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

OB Billing Procedures

Our office bills a one time "Global Maternity Fee" to your insurance company at the time of delivery. This fee includes all of your OB physician visits and *our physician portion* of your delivery. (Your insurance/you will still receive a bill from the hospital and any other providers of service, anesthesia, pediatrician, etc)

The services that are not included in the Global Maternity Fee are radiology services and laboratory services. All radiology and laboratory services will be billed at the time of service to your insurance company.

We do not send monthly statements to our OB patients. If your insurance company leaves you a balance on radiology or lab services, the front desk will tell you the balance due and expect payment in full. You should have already been notified by your insurance that you owe that amount. We do not determine your co pay, co ins, or deductible amounts, that is a contract between you and your insurance. We bill your insurance, they send you an explanation of benefits (EOB) and then they send us the same EOB. After we receive the EOB, we transfer the balance to you, per the instruction on the EOB.

Our office policy is to ESTIMATE and PRECOLLECT the amount your insurance tells us you will owe on the Global Maternity Fee. If your insurance says you have 90% coverage, we will precollect your portion, in this case 10%. The estimated patient portion of the Global Maternity Fee **is due before your 24th week of pregnancy**. It will automatically be divided into 2 monthly payments and the front desk will collect those payments at the time of your monthly appointment. If you cannot make the prepayment amount at the time of your appointment, payment is due by the end of that same month. Payment can be made by cash, check or credit card, in person, via mail, or over the phone. If the payment is not paid in full before your 24th week you may be dismissed from the practice and expected to transfer your care to another provider.

Our office charges $30.00 for any OB related forms. The $30.00 forms fee will be collected at the time you drop off the form. The form will not be completed until the fee is paid. Once completed, we will send, fax, or keep the form in our office for pickup.

If you transfer into or out of About Women OB/GYN during the pregnancy, we will NOT bill a global maternity fee. Your previous or new physician will bill their portion; About Women will bill our physician portion. We will bill you for balances that your insurance tells us you owe.

If you change insurance companies during the pregnancy, we will NOT bill a global maternity fee. We will bill each insurance company for services preformed during their coverage period. We will bill you for balances that your insurance tells us you owe. It is the responsibility of the patient to notify About Women OB/GYN of all insurance changes in writing within 30 days of the insurance change.

If you deliver a baby boy and you choose to have him circumcised, **we will bill you until you provide our office with his full name and insurance information.** Once you provide the baby's information we will bill the insurance if we are a participating provider. **Information must be received by our office within 30 days of the service date**.

Refunds cannot be made until all OB related services have been processed and reconciled by your insurance company.

If you have any questions related to the above information please call or visit the billing department.

Patricia Marquez, OB Coordinator, 703-878-0740, ext 324
Chris Allen, Business Office Manager, 703-878-0740, ext 332

Patient Signature _____ Date _____

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

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 to submit the charges to the correct plan for reimbursement.**
3) It is your responsibility to understand your benefit plan with regard to, 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.

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 administration fees according to the current state regulations. The fee is due at the time the records are delivered.**
6) **Co-payments** are due at the time of service. A **$22.00 service fee** will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.
7) Any account balance outstanding longer than 28 days will be charged **1% interest** for each 28-day cycle.
8) 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 28**% of the account balance**, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.
9) A **$34.00 fee** will be charged for any checks returned for insufficient funds.
10) If an insurance company mandates that a pre-authorization is required for a medication, a fee up to **$50.00** fee may 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 _____

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:

_____

_____

_____

_____

_____

Medical History Form

Name: _____ Date of Birth: _____ Today's Date: _____

Drug or Food Allergies: No Yes If yes, please list: _____

Problem List/Medical History: Please circle if you have had any of the following:

Breast:
Fibrocystic Breast
Mass
Discharge

Cancer:
Breast
Cervical
Colon
Ovarian
Uterine

Endocrine
Diabetes
Obesity
Hyper/Hypo Thyroid

Cardiac:
High Cholesterol
DVT/Pulmonary Embolism
Heart Disease
Hypertension
Mitral Valve Prolapse
Myocardial Infarction

Gynecologic:
Abnormal Cycle
Endometriosis
Female Infertility
Fibroids
Ovarian Cyst
Pelvic Inflammatory Disease
PMS

Urinary
Frequency
Stress Incontinence
Urgency

Infectious Disease:
Chlamydia
Gonorrhea
Streptococcal/GBS
Syphilis
Trichomoniasis
Hepatitis, A, B, C, or D
Herpes Simplex
HIV

Neuro/Psych:
Alcohol Abuse
Anxiety
Cerebrovascular Accident
Depression
Headache
Insomnia
Migraine
Suicide Attempt

Hematology
Lupus
Sickle Cell / Trait

Musculoskeletal:
Osteopenia
Osteoporosis

Respiratory:
Asthma
COPD

Menstrual History:

Age when you started your cycle?_____ Number of Days it Lasts ____ Days in Between Cycle: _____

Are you menopausal? No Yes If yes, have you experienced any of the following:
Hot Flashes Night Sweats Vaginal Dryness Other: _____

Immunization History:

Have you been vaccinated for any of the following?

Gardasil Tetanus Pneumonia Hepatitis B

Family History: Please circle if any of your family members have had any of the following:

Asthma or Respiratory Disease	No	Yes	If yes, which relative? _____
Anemia or Bleeding Disorder	No	Yes	If yes, which relative? _____
Blood Clots or Phlebitis	No	Yes	If yes, which relative? _____
Cancer – GYN or Ovarian	No	Yes	If yes, which relative? _____
Cancer – Colon	No	Yes	If yes, which relative? _____
Colitis or GI Ulcers	No	Yes	If yes, which relative? _____
Diabetes	No	Yes	If yes, which relative? _____
Heart Disease or Mitral Valve Prolapse	No	Yes	If yes, which relative? _____
Hepatitis	No	Yes	If yes, which relative? _____
High Blood Pressure	No	Yes	If yes, which relative? _____
High Cholesterol	No	Yes	If yes, which relative? _____
Stroke or Neurologic Disease	No	Yes	If yes, which relative? _____
Thyroid Disease	No	Yes	If yes, which relative? _____
Urinary Infections	No	Yes	If yes, which relative? _____

Other: _____

Did your mother take the drug "DES" while pregnant with you? No Yes Unknown

Social History:

Most Recent Occupation: _____

Do you drink? No Yes

If yes, what is the frequency? Occasional Moderate Heavy

Do you smoke? No Yes Cigarettes per day: _____

How many years have you smoked: _____

Do you use any street drugs? No Yes If yes, please list what kind: _____

Exercise: No Yes If yes, how often: _____

Ethnicity: _____

Languages Spoken: _____

Sexual History:

Were you sexually active before the age of 16?	No	Yes	
Number of current sexual partners:	_____		
5 or more lifetime sexual partners:	No	Yes	
Primary method of birth control:	_____		
Have you ever been the victim of rape or sexual assault?	No	Yes	
Are you currently sexually active?	No	Yes	Never Been
Have you ever tested positive for HIV?	No	Yes	If yes, when? _____

Medications:

List all medications including over the counter: _____

_____

Pregnancy History:

Are you currently pregnant? No Yes
Number of total pregnancies: _____ Number of Deliveries: _____ Vaginal _____ C-Section _____
Number of Living Children: _____ Abortions/Miscarriages: _____ Ectopic: _____
Stillbirth: _____

Have you ever had a delivery before 37 weeks? Describe the complications:_____
_____

Surgical History:

Please list all of your past surgeries including dates: _____
_____
_____

Health Maintenance:

Date of last pap smear: _____ Date of last HPV test: _____
Date of last colonoscopy: _____ Date of last Mammogram: _____
Date of last dexa scan: _____

List any abnormal pap smears (year and type of abnormality): _____
_____

Please circle if you have had any of the following procedures:

Colposcopy Cryotherapy Lletz/Leep Other (please explain): _____

I certify that the information reported herein is correct.

_____ _____
Patient's Name Signature