

COMPREHENSIVE OBGYN CARE

A Division of Southern New England Care for Women, LLC

A. Michael Coppa, M.D.

Jeiny Zapata, APRN

Board Certified Obstetrics & Gynecology

725 Reservoir Avenue Suite 203
Cranston, RI 02910
Tel. (401) 946-4022 Fax (401) 946-4077

14 Cedar Swamp Road
Smithfield, RI 02917
Tel. (401) 231-1450 Fax (401) 946-4077

Dear Patient:

You are receiving this paperwork because you have an upcoming appointment with us on

*******PLEASE ARRIVE 15-20 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT TIME*******

We would greatly appreciate your cooperation by completing the enclosed packet and bringing it back to us on your scheduled appointment. Also please bring your insurance cards with you on the day of your appointment.

I want to thank you in advance and we look forward to seeing you at your visit.

Sincerely,

Jeiny Zapata APRN and Staff.

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725 Reservoir Avenue, Cranston, RI 02910

Office: (401) 946-4022 Fax: (401) 946-4077

Office hours are: Monday 9am-5pm
Tuesday 9am-5pm
Wednesday 9am-2pm
Thursday 9am-5pm
Friday 9am-4pm

14 Cedar Swamp Road, Smithfield, RI 02917

Office: (401) 231-1450 Fax: (401) 946-4077

Monday 1pm-5pm

The Doctor and the staff at Comprehensive OBGYN Care would like to welcome you to our practice. We look forward to providing you quality care and will do our best to make your visit positive and successful. Enclosed you will find information that is important to review, as it states our policies of the office and to protection of your privacy. Thank you for choosing Comprehensive OB/GYN Care.

Our office offers the following Services and Procedures

- Doctors on call24/7
- On-Site Lab
- Infertility
- Family planning
- Non-Stress Testing
- Fetal Surveillance
- Complete Pre & Post Natal Testing
- Normal & High Risk Pregnancies
- Compassionate Postpartum Care
- Infertility
- The Latest in Surgical, Laser & Laparoscopic Procedures
- Urinary Incontinence
- Menstrual Problems
- Management of Menopause
- Testing & Treatment for STD and HPV
- Offer variety of Birth Control Contraceptive Options
- Low libido
- Hypothyroidism
- Vitamin B12 and/or D deficiency
- Obesity

Prescription Refills- Any prescription refill request should be called in to your pharmacy. Refills will not be filled during non-business hours.

Release of Medical Records- For your protection, we allow for the release of medical records only with your written consent. However, there is a fee associated with the release of medical records. Simply contact our office and we will happy to provide you with the medical request form that outlines fees, and necessary information needed to initiate your request.

Missed Appointments- You share responsibility of your medical care and obligated to keep your scheduled appointments. If you are unable to keep your appointment, we require 24 hours notice. If you miss the appointment without notice, you will be charged a No-Show fee of \$50.00. Patients who are more than 15 minutes late may have to reschedule.

Insurance Cards- Please be sure to bring your insurance card(s) and a picture ID with you to your appointment. If your insurance requires a referral, please be sure to bring it with you or have the office fax the referral to us. If you have had blood work, mammograms, or any other testing done, please have your doctor forward copies to us prior to your visit or bring a copy with you.

Emergencies- If you have an emergency during office hours, please call our office. If you have an emergency after hours, our answering service will contact the physician on call. If necessary, call 911 or go to the nearest emergency room.

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Patient Care Agreement and Release

I. Release of Information for Billing Purposes

I agree that Comprehensive OBGYN Care will release to and receive from my insurer(s), other payers or other persons as necessary for billing and related purposes, at reasonable times and in accordance with current policies and procedures, any information which may be needed for billing, collection or payment of claims for services provided.

This information may include my identity, diagnosis, prognosis, and treatment for physical illness or injury, surgical procedures, progress notes, and all other information contained in patient care records to the extent that such records are needed for billing or collection of benefits due me from any payer. I understand that I have the right, upon request, to inspect and receive a copy of all such records being disclosed.

II. Assignment of Benefits

In consideration for the care provided by Comprehensive OBGYN Care, I authorize payment of medical benefits directly to Comprehensive OBGYN Care from any third-party insurance, plan, or entity, covering such expenses.

If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made on my behalf to Comprehensive OBGYN Care for any and all care. I agree that these benefits otherwise payable to me shall be paid directly to Comprehensive OBGYN Care and that this agreement cannot be revoked without my and Comprehensive OBGYN Care's consent.

If I receive payment directly from my insurance company, it is my responsibility to forward it to Comprehensive OBGYN Care for payment within 30 days of receipt.

III. Financial Agreement

Comprehensive OBGYN Care will collect co-payments, co-insurances, as well as outstanding balances and deductible amounts that will be assigned against your visit, at check in. If you are scheduled for surgery, Comprehensive OBGYN Care will estimate your deductible, co-insurance, or co-payment and this amount will be due prior to your surgery. Comprehensive OBGYN Care reserves the right to cancel or postpone surgery in the event of non-payment.

If care is determined to be a benefit not covered by insurance or Medicare, including serviced deemed experimental or investigational, I will be responsible to Comprehensive OBGYN Care for payment of the entire bill. If I am a Medicare beneficiary, I understand that I will receive notice that the care will not be covered. If, following this notification, I choose to receive care I will be responsible to Comprehensive OBGYN Care for payment of the entire bill. I agree that, should the amount covered by insurance or Medicare be insufficient to cover the entire Comprehensive OBGYN Care expense, I will be responsible for the payment of the difference. It is further agreed that credit balances resulting from payments from me or other sources may be applied to any account owed Comprehensive OBGYN Care by the same guarantor (me or my family). I agree to pay for the charges not covered by this assignment, included but not limited to co-payments, co-insurance and deductible charges, in accordance with Comprehensive OBGYN Care's regular rates and terms as applicable.

IV. Referrals

I understand that this is my responsibility to procure a referral from my PCP, when required by my insurance plan, prior to seeking services from Comprehensive OBGYN Care. If I choose to receive services without prior authorization, I acknowledge that I will be responsible for payment at the time services are rendered.

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V. Consent to Obtain Medication History

By signing this consent form, I agree that Comprehensive OBGYN Care may request and use my medication history, including current/past medications, from other healthcare providers or third-party pharmacy benefits manager for treatment purposes.

VI. Telephone Consumer Protection Act

As a component of my care, I understand and agree that Comprehensive OBGYN Care, its providers or agents, including debt collectors, may contact me using automated calls, emails and text messaging sent to my landline and mobile device. These communications may notify me of upcoming appointments, test results, outstanding balances, or any other communication from the medical group.

VII. Notice of Privacy Practices Acknowledgement

By signing this form, I acknowledge that Comprehensive OBGYN Care has made the Health Insurance Portability and Accountability Act (HIPPA) notice effective April 14,2006 available to me on the date indicated below

- How Comprehensive OBGYN Care uses and discloses protected health information
- My privacy rights with regard to my protected health information
- Comprehensive OBGYN Care obligations to me concerning use and disclosure of protected health information

VIII. Notice Show Policy

By signing this document, I understand and will abide by the policy that Comprehensive OBGYN Care has for missed appointments. The No Show Policy encompasses that if a patient needs to reschedule or cancel a scheduled appointment, the patient is responsible to do so with at least 24-hour notice. If you, the patient, do not give a 24-hour notice or if you do not show up to your scheduled appointment, you are subject to charge a \$50.00 No Show fee for a missed appointment or procedure.

Document Acknowledgement

I certify that I have read and understand the foregoing Patient Care Agreement and Release and that I am competent and authorized to execute this document. I understand that I am not entitled to make any changes or alterations to this legal non-negotiable document. I will notify Comprehensive OBGYN Care should my insurance coverage (including eligibility for Medicare or Medicaid), home address or other contact information change.

Patient/legal representative (print)

Relationship

Date

Patient/legal representative signature

PATIENT REGISTRATION

Last Name: _____ First Name: _____ Date of Birth: _____
Maiden Name: _____ Marital Status: S M D W Social Security # _____
Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email: _____ Preferred method of Contact: (Please Circle One) Home# Work# Cell#
Language: English Spanish Other _____ Race: _____ Ethnicity: _____
Employer: _____ Occupation: _____ Phone: _____
Partner's Name: _____ Date of Birth: _____ Phone: _____
Primary Care Physician: _____ PCP Phone: _____
PCP Address: _____ City: _____ State: _____ Zip: _____
Pharmacy: _____ Pharmacy Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Insurance Plan Name: _____
Insurance Co. Address: _____ City: _____ State: _____ Zip: _____
Policy Holder Name: _____ Relationship: _____
Policy Holder Date of Birth: _____
Policy #: _____ Group #: _____

IF YOU HAVE TWO INSURANCES, PLEASE COMPLETE THE FOLLOWING:

Secondary Insurance Plan Name: _____
Insurance Co. Address: _____ City: _____ State: _____ Zip: _____
Policy Holder Name: _____ Relationship: _____
Policy Holder Date of Birth: _____
Policy #: _____ Group #: _____

I hereby authorize release of information necessary to file claim with my insurance company and assign to Southern New England Healthcare for Women (SNEHW). I agree that I will pay any collection or attorney fees and costs incurred in collection of my account by SNEHW. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to provide the practice with current/updated insurance information, obtaining the necessary referral and/or other authorization from my primary care and/or referring physician when required. A copy of this signature is a valid original.

I also acknowledge that the practice had made the Health Insurance Portability and Accountability Act (HIPPA) notice effective April 13, 2003 available to me on the date indicated below.

Patient Signature _____ Date _____

Last Name: _____ First Name: _____ Date of Birth: _____

GYN HISTORY

Age your period began: _____

Date of Last Pap Smear _____

Have you ever had an abnormal pap smear? Yes No

Are you sexually active? Yes No If Yes, Men Women Both

Current Birth Control Method _____

Have you ever been diagnosed with any sexually transmitted infection or disease? _____

Have you had an HPV vaccine? _____

If Post Menopausal, Age at Menopause _____

Are you currently taking any Hormone Replacement Therapy medications? Yes No Have you ever taken any Hormone Replacement Therapy medications? Yes No

Have you had any post menopausal bleeding? Yes No

Date of Last Mammogram: _____

Date of Last Colonoscopy: _____

Date of most recent bone density? _____

OBSTETRICAL HISTORY

Have you ever been pregnant? (Including termination of pregnancy) YES NO

How many times have you been pregnant? _____

number of full-term delivery(s) _____ number of premature delivery(s) _____

number of terminations/abortions _____ number of miscarriages _____

number of tubal pregnancies _____ number of twins/triplets _____

How many children living? _____

PAST PREGNANCIES

Last Name: _____ First Name: _____ Date of Birth: _____

	Delivery Date	# of Fetus	Weight	Sex	Delivery Type	Full-term or Pre-mature	Complications during pregnancy or delivery
1							
2							
3							
4							
5							
6							

PAST MEDICAL HISTORY: Circle all that apply.

Arthritis	Yes	No	GI Problems (please specify)	Yes	No
Acid Reflux(GERD)	Yes	No	GYN Cancer(please specify)	Yes	No
AIDS/HIV	Yes	No	Headaches/Migraines	Yes	No
Anemia	Yes	No	Heart Problems	Yes	No
Anxiety/Depression	Yes	No	Hematologic Disorders(please specify)	Yes	No
Asthma	Yes	No	Hepatitis	Yes	No
Bladder Disorder (please specify)	Yes	No	High Cholesterol	Yes	No
Breast Cancer	Yes	No	High Blood Pressure	Yes	No
Cancer (please specify)	Yes	No	Kidney Disorder(please specify)	Yes	No
Coronary Artery Disease	Yes	No	Lung Disease(please specify)	Yes	No
Diabetes	Yes	No	Osteoporosis/Osteopenia	Yes	No
DVT/PE	Yes	No	Psychiatric Illness	Yes	No
Endometriosis	Yes	No	Stroke	Yes	No
Glaucoma	Yes	No	Thrombophilia	Yes	No
Fibromyalgia	Yes	No	Thyroid Disorder	Yes	No
Other					

SURGICAL HISTORY – Please list any surgery you may have had in the past.

Type of Surgery	Date of Surgery

FAMILY HISTORY

Last Name: _____ First Name: _____ Date of Birth: _____

Mother Living Deceased - Cause and Age at death: _____

Father Living Deceased - Cause and Age at death: _____

Number of Siblings: _____ Living _____ Deceased _____ Cause _____

Has any of your blood relative(s) had the following, also specify the age and relationship:

	Yes/No	Relative		Yes/No	Relative
Ovarian Cancer			High Blood Pressure		
Uterine Cancer			Kidney Disease		
Colon Cancer			Hyperlipidemia		
Breast Cancer			Diabetes		
Melanoma			Depression		
Prostate Cancer			Bipolar Disorder		
Heart Disease			Stroke		
Thyroid Disease			Osteoporosis		
Other					

SOCIAL HISTORY

Occupation: _____

Level of Education: _____

Marital Status: (circle one) Single Married Divorced Separated Widowed Domestic Partner

Exercise Level: (circle one) None Occasional Moderate Heavy

Smoking Status: (circle one) Never a smoker Former Smoker Smoker Have been smoking since ____ years old

Alcohol Intake: (circle one) None Occasional Moderate Heavy

Do you use illicit drugs? No Yes _____

Have you ever had abuse or domestic violence directed at you: No Yes

Do you routinely use a seat belt? No Yes Do you use sunscreen regularly? No Yes

Is a blood transfusion acceptable in an emergency? No Yes

Do you have an advanced directive? No Yes