About Women OB/GYN, PC

Please Review for accuracy and missing information. All corrections should be noted on the form.

PATIENT INFORMATION

Name:	***Date of Birth:***	
Address One:	***Social Security #:***	
Address Two:	***Email:***	
City:	***Emergency Contact:***	**Relationship:**
State: ***Zip:***	***Emergency Contact Cell Phone#:***	
Home Phone#:	***Employer/School:*** ☐**FT** ☐ **PT**	
Work Phone#:	***Referring Physician:***	***Marital Status:***
Cell Phone #:	***Pharmacy*:**	
Race: ☐ ***American Indian or Alaskan Native*** ☐ ***Asian*** ☐ ***Black or African American*** ☐ ***Native Hawaiian*** ☐ ***Caucasian*** ☐ ***European Descent*** ☐ ***Middle Eastern*** ☐ ***North African Descent*** ☐ ***Hispanic or Latino*** ☐ ***Other Pacific Islander*** ☐ ***More than one race*** ☐ ***I do not wish to disclose this information***	***Language Spoken:***	
	Ethnicity: ☐ ***Hispanic or Latino*** ☐ ***Not Hispanic or Latino*** ☐ ***I do not want to disclose this information***	

GUARANTOR INFORMATION

Name:		***Date of Birth*:**
Address One:		***Social Security#:***
Address Two:		
City:		***State:*** ***Zip*:**
Home Phone#:	***Cell:***	***Work Phone#:***

INSURANCE INFORMATION

Primary Insurance:		***Secondary Insurance:***	
Certificate#:		***Certificate#:***	
Group Number :		***Group Number:***	
Group Name:		***Group Name:***	
Subscriber Employer:			
***Subscriber Name*:**	***DOB:***	***Subscriber Name:***	***DOB:***
Subscriber Relationship:	***Subscriber Sex:*** **M F**	***Subscriber Relationship:***	***Subscriber Sex:*** **M F**

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to About Women OB/GYN. If the above insurance information is not correct, I understand I'm financially responsible for unpaid balances.

Authorization to Release Medical Information to Third Party Organizations: I authorize About Women OB/GYN to release my billing information to Ultrasound Partners or LabCorp of America to bill for services rendered in our office.

Authorization To Release Medical Information to other healthcare providers. I hereby authorize About Women OB/GYN to release any information necessary for my course of treatment.

_____ _____ Acct#: «PNumber»

Signed (patient or parent if minor) Date

Family History Questionnaire for Common Hereditary Cancer Syndromes

Name: _____ Date of Birth: _____

While most cases of cancer happen by chance, ~10% of the time cancer is linked to a single gene mutation that has been passed down over generations. It's important to know that there are genetic tests available that can help you understand your risk of developing hereditary cancer and for your provider to manage your care appropriately.

Please circle yes to those that apply to you and/or your family. Consider these family members when completing the form:

Mother – Father – Sister – Brother -- Children -- Aunt – Uncle – Grandparent – Niece -- Nephew

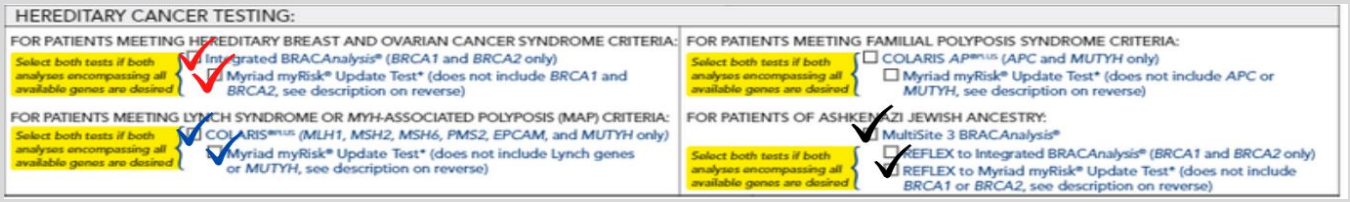
Both Maternal AND Paternal sides of the family

			Specify Relative(s):	Age of Diagnosis:
Have you been personally diagnosed with Breast Cancer	Yes	No		_____
Has anyone in your family had Breast Cancer before age 50	Yes	No	_____	_____
Has anyone in your family had Ovarian Cancer at any age	Yes	No	_____	_____
Has there been 3 Breast Cancers on the same side of the family (at any age)	Yes	No	_____	_____
Has anyone in your family had Pancreatic Cancer at any age	Yes	No	_____	_____
Do you have Ashkenazi Jewish Ancestry and a family member who had breast cancer at any age	Yes	No	_____	_____
Has there been 3 or more of the following cancers on the same side of the family: Uterine, Colorectal, Stomach	Yes	No	_____	_____

If you answered "yes" to any of the above questions, your provider will discuss genetic testing as an option for you. Genetic testing for cancer is an important piece in assessing your cancer risk.

OFFICE USE ONLY:

Patient offered genetic testing: Yes / No Accepted / Declined Provider Initials: _____



CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION TO FAMILY

I **consent to disclosure** of the following protected health information about me to the following **family member(s)** or **person(s)** involved in my care or payment for my care: _____.

Check all that may apply:

- ☐ All my medical information
- ☐ Information necessary to schedule appointments for me
- ☐ Lab or test results
- ☐ Information necessary to provide, call in or pick up prescriptions for me
- ☐ Information necessary to help my family member(s) take care of me
- ☐ Information necessary to allow my family member(s) to pick up or arrange for medical equipment to be provided for me
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payors

My consent will remain in effect as long as I am a patient of About Women Ob/Gyn, PC unless and until I notify About Women Ob/Gyn, PC in writing of any changes.

_____ _____

Signature of Patient Date

_____

Print Name

_____

Relationship of Representative to Patient

© 2013 Smith Moore Leatherwood LLP
All rights reserved.

Financial Policy

Insurance

1. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances and non-covered services
2. It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and submitting the charges to the correct plan for reimbursement.**
3. It is your responsibility to understand your benefit plan regarding, for instance, covered services and participating laboratories. For example,

a. Not all plans cover annual healthy (well/routine) physicals, radiology, and laboratory screenings. If these are not covered, you will be responsible for payment.
b. Some plans have a limit as to the number of allowable well/routine visits/services/screenings per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment.

4. It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Payment

1. If you do not have insurance, do not provide an insurance card or do not provide a social security number at the time of service, you will be considered a self-pay patient. Self-pay patients are required to pay for services in FULL at the time of the visit.
2. If we do not participate in your insurance plan, payment in full is required from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
3. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of your bill.
4. For scheduled appointments, prior balances must be paid prior to the visit.
5. We accept cash, checks, Visa, and MasterCard credit and debit.
6. If you participate with a high-deductible health plan (over $1000.00), we may require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file.
7. Patients may be subject to copay for a Nurse visit or Lab draw if an appointment was scheduled greater than 72 hours from the last office visit.
8. If you have an ultrasound in our office, you will also receive a bill from Ultrasound Partners as they interpret our ultrasounds.

Fees

1. If you are not able to keep an appointment, we would appreciate 24-hour notice. **There is a charge of $50.00 for missed appointments or cancellations within 24 hours of the appointment.**
2. **Cancellations of less than 7 days of a procedure or surgery are subject to a fee of $250.00.**
3. **A fee of $30.00 is due at the time of request for the completion of forms or letters. This is a non- insurance covered service. Forms and letters will not be processed until the fee has been paid.**
4. **A fee of $25.00 will be accessed for all non-emergent calls received after 5pm. This is a non-insurance covered charge.**
5. **Non physician requests for medical records will be assessed as an administration fee according to the current state regulations. The fee is due at the time the records are delivered.**
6. Any account balance outstanding longer than 28 days will be charged **1% interest** for each 28-day cycle.
7. Any balance outstanding longer than 90 days will be forwarded to a collection agency. You agree to reimburse us the fees of any collection agency, which may be based on a percentage of **33% of the account balance**, and all costs and expenses, including reasonable attorneys' fees; we incur in such collection efforts.
8. A **$34.00 fee** will be charged for any checks returned for insufficient funds.
9. If an insurance company mandates that a pre-authorization is required for a medication, a fee of $25 will be charged.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Responsible Party Member's Signature _____ Date _____

Patient Name _____ Account # _____

PATIENT PRIVACY POLICY ACKNOWLEDGMENT AND CONSENT

I have been given a copy of About Women OB/GYN, PC's Notice of Privacy Practices, version effective August 1, 2013. I consent to the uses and disclosures of my health information as outlined in the notice.

_____ _____

Signature of Patient or Representative Date

_____

Print Name

_____

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

_____

_____

FOR About Women OB/GYN, P.C.'s USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it:

_____

_____

_____

_____

_____

© 2013 Smith Moore Leatherwood LLP
All rights reserved.