Memphis Obstetrics & Gynecological Association, P.C.

Patient Information Sheet

Last Name:	Date: _____
First Name:	**Emergency Contact**
Preferred Name:	Name:
Middle Name:	Relationship:
Former Last Name:	Home Phone:
Sex: **Date of Birth:**	Mobile Phone:
Social Security #:	**Employment**
Address:	Employer:
Address line2:	Employer Phone:
Zip:	Occupation:
City: **State:**	Industry:
Home Phone:	**Guarantor (**one to whom statements are sent**)**
Cell Phone:	Patient's relationship to guarantor:
Consent to text: □ **Yes** □ **No**	Last name:
Work Phone:	First Name:
Patient Email:	Middle Name:
Contact Preference: □**Home** □**Work** □**Mobile** □**Mail** □**Portal**	Date of birth:
Primary office location:	**Mailing Address** □ Same as patient's address
Preferred Language:	Address:
Race: □American Indian □Asian □Asian Indian	Address line 2:
□Black/African American □European □Filipino □Japanese □Korean	Zip:
Native Hawaiian or Other Pacific Islander □White	City:
Marital Status: □Single □Married □Widowed □Divorced □Separated	State:
How did you hear about us?	Phone:

PRIMARY INSURANCE				
Insurance Name	**Mail to address:**	**City**	**State**	**Zip**
Patient's relationship to policy holder:				
Member/Subscriber id#	Policy/Group #			
Policy holder's name:		DOB:	Sex:	
Policy holder's address:		City:	State:	
Policy holder's Employer:				
SECONDARY INSURANCE				
Insurance Name	**Mail to address:**	**City**	**State**	**Zip**
Patient's relationship to policy holder:				
Member/Subscriber id#	Policy/Group #			
Policy holder's name:		DOB:	Sex:	
Policy holder's address:		City:	State:	
Policy holder's Employer:				

AUTHORIZATION—I hereby give my permission to Memphis Obstetrics & Gynecological Association, P.C.(MOGA) for medical treatment including but not limited to examination, injections, blood tests, diagnostic testing, or medical procedures deemed necessary and appropriate for diagnosis and treatment. I authorize MOGA to release any information concerning my treatment and irrevocably assign to them all insurance benefits for my treatment. I understand that I am financially responsible for payment of all charges at the time they are rendered including any charges in excess of my insurance as reasonable and customary, whether or not covered by Medicare or other insurance. I understand that I am responsible for verifying my insurance coverage and verifying my benefits with my insurance company. I also understand that I am responsible for 33% collection costs and/or attorney fees incurred in the collection of this account. A photocopy of this statement is considered to be as valid as an original.

Signed: _____ Date: _____

FINANCIAL & ADMINISTRATIVE POLICIES

Consent to Treat

- I hereby give my permission to Memphis Obstetrics & Gynecological Association, P.C.(MOGA) and the divisions' threreof for medical treatment including but not limited to examination, injections, blood tests, diagnostic testing, or medical procedures deemed necessary and appropriate for diagnosis and treatment.

DISCLOSURE OF TENNCARE COVERAGE

- You are responsible for notifying us of Tenncare coverage. I certify that I have provided all active insurance information to the practice.

PATIENT PAYMENT POLICY AND COVERED SERVICES

- I understand that I am financially responsible for payment of all charges at the time services are rendered including any charges in excess of my insurance as reasonable and customary, whether or not covered by Medicare or other insurance. I understand that I am responsible for verifying my insurance coverage and verifying my benefits with my insurance company.
- It is the policy of MOGA to collect all patient balances, co-pays, and deposits due from patients at the time of service.
- If you are being seen for maternity care or for certain other surgical or medical procedures, our office may contact your insurance carrier to verify your insurance coverage and benefits. An estimation of your financial responsibility will be determined according to the contractual agreement between MOGA and your insurance company for these services. Our Benefits Coordinators will review your benefits with you to explain your financial obligations to MOGA, and you may be required to pay a deposit prior to these services being rendered.
- If your insurance claim is denied due to incorrect personal information or incorrect insurance information that you have provided, you will be billed for any unpaid claims for your services, and payment in full will be due immediately.
- If your account or any account for which you are responsible is sent to a collection agency due to non-payment of any patient balance, you may be dismissed from the practice for any future care and services, which includes all providers at MOGA. Additionally, a collection fee of 33% will be added to your account balance.
- Your health insurance plan **may not** provide coverage for all medical services, tests, and/or procedures that our providers may offer or recommend for your treatment. It is your responsibility to know and understand the services covered by your insurance, and if your insurance does not cover these services, you will be responsible for payment.
- You are also responsible for knowing which hospital you insurance carrier allows you to utilize for your procedures, tests, and admissions.
- If you do not have medical coverage with an insurance for which MOGA participates or if you are a new patient and cannot supply your valid insurance card or for which coverage cannot be determined, you must pay in full at the time of service.
- Certain labs collected in this office may be sent to an outside lab for testing. As such, you may be billed by that reference lab for these.
- If you are required to have a referral or other prior authorization for medical services, it is your responsibility to obtain this.
- We will require that accounts with self-pay balances to pay their balances to zero ($0) prior to receiving further services by our practice.

RETURNED CHECK CHARGE

- MOGA will charge the patient account $25.00 for any returned checks to cover MOGA's cost for any related bank charges.

CANCELLATION POLICY

- MOGA requires a 24 hour cancellation notice for any scheduled medical appointment or surgery/procedure.
- No shows and cancellations without a 24-hour notice may receive a $20.00 charge for missed office visits and $150.00 for missed surgeries or procedures. This charge will be the patient's responsibility and will not be billed to or reimbursed by your insurance.
- If a patient repeatedly misses or cancels appointments, the patient may be dismissed from the practice.

WELLNESS/ANNUAL VISITS WITH OTHER PROBLEMS

- If during your annual/well-woman preventive care exam, you have or need treatment for a problem, if the problem is addressed during the visit in lieu of scheduling a separate appointment, in addition to the preventive exam it may be necessary that a problem/E&M visit be billed along with other labs, testing, and/or procedures, which may be subject to copays and/or deductible.

PERSONAL INFORMATION VERIFICATION

- It is our policy to verify your demographic and insurance information **at every visit** to help insure that claims are processed timely and accurately. Although it may seem unnecessary at the time, this is extremely important to our billing process. Please bring your insurance card with you **EVERY VISIT**. Additionally, a photo ID will be requested from all patients.

FORMS AND PAPERWORK

- There is a minimum fee of $20.00 for the release of medical records which is the responsibility of the patient to pay prior to receiving the records. For records that exceed twenty (20) pages, there may be an additional charge of $0.50 per page for all pages exceeding the first twenty (20) pages.
- A $25.00 fee will be charged to complete FMLA and standard disability forms. An additional fee of $25.00 will be charged for submitting subsequent forms.

Practice Guidelines

- Routine medication refills are called in only during office hours. We do not refill prescriptions after hours or on weekends. When calling for prescriptions, please have the phone number to your pharmacy.
- Requests for narcotics prescriptions will not be granted after hours or on weekends.
- If you have a question for the nurse or your provider, we will return your call as soon as possible, giving priority to emergencies and scheduled patients in the office. At the time of your call, please let us know if you will be unavailable at a certain time.
- Physician excuses for days missed from work or school are written only for the days you are seen in our office and additional days needed for recovery. We are unable to write excuses for illnesses not evaluated in our office. We also do not backdates excuses.

Patient Signature _____ Date: _____

HIPAA Privacy and Release of Information Authorization

I, _____ hereby authorize Memphis Obstetrics & Gynecological Association, P.C. and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to the practice. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____ _____

Patient Printed Name Date

_____

Patient Signature

Memphis Obstetrics & Gynecological Association, P.C.

Privacy Management - Protected Health Information & Communications

Protected Health Information:

I hereby authorize release of my protected health information (PHI), including account status, test results, scheduled appointments, and information regarding my treatment, to persons I have listed below. Any person who is not listed will not be able to obtain protected health information. It is not necessary to list other treating physicians or insurance companies.

Name of authorized person	Relationship
1.	
2.	
3.	
4.	
5.	

Patient Communications:

Our practice utilizes an electronic medical records system with an integrated patient portal which allows patients, providers & practice staff to communicate more securely and efficiently. We use the system to send appointment reminders, lab results, patient education documents, visit summaries, and billing notices to patients. When communications are sent to your secure patient portal account, you will be notified via email, phone and/or text. Please indicate any or all automated messaging preferences for each of the following items:

Health Notifications: □ Email □ Phone □ Text message

Appointments: □ Email □ Phone □ Text message

Announcements: □ Email □ Phone □ Text message

Billing: □ Email □ Phone □ Text message

Patient Signature: _____ Date: _____

Printed Name: _____ MRN# _____

Memphis Obstetrics and Gynecological Association, P.C. (All Divisions: MOGA/MCW/WPG)

CONFIDENTIAL PATIENT MEDICAL HISTORY

Name:_____ Birthdate:_____ Chart # _____ Date: _____

Allergies: _____

Do you have a **LATEX Sensitivity / Allergy**: Yes: □ No: □ **Other Allergies** (circle): Iodine, X-ray dye, Eggs, Peanuts

MEDICATIONS: Please list ALL medications that you take, the strength, and how often you take them

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PHARMACY (Name and Number): _____

OTHER HEALTH CARE PROVIDERS YOU CURRENTLY SEE (other than MOGA)

Provider Name	**Specialty (ie: PCP, Cardio)**	**Phone Number:**

IMMUNIZATIONS: Please check if you have received these adult immunizations and indicate when

□ Influenza (Flu) / Date:	□ Tetanus / Date:
□ Pneumonia / Date:	□ Tdap (Tetanus, Diptheria & Pertussis)/ Date:
□ HPV Vaccine/Gardasil (Series of 3 shots – Initial shot, 2 months later, then 6 months from 1st shot) Dates (Approx. date is ok): #1 _____ #2 _____ #3 _____	

FAMILY HISTORY: Check illnesses of your **IMMEDIATE BLOOD RELATIVES** and **LIST THE RELATION**

□ Adopted: Family history unknown	□ Hypertension/ High blood pressure / relation:
□ Blood clotting disorder / relation:	Malignant neoplastic disease/Cancer: (please list relative)
□ Cerebrovascular accident (CVA) / Stroke	□ Breast: _____ □ Uterine: _____
□ Cystic fibrosis / relation:	□ Colon: _____ □ Other: _____
□ Diabetes /relation:	□ Ovarian: _____
□ Disorder of thyroid/ relation:	□ Myocardial Infarction (heart attack)
□ Heart disease / relation:	□ Substance abuse:
□ Hypercholesterolemia / relation:	□ Other Family History:

SOCIAL HISTORY: Provide the following information about **YOURSELF**

Tobacco or Cigarette Use: □ Never Smoked □ Former Smoker - Date Quit _____ □ Current Smoker - # per day ____ # of years_____	Do you use recreational drugs? □ Yes □No If yes, which one(s) and how often? _____
Relationship Status: □ Single □ Married □ Widowed □ Divorced □ Separated	Sexual Orientation: □ Heterosexual □ Homosexual □ Bisexual
Lives □ alone or □ with others	Are you currently in a situation or relationship that makes you feel unsafe or threatened? □Yes □No If yes, explain _____
Education (highest grade completed): _____	
Occupation: _____	Do you refuse blood products or medical treatment of Any kind because of religious beliefs? □ Yes □ No Explain:_____
Work Status: □Part-time □Full-time □Retired □Unemployed □Disabled	
Do you drink alcoholic beverages? □ Yes □ No	Do you have an advanced directive: □ Yes □ No
If yes, how much? _____	Other: _____

Memphis Obstetrics and Gynecological Association, P.C. (All Divisions: MOGA/MCW/WPG)

CONFIDENTIAL PATIENT MEDICAL HISTORY

Name:_____ Birthdate:_____ Chart # _____ Date: _____

SURGICAL HISTORY: Please list surgeries or procedures and **provide dates (**month and/or year is fine**)**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

GYN History:

Birth control method: _____	□ Infertility
Are you sexually active? □ Yes □ No	□ Polycystic Ovarian Syndrome
If no, have you ever been sexually active? □ Yes □ No	Age of Menopause _____
Age of first sexual activity: _____	Postmenopausal Bleeding? □ Yes □ No
Number of sexual partners in lifetime: _____	Taking hormone replacement therapy? □ Yes □ No
Menses: (**only complete if still having periods**)	Have you ever had any of the following infections?
Age of first period _____	□ Chlamydia □ Gonorrhea □ Herpes □ HIV □ Syphilis
□ Regular (21-35 days apart) □ Irregular	Abnormal Pap Smear: □ Yes - date: _____ □ No
Duration of menses: _____ days	□ Colposcopy/Date: _____ □ Cryo/Date: _____
Menstrual Flow: □Mild □Moderate □Severe	□ LEEP/Date: _____ □ CKC/Date: _____

Date and Location of last preventative screenings

Last **Pap Smear**: Date:_____ Location: _____
Last **Mammogram**: Date: _____ Location: _____
Last **Complete Physical Exam with Primary MD**: Date: _____ Provider Name: _____
Last **DEXA Scan** (**Bone Density**): Date: _____ Location: _____
Last **Colonoscopy**: Date: _____ Provider Name: _____

OB History: (Please list details of each pregnancy below)

Total Pregnancies: ____ Full term: ___ Preterm: ___ Elective abortions: ___ Miscarriages: ___ Ectopics: ____ Multiple births ____ Living ____

Date	Weeks Delivered	Birth wt	Sex	Type of Delivery & Anesthesia	Preterm Labor or Other Complications

PAST MEDICAL HISTORY: Please check illnesses or conditions **YOU** have had.

□ Autoimmune Disorder	**Heart Disease**:
Blood disorders: □ Anemia	□Atrial Fibrillation □Congestive Heart Failure □CAD
□ DVT (Blood Clot in leg) □ PE (clot in lung)	□High Cholesterol □High Blood Pressure (HTN)
□ Blood Transfusion: Date(s): _____	**Kidney Disease:** □ Kidney Stones □ Other_____
Sickle Cell : □ Trait □ Disease	**Lung Disease**: □Asthma □COPD □Pneumonia
□ Breast Problems (specify) _____	Do you use a CPAP machine for sleep apnea? □ Yes
Cancer: □Breast □Ovarian □Uterine □Colon	**Musculoskeletal**:
□ Other Cancer(specify) _____	Arthritis: □ Osteoarthritis □ Rheumatoid Arthritis
□ Diabetes □ Gestational diabetes (in pregnancy)	□ Osteopenia □ Osteoporosis □ Other _____
□ Eating Disorder	**Neurological**: □ Migraine Headaches
Gastrointestinal Disorders:	□ Seizure Disorder/Epilepsy □ Stroke
□ Acid Reflux/ GERD □ Celiac Disease □ Cirrhosis	**Psychological:** □Anxiety □Bipolar □Depression □ADD
□ Crohn's Disease □ Diverticulitis □ Hepatitis/Liver Disease	**Thyroid Disorder**: □Goiter □Underactive □Overactive
□ Irritable Bowel □ Ulcerative Colitis	**Varicella**/Chicken Pox: □ Had Virus **or** □ Had Vaccine
□ Other (specify): _____	

Patient Signature: _____ Date:_____