# 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<br>____ 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

<table>
<tr><td colspan="2">Patient Name</td><td>DOB</td><td>Age:</td></tr>
<tr><td>Reason for your visit today:</td><td colspan="3">How long have you had this problem?</td></tr>
</table>

## Medical History

<table>
<tr><td>Age at first period?</td><td>Do you have regular monthly periods?<br>Yes No</td><td>How often does your period come?</td></tr>
<tr><td>Periods are:<br>Mild Moderate<br>Heavy</td><td>First Day Last Menstrual Period</td><td>Cramps: Yes No<br>If yes,<br>Mild Moderate Severe</td></tr>
</table>

<table>
<tr><td>Current Birth Control:</td><td>Are you happy with your birth control?<br>Yes No</td><td>Sexual Orientation:</td><td>Marital Status:</td></tr>
</table>

<table>
<tr><td>Do you have Fibroids?<br>Yes No</td><td>Do you have an ovarian cyst?<br>Yes No</td><td>Do you have endometriosis?<br>Yes No</td></tr>
</table>

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

<table>
<tr><td>Last Mammogram:<br>____/____</td><td>Have you ever had an abnormal Mammogram?</td><td>If yes, please give year and any procedures:</td></tr>
<tr><td>Last Colonoscopy:<br>____/____</td><td colspan="2">Last Bone Density ____/____</td></tr>
</table>

| Allergies: | Reaction: |
|---|---|
| | |
| | |
| | |
| | |

# Medical History Continued….

| Medications | Dosage |
| --- | --- |
| | |
| | |
| | |
| | |
| | |

| Smoking History: | | |
| --- | --- | --- |
| Do you currently smoke?______ If yes, _______packs/day<br><br>Have you ever smoked?_______ If yes, _______ packs/day | Do you currently use alcoholic beverages? Yes No<br>Have you ever used alcoholic beverages? Yes No<br><br>Have you ever used recreational drugs? Yes No<br>Do you currently use recreational drugs? Yes No | Do you do monthly breast exams?<br><br>Yes No<br><br>Do you currently exercise regularly?<br>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<br>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 __________________