Patient Information

Highlands
CENTER FOR WOMEN
OBSTETRICS & GYNECOLOGY

Patient's Full Name:

_____
Last First Middle

SSN: _____ Date of Birth: _____

Mailing Address: _____
PO Box/Street City State/ ZIP

County:_____

Primary Phone:_____ Secondary Phone:_____

Email:_____ Language:_____

Marital Status [ ] M [ ] S [ ] D [ ] W Ethnicity: _____ Race:_____

Employment Status: [ ] Full time [ ] Part time [ ] Unemployed [ ] Retired Employer: _____

Emergency Contact: _____ Relationship: _____Phone: _____

Referring Physician: _____

Primary Care Physician: _____

Responsible Party/Guarantor (please print):

Full Name: _____ Sex [ ] Female [ ] Male
Last First

DOB:_____ SSN:_____

Mailing Address:_____

Primary Phone :_____Secondary Phone:_____

Employment Status: [ ] Full time [ ] Part time [ ] Unemployed [ ] Retired Employer: _____

Insurance (please print):

Primary Insurance: _____

Group #: _____

Subscriber ID: _____

Group Name: _____

Relationship to Insured: _____

Subscribers Name: _____

Sex: [ ] Female [ ] Male DOB: _____

SSN: _____

Address: _____

Secondary Insurance: _____

Group #:_____

Subscriber ID: _____

Group Name: _____

Relationship to Insured: _____

Subscribers Name: _____

Sex: [ ] Female [ ] Male DOB: _____

SSN: _____

Address: _____

Health History Questionnaire- *Obstetrics (New patient)*

A) **NAME**_____ **Preferred Name:** _____

Age_____ DOB_____

1. Partner Name/DOB: _____
2. Occupation:_____
3. Preferred pharmacy (Store and Street/City): _____

B) **DRUG ALLERGIES** ☐ NONE ☐ YES: (please list): _____

_____

C) **CURRENT MEDICATIONS** (include dose/amount per day/medical reason for taking med)

Medication	Dose	Frequency	Reason for medicine

Are you taking a prenatal vitamin? ☐ Yes ☐ No

D) **GYNECOLOGIC HISTORY** (Prior to this pregnancy)

1. Age of first period: _____ years
2. Periods were ☐ regular (monthly), period start every _____ days
   ☐ irregular, periods start every ____ to _____ days (ex 12 to 60)
3. Duration of bleeding: _____ days
4. Periods were ☐ light ☐ medium ☐ heavy, changing a pad/tampon every ____ hour
5. Does bleeding or spotting occur between periods? ☐ Yes ☐ No
6. Pain associated with periods? ☐ Yes ☐ No ☐ Occasionally

E) PAP SMEAR HISTORY

1. Date of last pap smear: _____ ☐ Normal ☐ Abnormal
2. History of abnormal pap smears? ☐ Yes ☐ No
   If yes, what type of treatment have you had? (include year)
   ☐ Cryotherapy: _____ ☐ Cone biopsy (usually done in hospital): _____
   ☐ Laser: _____ ☐ Loop excision (LEEP- usually done in office): _____
3. Have you received the Gardasil (HPV) vaccination? ☐ Yes ☐ No

F) **OTHER PAST GYN HISTORY**: Check any that apply or ☐ None

☐ Herpes	☐ HIV/AIDS	☐ Syphilis	☐ Genital warts
☐ Chlamydia	☐ Gonorrhea	☐ Trichomonas	☐ Pelvic Inflammatory Dz (PID)
☐ Endometriosis	☐ Fibroids	☐ Ovarian cysts	☐ Other (specify)_____

G) **PAST MEDICAL HISTORY (Check any that apply)** ☐ None

☐ Diabetes	☐ Gallstones	☐ Respiratory problems (ex COPD)
☐ High blood pressure	☐ Liver disease, includes hepatitis	☐ Cancer:_____
☐ Asthma	☐ Autoimmune disorder	☐ Arthritis
☐ Thyroid disease	☐ Kidney disease	☐ Heart disease/problems
☐ Depression/anxiety	☐ High cholesterol	☐ Other _____
☐ Seizure disorder	☐ Blood clots legs/lungs	

H) **PREGNANCY HISTORY** ☐ This is my first pregnancy

Please include any history of miscarriage, abortion, and/or ectopic (tubal) pregnancy

Mo/Year	Delivery Location	Duration of Pregnancy (# of weeks)	Type of Delivery vaginal, c-section, abortion, miscarriage	Delivering Physician	Complications Mother and/or Infant	(Child) Sex	(Child) Birth Weight	(Child) Present Health

1. Last Menstrual Period (first day) _____ ☐ **Exact date** ☐ **Approximate date** ☐ **Unknown**
2. History of high blood pressure/ preeclampsia: ☐ Yes ☐ No
3. History of gestational diabetes/ PCOS ☐ Yes ☐ No
4. Recent travel (or planned travel) out of country: ☐ Yes ☐ No
5. Have you had chicken pox? ☐ Yes ☐ No
6. Have you received all standard vaccinations (MMR, flu etc) ☐ Yes ☐ No
7. Do you have pet cats? ☐ Yes ☐ No
8. Have you had genetic testing in the past? ☐ Yes ☐ No

I) **SOCIAL HISTORY**: (Do you currently use…)

Tobacco: ☐ Never ☐ Yes, Packs/Day: _____ ☐ Former ☐ Cigarettes ☐ Chew tobacco
Years smoked: _____ Quit date_____(Mo/Yr) ☐ VAP

Alcohol: ☐ Never ☐ Former ☐ Yes, Drinks/week:_____ Type:_____

Illicit Drugs: ☐ Never ☐ Former ☐ Yes, Type:_____

How many caffeinated drinks per day? _____ drinks/day

Lifestyle: Are you on a specific diet? ☐ Yes ☐ No If yes, which type of diet: _____
Do you exercise regularly? ☐ Yes ☐ No Days/Week:_____ Hours/Day:_____

History physical/sexual/emotional abuse? ☐ Yes ☐ No Do you currently feel safe? ☐ Yes ☐ No

J) **PAST SURGICAL HISTORY** (List all surgeries and year) ☐ None

Surgery	Mo/Year	Complications

K) **FAMILY HISTORY** ☐ None

	Yes	**Relatives** (mother, father, maternal/paternal grandparents etc) **Diagnosis age**
Diabetes	☐	_____
Heart disease/ High BP	☐	_____
High cholesterol	☐	_____
Breast cancer	☐	_____
Ovarian/uterine cancer	☐	_____
Colon/prostate cancer	☐	_____
Genetic disorder	☐	_____
Birth defects	☐	_____
Mental retardation	☐	_____
Clotting/bleeding prob	☐	_____
Other/specify	☐	_____

Receipt of Privacy Practice Information

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Patient's Full Name: _____

[ ] Yes [ ] No I have read and have access to the notice of privacy and acknowledgment used by Highlands Center for Women.

[ ] Yes [ ] No I authorize the release of my medical information to my insurance company should it be required for payment of my claim.

[ ] Yes [ ] No I authorized detailed messages regarding my treatment, laboratory results, etc to be left at the following phone numbers:
Home: _____ Cell: _____ Work:_____

[ ] Yes [ ] No In the event of an emergency, I authorize Highlands Center for Women to leave messages regarding my treatment, laboratory results, etc to the following individuals:

Name_____ Relationship:_____ Phone:_____

Name_____ Relationship:_____ Phone:_____

Name_____ Relationship:_____ Phone:_____

Appointment Reminders:

Highlands Center for Women will send a general reminder message prior to appointments.

[ ] Yes [ ] No I authorize Highlands Center for women to send annual appointment reminders via email to the following email address: _____

[ ] Yes [ ] No I authorize appointment reminders via text message
Phone number: _____

I UNDERSTAND THAT THESE AUTHORIZATIONS ARE IN EFFECT UNTIL REVOKED BY ME IN WRITING.

Signature: _____ Date:_____

(Continued on next page)

Policies for Patient Care Services

Highlands
CENTER FOR WOMEN
OBSTETRICS & GYNECOLOGY

Thank you for choosing Highlands Center for Women for your gynecologic and obstetric needs. We are dedicated to providing the best possible care for you and want you to completely understand our office policies.

Financial Policy

Insurance:

- Highlands Center for Women, PA participates with many insurance companies; however, we do not participate with all of them.
- It is the patient's responsibility to verify our participation with their plan. It is also their responsibility to be familiar with the specifics of their policy, including, but not limited to: visit coverage, referral/authorization requirements and lab tests.
- You must present your insurance card and photo identification at your first appointment and each year thereafter.
- If you do not provide proof of insurance, you will be billed as self-pay. We may be able to retroactively bill to your insurance plan depending on the plan's stipulations.
- It is the patient's responsibility to notify us if their insurance requires that we use a certain lab for any lab services.

Payment for Services:

- Every patient (parent or guardian if the patient is a minor) is responsible for the payment of any and all services provided by Highlands Center for Women, P.A.
- Payment is due at the time of service (this includes copay's, deductibles, co-insurance and outstanding balances)
    - Co-Pay: Fixed amount that you typically pay at the time of a visit
    - Deductible: The amount you are required to pay for certain services before your insurance plan starts to pay.
    - Co-Insurance: The percentage of costs of a covered health service that you pay after you've met your deductible.
- Patients that are self-pay (without insurance) are required to pay for services at the time they are rendered. If the total charge amount is not available at the time of checkout, you may be required to pay a deposit up to $200 that will be applied to your charges.
- We do not perform any third party billing (i.e. workers compensation).
- Our policy is to file insurance as a courtesy to you. The balance due is your responsibility and is expected from you within 30 days of receiving your first statement.
- Should your insurance reject or deny any claims we have submitted on your behalf, we will make every effort to dispute the denial/rejection. It will be your responsibility to pay for any outstanding balance should your insurance uphold their denial/rejection.
- Accounts older than 90 days will be turned over to a collection agency. If your account is turned over to collections, you will be responsible for the fee charged by the collection agency (23%) in addition to the amount owed. You may be discharged as patient and unable to schedule an appointment with us until the balance has been paid.

Policies for Patient Care Services

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OBSTETRICS & GYNECOLOGY

General Policies

Preventative Services (Annual Exams):

- Please check your insurance policy to make sure you have yearly preventative coverage for a pelvic and breast exam and/or pap-smear. If covered, most insurance companies allow for only one annual exam per 12 month period.
- An annual exam is a wellness visit and does not include discussion of new problems or a detailed review of chronic conditions. If you have a new health problem to address at your annual exam, your provider will determine if he/she can address your concerns at this time or if you need to schedule another appointment.
- If you have a wellness visit and request additional services (i.e a problem visit), you will be billed for the additional service(s).

Lab Services:

- All blood draws and pathology (i.e. pap smears and biopsies) will be processed by Labcorp unless you notify us that your insurance requires that you use a different company.
- These services will be billed to your insurance by Labcorp, not Highlands Center for Women, PA.
- If you receive a service in the lab, the technician will provide an estimate for the services if an estimate is available. If you are self-pay, you may have the option to pay in full to receive a discount.
- It is the patient's responsibility to know what their plan covers for any lab service. Highlands Center for Women, PA has no knowledge of how these tests will be billed, what your insurance will cover, and how much you may owe for these services.

FMLA:

- If your employer requires Family Medical Leave Act (FMLA) or Disability paperwork to be completed by your provider, we will complete these form(s) for you. Form completion requires 5-10 business days and a fee will be charged as below. *Please note: We do not complete FMLA for intermittent leave unless it's medically indicated.*

Appointments:

- If you arrive late for a scheduled appointment, you may be asked to reschedule your appointment or you may be asked to wait for an opening in the schedule (depending on availability).
- If you are unable to keep a scheduled appointment, we require 24 hour notice. If you fail to give appropriate notification, you will incur a missed or cancelled appointment fee as below.
- You may be discharged as a patient following three (3) no-shows in a one year period.

Additional Fees:

- Returned Checks: $35
- Prescription requests made outside of an office visit: $15
- Copies of Medical Records (separate authorization required): $15
- Disability/FMLA Forms: $20
- Missed or Cancelled appointments without a 24 hour notice $20

I have read the above Financial Policy, I understand and agree to my financial responsibilities.

_____ _____

Signature Date