



CATHY J. BERRY, M.D.
& ASSOCIATES | Joining Hands in Women's Wellness

Welcome!

We would like to take this opportunity to welcome you to Cathy J. Berry, MD and Associates. Our staff is anxious to discuss your health care concerns and develop with you the best plan of care for you. We will be committed to your well-being and satisfaction. Our offices include on-site sonography and laboratory services for your convenience.

Nurses are available Monday through Friday from 8:30-4:30 to speak with you and answer your questions. Our secretaries will relay your message or concern to them, and your call will be returned in the order in which it was received. In some cases, calls are returned in the order of medical importance. Please understand that our phones tend to be very busy in the mornings with patients who wish to be seen that same day. We make every attempt to return your call in a timely manner.

All our providers have varying hours and do have office hours while they are on call. They may not see patients everyday in the office. In addition to Dr. Berry, we have 2 Nurse Practitioners, one Midwife and 1 Physician Assistant.

Should you require a hospitalization, we only admit to Crouse Hospital.

A copy of our financial policy is enclosed. Please familiarize yourself with these policies. Bring a copy of your insurance cards and any applicable co-pays to your appointment with you. Since we want your account to remain in good standing with us, it is not our policy to bill you for copays. Copays and Coinsurances are expected at the time of service. If you are not able to pay your copay at the time of your appointment, your need for this appointment will be reviewed by your provider. If your appointment is not medically urgent, you may be asked to reschedule your appointment. If your appointment is deemed medically urgent, you may be asked to speak with the billing supervisor to discuss payment arrangements and a \$10.00 surcharge will be added. Payment plans for services other than maternity services will not be installed over more than 3 months.

There may be cases when lab tests, diagnostic tests or preventive examinations are not covered by your insurance or are subject to deductible or coinsurance. We must, and will, represent our services exactly as they are rendered to you. If we provide a service that is not a covered benefit by your insurance company, it will be your responsibility. Most insurance companies do not charge a copay for well woman preventive services, however if you present with health concerns and fall outside of the realm of "normal routine care" your account may incur a copayment. It is important for you to remember that your insurance coverage is outlined in the contract between you and them.

Since we have many patients with a variety of medical needs, our ability to accommodate everyone in a timely manner depends on your ability to keep your appointments. If you are not able to keep your appointment, 24-hour notice is required. Individuals who do not call to cancel or reschedule their appointments and who do not come in, will be required to sign a "No Show Contract". Individuals with a chronic history of cancels and / or reschedule may be denied further services at Cathy J. Berry, MD and Associates. Patients receiving a sonogram will be charged a fee of \$50 for late arrival of 15 minutes or more and may be asked to reschedule.

We would also like to remind you that routine GYN examinations require that you refrain from sex and place nothing in the vagina for 48 hours prior to your appointment. Certain objects (such as tampons) or creams (medications, hormones or sperm) may result in inaccurate or false positive test results. If you have a period on the day of your exam, you should reschedule your appointment.

Our on-site Sonographers are ARDMS registered and our facility is AIUM certified. While in our care, it is important for you to understand that you Sonogram is an essential diagnostic medical exam and very important for you and your baby's well-being. The sonogram schedule runs on-time, so we encourage you to arrive on time, prepared for your exam. You may invite 1 guests, 16 and over, in the sonography room during sono exams.

We want to support our patients in all areas of health and wellness, while upholding traditional women's OB/GYN health care. As a result, we advocate an integrative Health Model, one that fosters wellness for the body, the mind, and the spirit. To help you and your wellness we would be pleased to refer you to any of our community wellness partners.

Open communication is the key to any good relationship, and we look forward sharing this time with you. We welcome your thoughts, suggestions or concerns at any time.

Our staff will always make every effort to be respectful of your needs and personal space. We expect that everyone, including other people may invite to accompany you to your appointments do the same. Foul language, rude or disruptive behavior will not be tolerated under any circumstances. Recording devices, audio or visual, are strictly prohibited on the premises. It is the policy of this practice to enforce these rules strictly and may result in your discharge from care.

We have a working partnership with many traditional and non-traditional health care providers in the community. It is the goal of our physicians and staff to meet your changing healthcare needs in the best way for you.

Thank you for choosing us as your healthcare provider, and again, Welcome!

Cathy J. Berry, MD

Date: _____ Legal Name: _____ Preferred Name: _____

DOB: _____ Age: _____ Gender Identity/ Pronoun: _____

Allergies and reaction: _____

Current medications/Vitamins/Supplements (with dose): _____

First day of Last Period: _____ Do you perform Self Breast Exams? Yes, No, Sometimes

Current Method of Birth Control: _____

Previous Method of Birth Control: _____

Age at first Menses: _____ Days between Menses: _____ Regular? Yes or No

Duration of Menses: _____ Problems with Menses? _____

Year or age at Menopause: _____ History of HRT? _____

Date of Last Pap: _____ Location: _____

Date of Last Mammo: _____ Location: _____ Date of last Colonoscopy: _____

Date of Last Bone Density: _____ Location: _____

Age at First Intercourse: _____ # Partners in a Lifetime: _____ Preference? Men, Women, Both

History of Sexually Transmitted Diseases: _____

Pregnancies: Total: _____ Vaginal: _____ C-Section: _____ Abortion: _____

Miscarriage: _____ Ectopic: _____ Premature: _____ VBAC: _____ Living: _____

Pregnancy Complications: _____

Nurse will review details of pregnancies with you in the room if you are under age 50

Have you ever been diagnosed with Covid-19? Yes or No; Have you received the Covid-19 Vaccine? Yes or No

History of Childhood Illness (i.e., Chickenpox, mumps, measles, asthma, etc): _____

History of Serious Accidents or Injury: _____

Do you have a history of Abnormal Paps?: _____

History of Gynecological Procedures (Colposcopy, LEEP, conization, etc): _____

Past Medical Diagnosis' (i.e. Cancer, heart issue, diabetes, thyroid disorder, bleeding disorder, etc): _____

Surgical History (including wisdom teeth and tonsillectomy): _____

Any Anesthesia Complication: _____

Family Medical History (i.e. cancer, heart issues, diabetes, thyroid disease, kidney disease, GI disorder, bleeding disorder)

Father: Living? Y or N _____

Mother: Living? Y or N _____

Pat. G.mother Living? Y or N _____

Pat. G.father Living? Y or N _____

Mat. G.mother Living? Y or N _____

Mat. G.father Living? Y or N _____

Siblings: _____

Marital Status: _____ Highest Level of Education Completed: _____

Live with?: _____ Current Employment: _____

Diet (circle one) Excellent, Good, Fair, Poor Pets? _____ History of Drug Use: _____

Caffeine #/Day: Soda: _____ Coffee: _____ Tea: _____ Energy Drinks: _____

Are you/Have you ever been a smoker/Vape? _____ Packs/Day _____ Years smoked/Vaped _____

Alcohol? Never Daily Weekly Rarely

Name: _____

Chart# _____

In the last 12 months have you:

Been in jail?

Yes

No

had sex in exchange for money, food or shelter

Yes

No

Is your housing permanent?

Yes

No

Do you need help finding a place to stay?

Yes

No

Are you currently or have ever experienced physical, emotional or sexual abuse?

Yes

No

Are you receiving any form of counseling?

Yes

No

Is there anything you would like us to know about you?

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns

+ +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any* problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
 Somewhat difficult _____
 Very difficult _____
 Extremely difficult _____

Name: _____

Chart # _____

How Do YOU Identify Yourself?

Ethnicity	Language	Race	Sex Assigned at Birth	Gender	Sexual Orientation
Non-Hispanic	English	African/American/Black	Male	Woman/Girl	Straight/heterosexual
Hispanic/Latino	Spanish	Asian	Female	Transgender woman/girl	Lesbian
Declined to specify	Declined to specify	Native American	Intersex	Transgender man/boy	Gay
Other	Other	Native Hawaiian		Non-Binary	Bisexual
		Pacific Islander		Gender Non-Conforming	Pansexual
		White		Not sure/Questioning	Asexual
		Other			Queer
		Declined to specify			Not Sure/Questioning

(Please Circle all that apply; at least one (1) from each column please)

Cathy J. Berry, MD and Associates

8136 Oswego Road
Liverpool, New York 13090
Phone (315) 638-0263 Fax (315) 635-9004

101 Pine Street
Syracuse, New York 13210
Phone (315) 422-8105 Fax (315) 251-1388

PATIENT REGISTRATION FORM
(PLEASE PRINT)

Date: _____

Name: _____ Sex: ☐ F ☐ M

Preferred Name: _____

please note that all correspondence from our office will come addressed in your Legal Name

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Age: _____ DOB: _____

Marital Status: Single ☐ Married ☐ Divorced/Separated ☐ Widow/Widower ☐

Patients Employer: _____ Occupation: _____

Employers Address: _____ Work #: _____

Emergency Contact: _____ Phone: _____

Spouse / Significant Others Name: _____

Spouse / Significant Others DOB: _____

Spouse / Significant Others Employer: _____ Occupation: _____

Employers Address: _____ Work #: _____

Primary Care Physician: _____

PCP Address / Phone #: _____

Pharmacy: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Subscriber Name: _____ ID#: _____

DOB: _____

Secondary Insurance Company: _____

Subscriber Name: _____ ID#: _____

HIPAA

It is important to Cathy J. Berry and Associates to protect the privacy and confidentiality of health information as well as the safety and health of our patients. In order for us to protect your information the best we can, we ask you to please fill out the information below.

Appointment Information

Please check off all that apply to you:

Home Phone: ☐

Work Phone: ☐

Cell Phone: ☐

Text Message: ☐

Confirm appointment with another person: ☐ If so, please list name(s) below:

Medical Information

Please check off all that apply to you:

Home phone: ☐

Work Phone: ☐

Cell Phone: ☐

Patient Portal: ☐

Discuss medical information with another person: If ☐ so, please list name(s) below:

We encourage everyone to use our patient portal. The link is located at the bottom of our website. Please ask a secretary for your personal access code if you haven't already received one.

Signature: _____

Date: _____



CATHY J. BERRY, M.D.
& ASSOCIATES | Joining Hands *in* Women's Wellness

I give consent to Cathy J Berry, MD & Associates to electronically query and retrieve my medical records for treatment purposes from all available sources. This includes, but is not limited to, demographic information as well as other clinical documentation that may be available through sources such as the Carequality Interoperability Framework, Surescripts or other connected entities.

Printed Name

Signature

Date

MR #



Cathy J Berry & Associates

New York State Department of Health

**Authorization for Access to Patient Information
Through a Health Information Exchange Organization**

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealthConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealthConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealthConnections website at <http://healtheconnections.org/>.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.	
☐	1. I GIVE CONSENT for the Organization named above to access ALL of my electronic health information through HealthConnections to provide health care services (including emergency care).
☐	2. I DENY CONSENT for the Organization named above to access my electronic health information through HealthConnections for any purpose, even in a medical emergency .

If I want to deny consent for all Provider Organizations and Health Plans participating in HealthConnections to access my electronic health information through HealthConnections, I may do so by visiting HealthConnections website at <http://healtheconnections.org/> or calling HealthConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

FINANCIAL POLICIES AND PROCEDURES FOR CATHY J. BERRY MD, AND ASSOCIATES

We at Cathy J. Berry and Associates want to ensure you receive the best quality of healthcare. Your understanding of our financial policies is essential for good customer relations.

The following is a list of insurance companies we participate with. It is your responsibility to know what covered service under your individual policy is and what your financial responsibility will be. It is also the patient's responsibility to know what restrictions apply to their own individual insurance policy relating to laboratories and hospital facilities.

Aetna	Molina
Blue Cross / Blue Shield of CNY	Lifetime Benefit Solutions
BC/BS PPO	Healthnow
MVP Healthcare -Commercial and Medicare Plans	Cigna
UMR	Medicare
Blue Cross / Blue Shield PPO SEIBA	Fidelis
GHI - Upstate NY plans only Humana	Well Care
CDPHP - verify coverage in our area	GHI - Upstate NY plans only
Humana	Empire
United Health Care - Employer OR Medicare Advantage	Meritan

Payment for any co-pays, co-insurance, deductibles or non-covered services is to be made at time of service. Per New York States law, co-pays, co – insurance and deductibles cannot be waived. Co- payments are required and will be collected at the time of check-in. If you are not prepared to pay for your copayment at that time, you may be asked to reschedule your appointment.

If we do not participate with your insurance, you will be expected to pay for your services in full at the time the services are rendered. As a courtesy, we will then bill your insurance company and any reimbursement will be made directly to you.

In the case of financial hardship, payment arrangements will be made but only if agreed upon before services are rendered.

If you have an insurance company that requires a referral from your primary care physician, it is the patient's responsibility to obtain this and keep track of the expiration date/ we will be unable to see you for your scheduled appointment if we do not have the referral on or before your appointment date.

We accept cash, checks, Visa, Mastercard, Discover and American Express. There will be a \$25 charge for returned checks.

By paying with a CREDIT CARD I acknowledge this amount is no longer considered medical debt. I am foregoing certain federal and state protections around medical debt, specifically, Limitations on interest rates and the prohibition against wage garnishment, property liens and the reporting of medical debts to credit bureaus.

If you have any questions or concerns regarding these policies, please feel free to contact our billing department.

NO SHOW FEE AND LATE CANCELLATION FEE POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences.

Due to high patient demand and limited availability of appointments, we have instituted a \$100.00 fee for a no show, and a \$50.00 late cancellation fee. You must give 24-hour notice to cancel/reschedule appointments. Failure to do so will result in the above fees.

If you have 2 no show appointments, you may be discharged from the practice.

By signing below, I acknowledge that I have read and understand these policies.

Patient Name

Date