plan and for our no show/late cancellation policy. **Your card will only be charged for balances after all payments have been received from your insurance company and it is determined that the patient is responsible for the balance.**

We will charge your card based on the statement called an explanation of benefits or EOB that we received from your insurance company. If your card is charged, we ask that you contact your insurance for an explanation as our charges are based solely on the information they provide us. You should receive an explanation of benefits notice from your insurance in the mail shortly after your visit.

CANCELLATION/NO SHOW POLICY

We ask that you please cancel your appointment with at least 24 hours' notice so that your appointment time can be offered to other patients. If less than 24 hours' notice, the appointment will be documented as "no show". You will receive an automated message notifying you of your missed appointment. After 3 "no-show/missed appointments, dismissal from our practice may be considered. **Your card will be charged as follows:**

No Show/Canceled same day/Missed appointment/Laser $25
Surgery Cancellation $50 (less than 5 workday notice)
Sculpsure $75

Please be assured that all card numbers are kept in a secure password protected system. Before charging your card we will double check the claim to make sure it is correct and that our office has not made a mistake. By signing below, you acknowledge that you understand your financial responsibilities as a patient. You authorize payment in full via your credit card by your signature below for any and all payments due today and in the future dates of services, for consultation, evaluation and procedures performed. Please keep your credit card information updated.

By signing below, you acknowledge that you have had the opportunity to ask questions regarding this payment and cancellation policy and have had the opportunity to decline participation with the office.

COLLECTION POLICY

In the even that there is an outstanding balance on your account the following collection procedure will take place.

1. Your credit card on file will be charged for any balances as outlined in our payment policy above.
2. If a balance is higher than $50 is owed you will be notified.
3. If we are unable to charge your account, after 90 days' notice and final notice, your account will be forwarded to Suburban Credit and Collections.

_____	_____	_____	_____
Credit Card #	Exp Date	3 Digit Code	Billing Zip

_____	_____	_____
Print full name as appears on credit card	Signature	Date