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.

Comprehensive OBGYN Care

A division of Southern New England Women's Health, LLC

A Michael Coppa M.D.

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

Jeiny Zapata APRN

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, it's 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

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NOTICE AND CONSENT OF PATIENT FINANCIAL RESPONSIBILITY FOR LABORATORY TESTING

The laboratory test(s) ordered by your provider may require a prior authorization or may not be a covered benefit under your health insurance plan. Should your insurance plan determine the test(s) performed were not a covered benefit, were not medical necessary, and/or were not pre-authorized you understand and agree that Comprehensive OBGYN Care is not responsible for the charge(s) billed to you.

By signing below I acknowledge, my insurance plan may not cover the charge of some or all of the laboratory tests ordered by my health care provider and it is my responsibility to contact my insurance company regarding coverage of laboratory test(s).

X _____
Patient Signature

Printed Patient Name: _____

DOB: _____

Date: _____

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 _____

HISTORY INTAKE

Today's Date: _____

Last Name: _____ **First Name:** _____ **DOB:** _____

Important: In order to provide the highest quality health care possible, it is important that we have the following information. Please answer all the questions as accurately as possible. If you do not understand the questions, please ask for assistance. Thank you.

PHARMACY _____ **PHARMACY PHONE** _____

Address _____ City _____ State____ Zip_____

TELL US ABOUT OTHER PHYSICIANS YOU SEE:

PRIMARY CARE PHYSICIAN _____ **PCP PHONE:** _____

Address _____ City _____ State ____ Zip _____

GYNECOLOGIST _____ **GYN PHONE** _____

Address _____ City _____ State ____ Zip _____

LIST ALL ALLERGIES: _____

_____

LIST ALL MEDICATIONS: PRESCRIBED, OVER THE COUNTER AND HERBAL

May we have your permission to contact your insurance to obtain a list of the medications you have filled during the last 13 months? (Circle one) YES NO

MEDICATION/DOSE/FREQUENCY	MEDICATION/DOSE/FREQUENCY

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, (circle one) Men Women Both

Current Birth Control Method _____

If Post-Menopausal, age at Menopause _____

Are you currently taking any Hormone Therapy medications? Yes No _____

Have you ever used Hormone Therapy medications in the Past? 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: _____

_____

PAST MEDICAL HISTORY

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	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 surgeries you may have had in the past.

TYPE OF SURGERY	DATE OF SURGERY

FAMILY HISTORY

Mother: □ Living □ Deceased –Cause of Death: _____

Father: □ Living □ Deceased – Cause of Death: _____

Number of Siblings: ____ Living: ____ Deceased: ____ If so, what was the cause? _____

Have any of your blood relatives had the following? If so, please specify the age and relationship. Also state if maternal (M) or paternal (P).

	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: _____

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

How many children? _____

Exercise level: (Circle one) None Occasional Moderate Heavy

Smoking Status: (Circle one) Never a Smoker Former Smoker Smoker, for how many years? ____

Alcohol Intake: (Circle one) None Occasional Moderate Heavy

Do you use any illicit drugs? No Yes If yes, please state what drug(s) _____