Patient Information

First Name	MI	Last Name	DOB

Address	City	State	Zip

Home #	Cell Phone #	Work #

Email:

Social Security #	Race:	Marital Status:	How did you find out about us?
		____ Single ____ Married ____ Divorced ____ Widowed	

Pharmacy Name, Location, Phone:

Primary Care Physician & Phone

Employer:	Employer's Address:

Insurance Information

Name of Primary Insurance:	Insurance Address:

Insurance ID:	Group #

Subscriber's Name:	Subscriber's Social Security:	Subscriber's DOB:

Emergency Contact Information

Last Name:	First Name:	Relationship to Patient:

Address:	City:	State:	Phone #

The information I have provided is accurate and I understand Mid-Atlantic OB-GYN will not be held responsible for any charges not paid by my insurance company due to errors submitted on this form.

Signature: _____ Date: _____

Medical Information

Patient Name	DOB	Age:

Reason for your visit today:	How long have you had this problem?

Medical History

Age at first period?	Do you have regular monthly periods? Yes No	How often does your period come?

Periods are: Mild Moderate Heavy	First Day Last Menstrual Period	Cramps: Yes No If yes, Mild Moderate Severe

Current Birth Control:	Are you happy with your birth control? Yes No	Sexual Orientation:	Marital Status:

Do you have Fibroids? Yes No	Do you have an ovarian cyst? Yes No	Do you have endometriosis? Yes No

Are you sexually active?	Last Pap Smear: ____/____	Have you ever had an abnormal Pap?	If yes, please give year and any procedures:

Last Mammogram: ____/____	Have you ever had an abnormal Mammogram?	If yes, please give year and any procedures:

Last Colonoscopy: ____/____	Last Bone Density ____/____

Allergies:	Reaction:

Medical History Continued….

Medications	Dosage

Smoking History: Do you currently smoke?_____ If yes, _____packs/day Have you ever smoked?_____ If yes, _____ packs/day	Do you currently use alcoholic beverages? Yes No Have you ever used alcoholic beverages? Yes No Have you ever used recreational drugs? Yes No Do you currently use recreational drugs? Yes No	Do you do monthly breast exams? Yes No Do you currently exercise regularly? Yes No

Anemia	Yes	No	Blood Transfusion	Yes	No	COPD	Yes	No
Blood Clots	Yes	No	Leukemia	Yes	No	Pneumonia	Yes	No
Varicosities	Yes	No	RH Disease	Yes	No	Arthritis	Yes	No
Stroke	Yes	No	Epilepsy	Yes	No	Lupus	Yes	No
Depression	Yes	No	Anxiety	Yes	No	Cytomegalovirus	Yes	No
Multiple Sclerosis	Yes	No	Asthma	Yes	No	Rubella	Yes	No
Chicken Pox	Yes	No	MRSA	Yes	No	Heart Disease	Yes	No
Hypertension	Yes	No	Rheumatic Fever	Yes	No	Hepatitis	Yes	No
Gallbladder Disorder	Yes	No	Crohn's	Yes	No	Peptic Ulcer	Yes	No
Colitis	Yes	No	Renal Disease	Yes	No	Chronic UTI's	Yes	No
Diabetes	Yes	No	Thyroid Disorder	Yes	No	Osteoporosis	Yes	No
Scoliosis	Yes	No	Cancer If so, what type?	Yes	No	Glaucoma	Yes	No
HIV/AIDS	Yes	No	Chlamydia	Yes	No	Gonorrhea	Yes	No
Syphilis	Yes	No	Genital Herpes	Yes	No	HPV	Yes	No
Group B Streptococcus	Yes	No	Trichomoniasis	Yes	No	Tuberculosis	Yes	No

Family Medical History

Are you adopted? Yes No | Are you of Jewish Descent? Yes No

Please check all that apply under the appropriate family member: (For brother and sister please list which sibling or both) Please list Age

	Self	Age	Parents/ Siblings/ Children	Age	Relatives on Mother's side	Age	Relatives on Father's	Age
Breast Cancer								
Ovarian Cancer								
Uterine Cancer								
Colon/Rectal Cancer								
Other Cancer (Specify cancer type)								
High Cholesterol								
Osteoporosis								
Birth Defects								
Diabetes								
Gestational Diabetes								
Hypertension								
Hypertension in Pregnancy								
Heart Disease								

Reproductive History

Total # of Pregnancies	Full term births	Premature births	Spontaneous Abortions	Induced Abortions	Ectopic	Stillbirths	Living

Date	Months	Infant weight	Sex	Delivery Type (Vaginal or Cesarean):	Anesthesia Received (i.e. Epidural):	Complications	Location

Surgical History

Have you had any of the following surgeries?	
Oral: Yes No	If so, What and When?
Abdominal: Yes No	If so, What and When?
Breast: Yes No	If so, What and When?
Gynecological: Yes No	If so, What and When?
Orthopedic: Yes No	If so, What and When?
Cardiac: Yes No	If so, What and When?
Spinal: Yes No	If so, What and When?
Other: Yes No	If so, What and When?

Patient Policy for Missed Appointments

If you know that you will be unable to keep your appointment, please notify us within 24 hours of your scheduled appointment so that we may accommodate other patients that may require our services. This will assist us in meeting the medical needs of the community that may require immediate attention.

You will be charged a $50.00 fee for missed new patients and follow-up appointments when you do not provide a 24-hour notice.

We appreciate your business and look forward to serving you and your medical needs in the future.

Patient Signature: _____ Date ____/____/____

Patient Name (PRINT): _____

Notice of Deemed Consent to HIV, HEPATITIS B,HEPATITIS C Blood Testing

A Virginia law was enacted in 1989 that allows health care providers to test their patients for HIV antibodies, Hepatitis B, and Hepatitis C when a health care worker is exposed to the blood or body fluids of a patient which may transmit human immunodeficiency virus (HIV), the virus which causes Aids or Hepatitis B. Because this is a law, in the event of such exposure, you will be deemed to have consented to such testing, and to have consented to the release of test results to the exposed worker. Except in emergencies, you will be informed before any of you blood is tested for HIV antibodies, Hepatitis B, and Hepatitis C, the testing will be explained to you and you will be given the opportunity to ask any questions you may have. You will be provided with the test results and appropriate counseling. Test results, if positive, are required by law to be reported to the Virginia Department of Health. I have read and understood the above information.

Patient Signature: _____

Date: _____

Financial Policy Statement

Welcome to Mid-Atlantic OB-GYN. We are pleased you have chosen our practice for your medical care. We ask that you carefully read and sign this Financial Policy Statement. As your medical care provider, our relationship is with you and not your insurance carrier. As a courtesy to you, we will file your claim with your insurance company. However, you are solely responsible for all charges and payment to Mid-Atlantic OB-GYN. Benefit eligibility obtained from your insurance company is for informational purposes only and not a guarantee of payment. If we are contracted with your insurance company, we will accept assignments. You will be responsible for your payment portion at the time of service. After 45 days from the date of service, you agree to pay any unpaid amounts that are not paid by your insurance. It is your responsibility to provide necessary referrals and/or authorizations. You are expected to understand your benefits, coverage and responsibilities. This includes obtaining any referrals and/or authorizations which your insurance company might require before care is provided.

* All co-pays, co-insurance and deductibles are due and payable at the time services are rendered. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at the time services are rendered.

*If your account balance is under $300.00 we will automatically deduct the monies owed with the credit card/debit card on file.

Any amounts owed to Mid-Atlantic OB-GYN after 90 days from the date of service will be referred to an outside agency and/or attorney for collection. You agree to pay Mid-Atlantic OB-GYN interest at the rate of 18% per annum from the date of service on any amounts that are not paid after 45 days from the date of service. You agree to pay Mid-Atlantic OB-GYN all costs of collection, including but not limited to all collection costs, attorneys' fees, court costs, and expert costs from the date your account is turned over to an outside agency or to an attorney for collection.

In consideration of the services performed by Mid-Atlantic OB-GYN Associates, you agree to abide by the terms of this Financial Statement.

Patient Signature _____ Date_____

Printed Name _____

Guarantor Signature _____ Date_____

Printed Name _____

Authorization

I, _____ hereby authorize Mid-Atlantic OB-GYN, to apply for benefits on my behalf for services rendered. I certify that the information I have provided is correct. I authorize the release of any necessary information, including medical information for this or any related claim to the health insurance I have provided. Should collection action become necessary, I further authorize the release of demographic information including cell phone numbers to outside agencies to facilitate collection of my debt. I permit a copy of the authorization to be used in place of the original. I may revoke this authorization at any time in writing.

Patient Signature _____ Date_____

Printed Name _____

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Patient Signature _____ Date_____

Printed Name_____

HIPAA

Section I: Patient Acknowledgment & Consent Form (This section is a summary of the government mandated HIPAA)
Mid-Atlantic OB-GYN may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices states that we reserve the right to change terms described as determined by the government. Should this happen we will display the new policy and effective date at our office locations. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you.

Section II: Consent for use and Disclosure of Information by Mid-Atlantic OB-GYN
By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, except where we have already made disclosures in trust on your prior consent. "I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Mid-Atlantic OB-GYN for any services furnished to me by my physician, I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits for related services. I agree to provide all reference and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements."

Patient's Signature _____Date _____

Section III (Optional): Name Personal Representative(s), Family, or Other Entities whom you want to grant Authorized Access to YOUR Protected Health Information Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations:

_____
Name of Authorized Person Relationship Phone #

_____
Name of Authorized Person Relationship Phone #

Section IV: Authorization for use of Answering Machine, Voice Mail, AND/OR Email Address
Mid-Atlantic OB-GYN is sometimes unable to contact patients directly during normal business hours. On these occasions our office leaves messages on communication devices provided by our patients. Information that we may possibly disclose on your home, work, cell phone, or email address would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

_____ (Initial) I agree to allow Mid-Atlantic OB-GYN to leave messages that include Protected Healthcare

Information on the following: Please mark the applicable communication devices:

□ Home □ Work □ Cell □ Email Address

_____ (Initial) No, I do not agree to allow Mid-Atlantic OB-GYN to leave messages that include Protected

Healthcare Information on my home, work, cell phone, or email address.

Patient's Signature _____ Date _____