A WOMAN'S PLACE

Obstetrics & Gynecology

2018 Patients Personal Profile: Please print and complete the registration. All insurance cards must be presented prior to services rendered.

Last Name | Legal First Name | MI

Maiden Name | Any Alternate Names

Home Address | Town | State | Zip Code

Home Telephone | Cell Phone | Fax | E-Mail

Date of Birth | Age | Social Security | Marital Status

Emergency Contact | Relationship | Telephone

Pharmacy | Telephone | Participating Laboratory (Quest/Labcorp)

Referring/Primary Care Physician | Telephone | Referred by Patient

Primary Insurance Information

Insurance Carrier | Plan Name

ID# | Group #

Policy Effective Date | Term Date | Co-Pay

Name of Insured | Relation (self/spouse/child)

Insured's SS# | Insured's DOB

Insured's Address

City | State | Zip

Employer | Address

Secondary Insurance Information

Insurance Carrier | Plan Name

ID# | Group #

Policy Effective Date | Term Date | Co-Pay

Name of Insured | Relation (self/spouse/child)

Insured's SS# | Insured DOB

Insured's Address

City | State | Zip

Employer | Address

I agree that, regardless of my insurance status, I am financially responsible for any services rendered by this office. In addition I accept responsibility to promptly notify this office in writing of any changes in insurance and/or changes in information provided on this form. In the event that I neglect to update my information on file with this office, I understand that I am financially responsible for any resulting unpaid services. Furthermore, this office has advised me that they do not participate with the following: straight Medicaid, NJ Health, and Healthnet Medicaid. I request payment of authorized medical benefits for services rendered by this office be released directly to a woman's place, on my behalf; I also authorize the release of medical information requested by the insurance carrier(s) listed above to determine the payment of such medical benefits. If, for whatever reason, my account is sent to collections, I agree to be responsible for attorney fees, court costs, interest and any other fees associated with the collection of my balance. I have carefully completed this form and certify that the information provided is accurate, to the best of my knowledge. In conclusion, I agree to adhere to all Policies & Procedures set forth by this office. By signing, you state that you fully understand and agree to the above statement.

Today's Date | Signature

A WOMAN'S PLACE

Obstetrics & Gynecology

PLEASE READ CAREFULLY

Office Policies & Procedures (This form may be updated at any time without prior notice)

Registration:

- We encourage the use of our website, awomansplacenj.com, prior to your appointment. You may wish to print out our registration packet in advance of your visit. You may also send us prescription refills and general questions via our Patient Portal. Please print entire registration packet, as incomplete forms will delay your appointment. Only completed forms will be accepted.
- All current, valid insurance cards must be presented at the time of each visit.
- A valid driver's license or state, or county issued ID or military ID must also be presented prior to service.

Appointments:

- As a courtesy to all, kindly notify our office within twenty-four hours of any cancelled appointments. There will be a charge for any Ultrasound Appointments that are not cancelled with at least 24 hour notice.

Insurance & Payments:

- Should your insurance carrier change, you will need to supply a Certificate of Group Health Plan Coverage or Certificate of individual Health Plan Coverage indicating policy termination before we can bill your carrier. If we do not receive proof of insurance termination within 14 days of service, we will expect payment in full and will provide you with a health insurance claim form to self-submit.
- Payment and Co-payments are due at the time service is rendered; otherwise you will be charged an additional $20.00 fee.
- Budget plans are an option. These should be arranged with the billing staff.
- Receipts are issued upon request, and issued for all cash payments. It is important for you to retain receipts for your future reference.
- There will be a $35.00 fee for all returned checks.
- Claims not processed by your insurance carrier due to information they requested from you (e.g., letter of inquiry, coordination of benefits, student status, etc.) are patient responsibility. Our office does not resubmit claims. You need to contact your insurance carrier for reprocessing.
- Although all payments are applied to your account, some may be applied to satisfy open balances of differing dates of services. We strive to keep all accounts at a zero balance.
- Please allow 3-5 business days for all authorizations, referrals and disability forms. Although we would like to expedite requests, due to the differing Insurance Carrier guidelines, we are unable to complete same-day authorizations and referrals.

Laboratory:

- A lab phlebotomist is available to draw your blood in our office at designated times. Please note that laboratory fees are not billed by our office; they are billed separately by the processing laboratories.

Prescription Request:

- For your convenience prescription request will be honored Monday through Friday, 9-5, and also on weekends as needed.

Release of Medical Records and fees:

- For privacy protection, we are not permitted to fax your medical records. A request for records release must be completed in person at least two weeks in advance. Please know, we allow 14 days for our office staff to process your request. Please call ahead to confirm they are ready.

Thank you for taking the time to review our policies. If you have any questions please feel free to ask.

_____ _____

Your Signature Today's Date

_____ _____

Please Print Your Name Date of Birth

A WOMAN'S PLACE

Obstetrics & Gynecology

HIPAA: PATIENT RESTRICTION OF DISCLOSURES

The HIPAA privacy rule, gives you, the patient, the right to request a restriction on uses and disclosures of your protected health information (PHI). Please carefully complete the following statement by initialing all options that apply:

I may be contacted in the following manner…

Home Telephone	**Work Telephone**	**Cell Phone**	**Written Communication**
___ Detailed Message	___ Detailed	___ Detailed	___ Detailed
___ Limited Message	___ Limited	___ Limited	___ Limited

Best Contact Number: _____

HIPAA: PATIENT DESIGNATION OF DISCLOSURES

Please Print. Only completed forms will be accepted.

The HIPAA privacy rule gives you, the patient, the right to designate a person(s), to act on your behalf.

Please carefully complete the following statement:

I designate the following person(s) to act on my behalf. Such action may include, but is not limited, the discussion of my medical and surgical care, treatment plans, prescription requests, documentation of medical records, and my financial obligation.

Full Name of Designee:	Relation to Patient:
_____	_____
_____	_____
_____	_____

_____ _____

Your Signature Today's Date

_____ _____

Print Name Date of Birth

A WOMAN'S PLACE
Obstetrics & Gynecology
Medical History

Patient Name: _____ D.O.B. _____ Today's Date: _____

Marital Status: (please circle) **Married Single Living w/partner Widowed Divorced**

Menstrual History: LMP: _____ Age Started: _____ Duration: _____ days
Date of last breast exam by a physician: _____
Date of last Mammogram: _____
Date of Last Colonoscopy: _____

Current Medications, Vitamins and Supplements (need dosage and how often):

_____
_____
_____
_____

Allergies: None Medication (reaction):_____
_____
_____**Other** (reaction):_____
_____

Language: [] English [] Spanish [] Hebrew [] Russian [] Other _____

Race: [] American Indian or Alaskan Native [] Asian [] Black [] Hispanic
[] Native Hawaiian [] Other Pacific Islander [] White [] Other

Ethnicity: [] Latino/Hispanic [] Non- Latino/Hispanic [] Jewish [] Other _____
[] Not Reported/Refused

Social History (Please answer the following):

Alcohol? [ ] Current [ ] Past [ ] Never Age started: _____ Age stopped: _____
Frequency? _____ Ready to Change? Yes No

Smoke? [ ] Current [ ] Past [ ] Never Age started: _____ Age stopped: _____
Frequency? _____ Ready to Change? Yes No

Substance Abuse? [ ] Current [ ] Past [ ] Never Age started: _____ Age stopped: _____
Frequency? _____ Ready to Change? Yes No

Sexual History:

Sexually Active: Yes No First Active at Age: _____

Current Partners: _____ # of Lifetime Partners _____ Uses Condoms: Yes No

Method of Contraception: [ ] Abstinence [ ] BC Implant [ ] BC Patch [ ] BC Pill [ ] BC Shot
[ ] Diaphragm [ ] IUD [ ] Vaginal Ring [ ] None [ ] Other: _____

History of Sexual Abuse: Yes No History of STD: Yes No

Self-Described Orientation: [] Heterosexual [] Homosexual [] Bisexual [] Transgender
[] Other _____

Obstetrical History
(Must list all pregnancies and/or miscarriages in full)

No.	M/D/Y	Weeks at Delivery	Type of Delivery	Sex	Wt.	Anesthesia Type	Hours of Labor	Complications
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

If more than 15, please continue on back

Procedures/Surgeries:

M/D/Y	Procedure	M/D/Y	Procedure

If you need more space, please continue on back

Personal/Family Medical History:
(Please (x) if you or a member of your immediate family have now/or in the past has any of the following)

For PT (patient), please mark with an **A** (active) or a **R** (resolved)	PT	Mother	Father	Sister	Brother	Grandmother (M)	Grandmother (P)	Grandfather (M)	Grandfather (P)	Other	Comments
Anemia											
Anxiety											
Arthritis											
Asthma											
Breast Cancer											
Cancer (Type)											
Colitis											
Depression											
Diabetes Mellitus											
Endometrial Cancer											
Epilepsy											
Gallbladder Disease											
Headache											
Heart Disease											
Hemorrhoid											
Hepatitis											
Hernia											
Hypertension											
Kidney Disease											
Kidney Infection											
Kidney Stone											
Mental Illness											
Osteoporosis											
Phlebitis											
Sexually Transmitted Disease											
Skin Disorder											
Stroke/ CVA											
Thyroid Disease											
Tuberculosis											
Ulcer											
Urine/ Bladder Incontinence											
Varicose Vein											
Weight Loss/Gain											
Alcohol User											
Substance User											
Tobacco User											
Celiac Disease											
Cystic Fibrosis											
Down's Syndrome											
Muscular Dystrophy											
Sickle Cell Trait											
Tay-Sachs Disease											
Other											

A WOMAN'S PLACE
PATIENT PORTAL

Please supply us with the following information so we can send you an invitation to our Patient Portal. This will allow you to access some of your health information as well as request appointments, request prescription refills and ask general questions.

Please print clearly:

Full Name: _____

DOB: _____

E-Mail Address: _____

Zip Code: _____ (This will be your security question with us)

Please check your e-mail within a couple of days and accept our invitation.

Thank you for your cooperation with this.

A WOMAN'S PLACE
INSURANCE AGREEMENT

Name: _____

DOB: _____

I understand that it is my responsibility to make sure that A WOMAN's PLACE has a copy of **ALL my insurances**. I have been informed that if I have more than one insurance or if my Insurance changes at any time, I must notify the office. I may not pick and choose which insurance I want to use. Doing so would cause mispayment to the doctor.

I also understand that I should have knowledge and an understanding of my insurance policy.

I agree that if services are non-covered because I failed to give all insurances that I will be responsible to pay the amount in full that would have been paid by my insurance company.

I agree that I will pay in full all Deductible's, Co-Insurance's and Copay's that my insurance says I am responsible for.

I am aware that A WOMAN's PLACE does not take any Medicaid Insurances except United Healthcare Community Plan. I understand that I am responsible for all payments associated with my visits and care.

Signature: _____

Date: _____