Obstetrics & Gynecology

***Christina Collins**, M.D. F.A.C.O.G*

Ph: (808) 331-2300 • Fax: (808) 331-2330
75-5905 Walua Rd., Suite 3 • Kailua Kona, HI 96740

Name: _____ *Date of Birth:* _____

Physical Address: _____

Mailing Address: _____

City: _____ *State:*_____ *Zip:* _____ *Phone: (___)*_____

*Cell: (___)*_____ *Work: (___)*_____ *Email:*_____

Employer: _____ *Occupation:* _____

*SSN#:*_____ *Marital Status: S M W Other*

Responsible Party (if other than self) : _____

Relationship: _____ *Date of Birth:* _____

Phone: _____

I release authorization of confidential medical information to the following person (s):

Name: _____ *Relationship:* _____ *Tel:* _____

Name: _____ *Relationship:* _____ *Tel:* _____

EMERGENCY CONTACT: _____ *Tel:* _____

**Release of Medical Records to PCP: (annual exam, PAP & mammogram) to: (valid up to one year)*

Provider Name: _____ *Phone (___)*_____

Patient Signature: _____

I verify that the above information is correct. I understand that I am financially responsible for all charges, regardless of insurance coverage. I request that the payment of insurance benefits be made on my behalf to : Dr. Christina Collins for any services furnished to me.

*Signature :*_____ *Date:* _____

Obstetrics & Gynecology

Christina Collins, M.D. F.A.C.O.G

Ph: (808) 331-2300 • Fax: (808) 331-2330
75-5905 Walua Rd., Suite 3 • Kailua Kona, HI 96740

Welcome to our office

We would like you to become familiar with our office...

We kindly request that payments be made at the time services are rendered:

* By doing this, we will be able to minimize the cost of billing and postage and as a benefit to you, keep medical costs down.
* If any financial difficulty arises, please feel free to discuss this with us.
* Visa & MasterCard are accepted.
* Delinquent payments after 90 days will be referred to a collection agency.

Appointments:

* Office appointments are limited and therefore in consideration to other patients if you are unable to keep your appointment, please notify our office as soon as possible.
* In order to provide an optimum patient flow, we would appreciate your arrival time to be no more than 5 minutes prior to your scheduled appointment.
* Due to the nature of our specialty, there will be times when the doctor will be called out of the office for an emergency. At this time you will have the option of rescheduling or returning for a later appointment.

Authorization to release information and pay insurance benefits:

I request that payment of authorized Medicare/other insurance company benefits be made to me or on my behalf to Dr. Christina Collins, M.D. for any services furnished to me by that physician. I authorize any holder of medical information about me to be released to my insurance carriers or the Health care Financing Administration and its agents if required, any information needed to determine these benefits or the benefits payable for related services which may include information on sexually transmitted diseased and HIV.

I understand that I am responsible for any amount not covered by insurance.

_____ _____

Signature Date

Obstetrics & Gynecology

Christina Collins, M.D. F.A.C.O.G

Ph: (808) 331-2300 • Fax: (808) 331-2330
75-5905 Walua Rd., Suite 3 • Kailua Kona, HI 96740

Financial Agreement

Office Policy:

Your insurance co-payment is due and payable **at the time services are rendered.** Our office does all it can to obtain correct and current insurance coverage information and eligibility. However, **no insurance company can guarantee coverage** prior to the time a claim is processed. If you are not covered by an insurance company at the time services are rendered, you must pay the entire account balance.

HMSA HMO / Quest Policy:

Dr. Christina Collins office is a specialty obstetrical and gynecologic practice. Therefore, any patient with HMSA HMO or HMSA Quest insurance is responsible to obtain an insurance referral prior to your appointment. Failure to obtain an insurance referral will result in rescheduling the appointment.

Patient Agreement:

I understand that I am responsible to pay for **any balances accrued and unpaid medical insurance claims**. I understand that if my account goes unpaid for 90 days or more, my account will be pursued by a collection agency. Should this be necessary, I am responsible for all expenses and legal fees incurred for that purpose.

Payments:

Cash, Visa, MasterCard and checks are accepted. There is a $30.00 fee for all returned checks.

I have read and asked any questions regarding the financial agreement. I understand the terms and conditions of Dr. Christina Collins financial policy. I agree that this information is correct.

Signed: _____ Date: _____

Obstetrics & Gynecology

Christina Collins, M.D. F.A.C.O.G

Ph: (808) 331-2300 • Fax: (808) 331-2330
75-5905 Walua Rd., Suite 3 • Kailua Kona, HI 96740

Late Appointment & No Show Policy

To ensure quality of care Dr. Christina Collins recommends:

Please arrive 5 minutes prior to your scheduled appointment, so that we are able to start your appointment on time. Failure to do so interrupts your time and other scheduled patients appointments with Dr. Collins.

If you know that you are going to be late for your appointment, please contact our office 30 minutes prior to your scheduled appointment. If you do arrive late for your appointment you may be required to reschedule your appointment and a $25.00 fee will be applied.

We require 24 hours notice for any rescheduled or cancelled appointments. Failure to contact our office 24 hours in advance will result in a $25.00 "No Show Fee".

We appreciate your accordance with our policy as a patient of Dr. Christina Collins.

Conduct Policy

We value you as a patient and strive to provide high-quality care and service. To do so, we need to foster an effective provider–patient relationship. Should disruptive behavior towards a provider, staff, or another patient occur; the office reserves the right to immediately terminate the relationship between you and the organization.

Disruptive behavior is any inappropriate behavior, confrontation, or conflict, ranging from combative behavior to verbal/physical abuse or sexual harassment.

I hereby sign that I have read, understand and agree to the above stated "Late Appointment & No Show Policy" and “Conduct Policy”.

_____ _____

Signature Date

Obstetrics & Gynecology

Christina Collins, M.D. F.A.C.O.G

Ph: (808) 331-2300 • Fax: (808) 331-2330
75-5905 Walua Rd., Suite 3 • Kailua Kona, HI 96740

Notice of Privacy Practices
This notice describes how protected medical information about you may be used and how you can gain access to this information. Please review carefully.

1. Christina Collins, M.D. is permitted to make uses and disclosures of your protected health information for treatment, payment and health care operations, as described in the follow examples:

a.For treatment - (a) the provision, coordination, or management of health care and related services by health care providers: (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

b.For payment - (a) billing and collection activities and related data processing: (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement; (c) determinations necessity and appropriateness of care review, utilization review activities; (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

c.For health care operations - (a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of an training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; (f) general administrative activities such as customer service and date analysis.

2. Christina Collins, M.D. is permitted or required, under specific circumstances, to use or disclose your protected health information without your written authorization. Examples include:

a. Public health activities.
b. Disclosure regarding victims of abuse, neglect or domestic abuse.
c. Health oversight activities such as audits, criminal investigations and inspections.
d. Judicial and administrative proceedings.
e. Law enforcement purposes.
f. Military and veteran activities.
g. Correctional institutions and other law enforcement custodial situations.
h. Covered entities that are government programs providing public benefits and for workers compensation.

3. Other uses and disclosures will be made only with your written authorization and you may revoke such authorization.

4. Christina Collins, M.D. intends to engage the following activity:

a.Christina Collins, M.D. may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest.

5. You have the following rights regarding your protected health information, which may require written request from you:
a.The right to request restrictions on certain uses and disclosures of you protected health information, however, Christina Collins, M.D. is not required to agree to a requested restriction.
b.The right to receive confidential communications of your protected health information, as applicable.
c.The right to inspect and copy your protected health information, as provided in the Privacy Regulation.
d.The right to amend your protected health information, as provided in the Privacy Regulation.
e.The right to receive an accounting of disclosures of your protected health information.

6. Christina Collins, M.D. is required by law to maintain the privacy of your protected health information and to provide you with notice of its legal duties and Privacy Practices with respect to your protected health information.

7. Christina Collins, M.D. is required to abide by the terms of the Notice currently in effect.

8. Christina Collins, M.D. reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.

9. Christina Collins, M.D. will provide you or the patient with a revised Notice upon first service delivery after revision and will provide a copy on request.

10. You may complain to Christina Collins, M.D. and to the Secretary of the Department of Human Services without fear or retaliation by the organization if you believe your privacy rights have been violated. A brief description of how you may file a complaints follows:
You must submit your complaint in writing by mail to Privacy Official at Kona Community Hospital. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this privacy policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred.

This notice is first in effect on 05/01/07

I hereby acknowledge that I have read, understand and asked any questions regarding Christina Collins, M.D. Notice of Privacy Practices.

_____ _____
(Print Name) (Signature)

_____
(Date)

_____ Yes, I would like to receive a copy of Christina Collins, M.D. Notice of Privacy Practices
_____ No, I would not like a copy of Christina Collins, M.D. Notice of Practices at this time. However, by not accepting a copy at this time, I am allowed to request a copy in the future.

Brief Personal Medical History

Name: _____ **Birth date:** _____ **Age:** _____

Do you have any drug sensitivity or Drug allergies: Yes: _____ No: _____

If yes, please list & describe reaction: _____

Please list prescription medications you are currently taking **or** **I'm not taking any medication** _____

Medication	**Dosage**
_____	_____
_____	_____
_____	_____
_____	_____

Personal Medical History, check all that apply:

Diabetes _____ Stroke _____ Hypertension _____ Heart Disease _____ Bleeding Disorder _____

Cancer__ _____ If yes, what type of Cancer and when _____

*List all other medical history conditions:_____

List previous surgeries: _____

Personal History, check all that apply:

Current Smoker _____ Drink Socially & on Occasion _____ Currently Sexually Active ____ History of Sexual Assault _____

Drug Use _____ If yes, specify: _____

Immediate Family Medical History:

Relative & Disease: _____

PAST PREGNANCIES:

DATE / MONTH/YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE OF DELIVERY	ANES	PLACE OF DELIVERY	PRETERM LABOR Y/N	COMMENTS / COMPLICATIONS

Tubal pregnancies: _____ Miscarriages: _____ Terminations: _____

GYN History, check all that apply:

History of: Chlamydia: _____ Gonorrhea: _____ Herpes: _____ Syphilis: _____ HIV: _____

Do you have regular menstrual periods: Yes: _____ No: _____ If yes, they occur every _____ days.

1st day of your last menstrual period: _____

Current form of birth control: _____ Tubal Ligation: Yes: _____ No: _____

History of abnormal Pap Smear: No: _____ Yes: _____ If yes, what were the results: _____

Last Pap Smear done: _____ Last Pap done by: _____ Results: _____