Madonna OB/GYN

FIRST NAME MI LAST NAME DATE OF BIRTH

STREET ADDRESS CITY STATE ZIP

HOME PHONE WORK PHONE CELL PHONE

E-MAIL ADDRESS

RACE (*Circle One)*

White
Black/African American
Asian
Native Hawaiian/Other Pacific Islander
Native American/Alaska Native
Other _____

ETHNICITY (*Circle One)*

Spanish/Hispanic Origin
Not of Spanish/Hispanic Origin

PRIMARY LANGUAGE (*Circle or List Other*)

English

Other _____

EMPLOYMENT STATUS:

❒FULL TIME ❒PART TIME ❒UNEMPLOYED ❒RETIRED

OCCUPATION _____

EMERGENCY CONTACT INFORMATION

FIRST NAME MI LAST NAME RELATION TO PATIENT

STREET ADDRESS CITY STATE ZIP

HOME PHONE WORK PHONE CELL PHONE

PRIMARY CARE PHYSICIAN

FIRST NAME LAST NAME

Madonna OB/GYN

PRIMARY MEDICAL INSURANCE :

INSURANCE CARRIER NAME

ADDRESS (IF LISTED ON THE BACK OF YOUR INSURANCE CARD) CITY STATE ZIP

MEMBER ID # EFFECTIVE DATE

NAME OF POLICY HOLDER BIRTH DATE SSN# (IF KNOWN) RELATIONSHIP TO PATIENT

SECONDARY MEDICAL INSURANCE:

INSURANCE CARRIER NAME

ADDRESS (IF LISTED ON THE BACK OF YOUR INSURANCE CARD) CITY STATE ZIP

MEMBER ID # EFFECTIVE DATE

NAME OF POLICY HOLDER BIRTH DATE SSN# (IF KNOWN) RELATIONSHIP TO PATIENT

AGREEMENT AND ACKNOWLEDGEMENT

I understand that as part of my treatment plan, it may become necessary to disclose my protected health information to other entities to assist with my medical care and billing. I consent to such disclosure. In the event that my insurer determines the service is "not covered" by the terms of my health care plan. I accept responsibility for payment in full.

Print Name: _____

Signature: _____

Date: _____

Madonna OB/GYN

HIPPA Privacy Information for _____
Name

I authorize Madonna OBGYN to discuss my PHI (Protected Health Information) with the following person(s) or entity (ies):

NAME	RELATIONSHIP	RESTRICTION REGARDING THE SHARING OF INFORMATION
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOW MAY WE CONTACT YOU?

	APPOINTMENT INFORMATION:	**MEDICAL INFORMATION:**
ON HOME PHONE (INCLUDING AUTO CALL)?	❒	❒
ON CELL PHONE (INCLUDE AUTO CALL)?	❒	❒
TEXT MESSAGE (APPOINTMENT REMINDER ONLY)?	❒	❒
ON OFFICE VOICE MAIL?	❒	❒
SEND VIA E-MAIL?	❒	❒

Madonna OB/GYN

Restriction of use and the disclosure of your Protected Health Information (PHI)

As of 4/14/03 you have the right to request that the use and disclosure of your protected health information (PHI) be restricted for treatment, payment and health care operations, as well as restricting disclosure to only certain people, such as specific family members.

The restriction request must be in writing, be specific as to what information is covered by the request, whether it covers use, disclosure, or both, and to whom those limitations apply.

Madonna OB/GYN does not have to agree to your request. If Madonna OB/GYN agrees to the request, it will honor the request except when overriding laws or emergencies apply.

I have been advised that a copy of the Notice of Privacy Practices from Madonna OB/GYN is available at my request.

If a guarantor other than you is listed as the person responsible for payment, they may receive treatment/diagnostic information for billing purposes.

_____ _____

PATIENT NAME (PLEASE PRINT) DATE

_____

PATIENT SIGNATURE

_____ _____

WITNESS SIGNATURE (IF APPLICABLE) DATE

_____ _____

PRINT WITNESS NAME RELATION TO PATIENT

Madonna OB/GYN

Financial Policy and Release of Medical Records Policy Agreement and Acknowledgement

- Insurance co-pays/deductible amounts are due at the time of your appointment. Your insurance policy may require you to make co-payment or pay a deductible for an office visit and/or a procedure; therefore **PAYMENT IN FULL IS EXPECTED ON THE DATE OF SERVICE**.

- A $10.00 service fee is charged if the co-pay is not paid at the time of service

- A $20.00 service fee is charged for any returned checks.

- Our office accepts many health care plans. We will bill those plans with which we have an agreement with and collect co-pays/deductible amounts at the time of service. In the event that your insurer determines the service is "not covered" by the terms of your health care plan, you will be responsible for payment in full on the date of service(s) to include office visits, procedures and in-patient surgical procedures.

- In the event that our physician(s) are not enrolled with your health care plan, you will be responsible for payment in full on the date of service(s). In this instance, you may submit your claim directly to your insurance carrier to request reimbursement.

- In the event that your medical expenses will not be submitted to an insurance carrier, payment is due at the time of service which includes office visits, procedures, and diagnostic test and in advance of any surgical procedures.

- **Many insurance companies require an authorization for visits to receive full benefit coverage.** If you are unsure if authorization is required, please call your insurance carrier directly. If required, the authorization must be received before your visit. Failure to provide us with the proper authorization may result in the rescheduling and/or cancellation of your appointment.

- **For appointments that are missed or not cancelled at least 24 hours prior to the scheduled office visit, there will be a no-show fee charged:**
    - $50 fee for office appointment with a physician or nurse practitioner.
    - $100 fee for hospital, office procedure appointment, or ultrasound
    - $100 fee for aesthetics ie: Botox, Filler, Laser-your credit card will be billed automatically

- **Your medical records may be copied upon request with written authorization. The New York Legislature has determined that a reasonable fee for copying medical records is $.75 per page. This fee is assessed and due upon request of records.**

- Form fees are not covered by your insurance company. For each injury/problem, one form will be completed free of charge. Thereafter, there will be a $15 charge for each form. This is to be paid in advance.

Madonna OB/GYN

Financial Policy and Release of Medical Records Policy Agreement and Acknowledgement

Financial Agreement

I hereby assume full responsibility for all charges incurred for professional services rendered by Madonna OB/GYN, including 33 1/3% collection cost and 50% attorney fees, unless the services are deemed "paid in full" as a result of a contractual agreement between Madonna OB/GYN and my insurer.

Authorization for the Release of Information

I hereby authorize Madonna OB/GYN to release any medical, psychiatric, infectious disease (including AIDS confidential information) or drug and/or alcohol related information to my referring physician and any insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date except to the extent that action has been taken reliance hereon.

Group & Individual Insurance, Assignment of Benefits

I authorize my health insurance benefit plan to pay directly to Madonna OB/GYN, the surgical and/or medical, if any, otherwise payable to me for their services as described on attached claim but not to exceed the charges for those services. I understand I am financially responsible to Madonna OB/GYN for charges not covered by this assignment.

Medicare, Claim Authorization and Payment Request

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it intermediaries or carrier any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts this assignment. Regulations pertaining to Medicare assignment of benefits apply.

- **I acknowledge that I have read and agree to the Financial Policy of Madonna OB/GYN.**

- **I acknowledge that I have read and agree to the Privacy Policy of Madonna OB/GYN.**

_____

TO BE SIGNED ELECTRONICALLY IN OFFICE

Madonna OB/GYN

Agreement as to Resolution of Concerns and Handling of Dissatisfaction

We take pride in our reputation for providing the highest level of quality medical care to our patients. However, we realize there are times when patients will not be satisfied with the outcomes of their treatments. We therefore recognize and respect a patient's right to pursue legal action if she feels we have been negligent in some way.

While some health care legal claims are justified, there are also more frivolous legal claims filled in our country, which drive up insurance rates and adversely impact court decisions for patients who deserve compensation. As such, we believe that an agreement early in the treatment process regarding the use of board-certified experts may help expedite resolution of concerns.

OUR COMMITMENT TO YOU: We commit to using only American Board of Medical Specialties (ABMS) board-certified expert witness(es), in any legal situation, who follow the code of ethics of our national specialty society. These steps insure that the expert medical witnesses we use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics.

WHAT WE ARE ASKING YOU TO DO: We are asking you or your representative to commit to using only board-certified physician expert medical witness(es) if you are dissatisfied with your medical care and decide on legal action.

I understand that I am entering into a contractual relationship with Madonna OB/GYN for professional services. I further understand that claims that are without merit or are frivolous have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Madonna OB/GYN, I agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against providers within Madonna OB/GYN or its partner companies.

Should I initiate or pursue a medical malpractice claim against a provider within Madonna OB/GYN, I agree to use only physicians who are board certified by the American Board of Medical Specialists in the same or similar specialty as the provider against whom the claim is being made, as expert witnesses. Further I agree that physicians retained by me or on my behalf to be an expert witness will be a member in a good standing of the medical specialty society to which the provider belongs. I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by that physician's or provider's specialty society.

I agree to require an attorney I hire and physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, the Physicians and Staff of Madonna OB/GYN agrees to the same above referenced stipulations.

Each party agrees that her counsel shall have the right and be free to depose the other party's expert witness(es) at least 120 days before the scheduled trial date.

Each party agrees that this agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses.

Each party agrees that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, assault or any other theory of recovery.

_____

TO BE SIGNED ELECTRONICALLY IN OFFICE

ROCHESTER RHIO

Regional Health Information Organization

In this Consent Form, you can choose whether to allow the provider named above to obtain access to your medical records through a computer network operated by the Rochester RHIO, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow the provider named above to see and obtain access to Your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your decisions will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, the above named provider's staff involved in my care may see and get access to all of my medical records through the Rochester RHIO."

If you check the **"I DENY CONSENT"** box below, you are saying "No, the provider named above may not be given access to my medical records through the Rochester RHIO for any purpose."

The Rochester RHIO is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask this provider for it, or go to the website www.ehealth4ny.org.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices.

- ❒ **I GIVE CONSENT for the Provider named above to access ALL** of my electronic health information through the Rochester RHIO in connection with providing me any health care services, including emergency care.

- ❒ **I DENY CONSENT for the Provider named above to access** my electronic health information through the Rochester RHIO for any purpose, *even in a medical emergency*.

  NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the Rochester RHIO.

_____

TO BE SIGNED ELECTRONICALLY IN OFFICE

Details about patient information in the Rochester RHIO and the consent process:

1. How Your Information Will be Used. Your electronic health information will be used by your healthcare provider name don this form **only** to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care provided to all patients.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. What Types of Information about You Are Included? If you give consent, the provider named on this form may access ALL of your electronic health information available through the RHIO. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

3. Where Health Information About You Comes From. Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other health organizations that exchange health information electronically. A complete list of current Information Sources is available from the Rochester RHIO. You can obtain an updated list of Information Sources at any time by checking the Rochester RHIO's website at www.grrhio.org or by calling 877.865.RHIO (7446).

4. Who May Access Information About You, If You Give Consent. Only these people may access information about you: doctors and other health care providers who serve on the provider named on this form's medical staff who are involved in your medical care; health care providers who are covering or on call for this provider's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. Penalties for Improper Access to or Use of Your Information. There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the provider named on this form at 585-698-7077: or visit the Rochester RHIO's website: www.grrhio.org; or call the NYS Department of Health at 1-877-690-2211.

6. Re-disclosure of Information. Any electronic health information about you may be re-disclosed by the provider named on this form to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. The Rochester RHIO and persons who access this information through the Rochester RHIO must comply with these requirements.

7. Effective Period. This Consent Form will remain in effect until the day you withdraw your consent.

8. Withdrawing Your Consent. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to the Rochester RHIO. You can also change your consent choices by signing a new Consent Form at any time.
You can get these forms on the Rochester RHIO's website at www.grrhio.org, or by calling 877.865.RHIO (7446). **Note: Organizations that access your health information through the Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.**

9. Copy of Form. You are entitled to get a copy of this Consent Form after you sign it**.**

Madonna OB/GYN

OFFICE USE ONLY		
RHIO	YES	NO
SURESCRIPTS	YES	NO

Appointment Date: _____

Name_____ Age_____ DOB_____

Preferred Pharmacy _____ Location _____

What is the reason for your visit? _____ (Annual exam) (Other) _____

Current medication and dosage _____

_____

_____

Medication Allergies _____ Do you have a LATEX Allergy? ____ (yes) ____ (no)

Date of last: PAP Smear_____ Tetanus Shot _____ Mammogram_____ Bone Density_____

Colonoscopy_____ Cholesterol Check_____ HPV Vaccine (Gardasil) _____

Pregnancy History: # of pregnancies _____ # of deliveries _____ # of living children _____

# of miscarriages _____ # of terminations _____ # of ectopic _____

❑ I have updated my medical history through the patient portal within the last year. **INTITAL AND DATE _____**

Please tell us about YOUR gynecological history.

When was the first day of your last menstrual period? _____ Number of days between cycles? _____

Age of first period _____ Are cycles regular? ___ (yes) ___ (no)

Please check if YOU are being treated or have been treated for any of the following: ❑ NONE

❑ SAME AS PREV. YEAR INTITAL AND DATE _____

- ☐ Herpes
- ☐ Endometriosis
- ☐ Infertility
- ☐ Colposcopy

❑ SAME AS PREV. YEAR INTITAL AND DATE _____

- ☐ Gonorrhea
- ☐ Pelvic Pain
- ☐ Ovarian Cancer
- ☐ LEEP

❑ SAME AS PREV. YEAR INTITAL AND DATE _____

- ☐ Chlamydia
- ☐ Ovarian Cysts
- ☐ Uterine Cancer
- ☐ Cryo (freezing)

❑ SAME AS PREV. YEAR INTITAL AND DATE _____

- ☐ Genital Warts
- ☐ Polycystic Ovaries
- ☐ Heavy Periods
- ☐ Other _____

Please check if YOU are being treated or have been treated for any of the following: ❑ NONE

❑ SAME AS PREV. YEAR INTITAL AND DATE _____

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Breast Cancer
- ☐ Other_____

❑ SAME AS PREV. YEAR INTITAL AND DATE _____

- ☐ Colon Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis

❑ SAME AS PREV. YEAR INTITAL AND DATE _____

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irritable Bowel
- ☐ Migraines

❑ SAME AS PREV. YEAR INTITAL AND DATE _____

- ☐ Osteoporosis/Osteopenia
- ☐ Reflux/GERD
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease

Please check if YOU have had any of these surgeries/treatments, including dates ❑ NONE

❑ SAME AS PREV. YEAR INTITAL AND DATE _____

- ☐ Appendectomy
- ☐ Gallbladder
- ☐ Bowel
- ☐ Uterine Ablation

❑ SAME AS PREV. YEAR INTITAL AND DATE _____

- ☐ Heart Surgery
- ☐ Back/Neck
- ☐ Breast

❑ SAME AS PREV. YEAR INTITAL AND DATE _____

- ☐ C-Section
- ☐ D&C
- ☐ Tonsillectomy

❑ SAME AS PREV. YEAR INTITAL AND DATE _____

- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Ovarian

Name: _____

Please check if anyone if your immediate family (parents, siblings) has ever had the following. ❑ **NONE**

❑ **SAME AS PREV. YEAR INTITAL AND DATE** _____ ❑ **SAME AS PREV. YEAR INTITAL AND DATE** _____

☐ Breast Cancer	☐ Stroke	☐ Thyroid Disease	☐ Other _____
☐ Colon Cancer	☐ Heart Disease	☐ High Cholesterol	☐
☐ Ovarian Cancer	☐ Diabetes	☐ Osteoporosis/Osteopenia	
☐ Uterine Cancer	☐ Blood Clots	☐ High Blood Pressure	

Please CIRCLE if you are having a CURRENT problem with any of the following that you would like to discuss TODAY.

Sudden Weight Gain	Sudden Weight Loss	Fatigue	Fever	Blurry Vision	Spots Before Eyes	Ear Ache	Ringing In Ears
Bleeding Gums	Mouth Sores	Sore Throat	Chest Pain	Palpitations	Irregular Heartbeat	Swelling Of Legs	Cough
Shortness Of Breath	Wheezing	Nausea	Vomiting	Abdominal Pain	Diarrhea	Constipation	Bloating
Rectal Bleeding	Hemorrhoids	Pain With Intercourse	Irregular Periods	Abnormal Vaginal Discharge	Vaginal Dryness	Pelvic Pain	Pain With Urination
Incontinence	Frequent Urination	Urgent Voiding	Blood In Urine	Swelling In Joints	Pain In Joints	Muscle Weakness	Skin Changes
Dizziness	Numbness	Seizures	Trouble Walking	Fainting	Headache	Depression	Anxiety
Poor Sleep	Impaired Memory	Mood Changes	Excessive Sweating	Excessive Thirst	Increased Urination	Hot Flashes	Night Sweats
Dry Skin	Easy Bleeding	Easy Bruising	Swollen Lymph Nodes	Seasonal Allergies	Food Allergies	Medication Allergies	Rash
Changes In Moles	Abnormal Lumps						

Note: The discussion of any of the above issues may results in an additional fee for today's visit.

Occupation: _____

Marital Status: _____ with whom do you live _____

Are you sexually active? ___ (yes) ____ (no) Gender of partner(s): _____

Have you had unprotected sex with a partner who has traveled to an area with active Zika virus transmission ___ Yes ___ No

Contraception use (methods):_____

Do you preform self-breast exams? ____ (yes) _____ (no)

Do You?

Smoke	☐ No	☐ Yes _____packs/day?	☐ Quit	
Drink Alcohol	☐ No	☐ Yes, Occasionally	☐ Yes, Daily	
Use Marijuana	☐ No	☐ Yes, How Often:_____		
Use Street Drugs	☐ No	☐ Yes, List Drugs:_____		
Exercise	☐ No	☐ Yes, How Often:_____		

Do you take Calcium/Vitamin D?	☐ Yes	☐ No
Do you take a Multivitamin?	☐ Yes	☐ No
Do you use seat belts?	☐ Yes	☐ No
Do you have a Health Care Proxy	☐ Yes	☐ No

Are you being physically, sexually, or emotionally abused?	☐ Yes	☐ No
Do you want an HIV test?	☐ Yes	☐ No
Do you want any other STD testing?	☐ Yes	☐ No