A WOMAN'S PLACE

Obstetrics & Gynecology

2022 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

Primary Phone | Secondary Phone | E-Mail

Date of Birth | Age | Social Security | Marital Status

Emergency Contact | Relationship | Telephone

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 of 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 and NJ Health. 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.

Signature | Date

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 24 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 7-10 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. Prescription refills can be requested anytime via the patient portal.
- **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 2 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

1/22

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…

Primary Telephone	**Secondary Phone**	**Written Communication**
___ Detailed Message	___ Detailed	___ Detailed
___ Limited Message	___ 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
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 only takes the following Medicaid Insurances: United Healthcare Community Plan, Amerigroup, Aetna & Wellcare. I am also aware that they do not participate in Straight Medicaid or NJ Health. I understand that I am responsible for all payments associated with my visits and care.

Signature: _____

Date: _____

A WOMAN'S PLACE
Obstetrics & Gynecology

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
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 Mammogram: _____ Date of Last Colonoscopy: _____

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

_____

_____

_____

_____

Allergies: None Medication (reaction): _____

_____

_____

Other (reaction): _____

_____

Social History (Please answer the following):

Alcohol? [ ] Current [ ] Past [ ] Never
Smoke (Tabacco) ? [ ] Current [ ] Past [ ] Never
Electronic Cigarette/ Vaping ? [ ] Current [ ] Past [ ] Never
Substance Abuse? [ ] Current [ ] Past [ ] Never

Sexual History:

Sexually Active: Yes No First Active at Age: _____ Current Partners: _____
# of Lifetime Partners _____ History of Sexual Abuse: Yes No History of STD: Yes No
Method of Contraception: [ ] Abstinence [ ] BC Implant [ ] BC Patch [ ] BC Pill [ ] BC Shot
[ ] Diaphragm [ ] IUD [ ] Vaginal Ring [ ] None [ ] Other: _____
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 Medical History:

Please mark A (active), R (resolved) or leave blank if it does not apply

_____ Anemia

_____ Anxiety

_____ Arthritis

_____ Asthma

_____ Breast Cancer

_____ Cancer (Type) _____

_____ Celiac Disease

_____ Colitis

_____ Cystic Fibrosis

_____ Depression

_____ Diabetes Mellitus

_____ Down's Syndrome

_____ Endometrial Cancer

_____ Epilepsy

_____ Gallbladder Disease

_____ Headache

_____ Heart Disease

_____ Hemorrhoid

_____ Hepatitis

_____ Hernia

_____ HIV

_____ Hypertension

_____ Kidney Disease

_____ Kidney Infection

_____ Kidney Stone

_____ Lymes

_____ Mental Illness

_____ Multiple Sclerosis

_____ Muscular Dystrophy

_____ Osteoporosis

_____ Phlebitis

_____ Sexually Transmitted Disease

_____ Sickle Cell Trait

_____ Skin Disorder

_____ Stroke

_____ Tay-Sachs Disease

_____ Thyroid Disease

_____ Tuberculosis

_____ Ulcer

_____ Urine Incontinence

_____ Varicose Vein

_____ Weight Gain

_____ Weight Loss

_____ Other: _____

Family Medical History:
Please (X) if a member of your immediate family now or in the past has any of the following

	Mother	Father	Sister	Brother	Grandmother	Grandfather			Mother	Father	Sister	Brother	Grandmother	Grandfather
Anemia								Sexually Transmitted Disease						
Anxiety								Skin Disorder						
Arthritis								Stroke/CVA						
Asthma								Thyroid Disease						
Breast Cancer								Tuberculosis						
Cancer (Type)								Urine Incontinence						
Colitis								Varicose Vein						
Depression								Weight Gain						
Diabetes Mellitus								Weight Loss						
Endometrial Cancer														
Epilepsy								Alcohol User						
Gallbladder Disease								Substance User						
Headache								Tobacco User						
Heart Disease														
Hemorrhoid								Celiac Disease						
Hepatitis								Cystic Fibrosis						
Hernia								Down's Syndrome						
Hypertension								Muscular Dystrophy						
Kidney Disease								Sickle Cell Trait						
Kidney Infection								Tay-Sachs						
Kidney Stone														
Mental Illness								Other						
Osteoporosis														
Phlebitis														

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Obstetrics & Gynecology

CORD BLOOD ACKNOWLEDGEMENT

I acknowledge that I have been notified that A WOMANS'S PLACE charges a $200.00 fee for the collection of Stem Cells. This fee is to be paid by my Post Partum visit. I will discuss with my doctor further about cord blood if I have any questions about banking cord blood. If I decide to Bank, then I understand that it is my responsibility to contact the companies and register with them before I deliver.

_____

Signature

_____

Print Name

_____

Date

Cord Blood Banks:

CBR: 1-888-267-3256 (cordblood.com)

Family Cord: 1-888-828-2673 (familycord.com)

Lifebank USA: 1-877-543-3226 (lifebankus.com)

Stemcyte: 1-866-389-4659 (stemcyte.com)

Viacord: 1-877-925-2829 (viacord.com)