General Information Form

Date:

Name:	
Date of Birth:	
Age:	

Contact Information

Address:	
Home Phone:	
Cell Phone:	
Email Address:	

Employment Information

Are you employed outside the home?	[ ] Yes [ ] No
Employer Name:	
Position:	

Emergency Contact

Name:	Relation:
Phone#1	Phone#2

Insurance Information

Primary Insurance:	Group#:
Subscriber:	Policy#:
Subscriber SS# (req.):	Subscriber DOB:
Secondary Insurance:	Group#:
Subscriber:	Policy#:
Subscriber SS#:	Subscriber DOB:

Other

How did you hear about us?
Name of Primary Care Physician (if app):

Patient Health Information Form #1

Date:

Name:	DOB:

Please answer all questions that you feel comfortable answering. Other questions can be discussed privately with the doctor.

Gynecologic History

First Day of Last Period:
Are your cycles regular:
Are your cycles painful:
Normal Length of Cycles (Days of Bleeding):
Normal # of days from first day of period to first day of next:

Last Pap Smear:	Any abnormal paps? Y N
Last Mammogram:	Any abnormal mammos? Y N

Are you sexually active? Yes Never In the Past
Number of Current Partners:
Number of Lifetime Partners:
Are you sexually active with: Men Women Both
Are you using any method to prevent pregnancy? Y N
If yes, what?

Do you have any GYN problems? Yes No In the Past
Please explain:

Obstetrics History

Please List all Pregnancies, Including Miscarriages, Losses, and Terminations of Pregnancy

Year	Type (Vaginal, Cesarean, Miscarriage, Termination)	Weeks Pregnant	Birth Weight	Sex

Please list any pregnancy complications:

109 Valley Rd. Montclair, NJ 07042
www.wombkeepers.com
Fax: 973-655-9665
Phone: 973-655-9662
staff@wombkeepers.com

Patient Health Information Form #2

Name:	DOB:

General Medical History

Please list all current and past medical conditions for which you have seen a doctor

Year Began	Year Resolved	Condition

Past Surgeries/Hospitalizations

Year	Procedure or Reason For Hospitalization

Current Medications

Medication	Dose (if known)

Allergies to Medications

Medication	Reaction

Social History

Do you smoke? Y N	Drink Alcohol? Y N	Use Substances? Y N

109 Valley Rd. Montclair, NJ 07042
www.wombkeepers.com
Fax: 973-655-9665
Phone: 973-655-9662
staff@wombkeepers.com

Patient Health Information Form #3

Name:	DOB:

Family History

Please list any medical conditions that run in your family, especially any female cancers

Relative (Indicate Maternal or Paternal)	Condition

Current Symptoms

Please circle any current symptoms you are experiencing

	Symptom
General	Weight Loss Weight Gain Fever Fatigue
Head & Eyes	Headache Vision Change Dry Eyes
Ear, Nose, Throat	Sore Throat Sinus Problems Hearing Loss Ear Pain
Cardiovascular	Chest Pain Palpitations Irregular Heart Beat Leg Swelling
Respiratory	Shortness of Breath Wheezing Cough
Gastrointestinal	Constipation Diarrhea Vomiting Indigestion Bloody Stool Fecal/Gas Incontinence Abdominal Pain Food Intolerance
Urinary	Painful Urination Urgency Frequency Incontinence Bloody Urine
Gyncologic	Abnormal Periods Pain with Intercourse Abnormal Discharge Pelvic Pain PMS Abnormal Vaginal Bleeding
Musculoskeletal	Muscle Weakness Muscle Pain Joint Pain Joint Swelling
Skin	Dryness Rash Moles Sores
Breast	Pain Discharge Lump/Mass
Endocrine	Hot flashes Heat/Cold intolerance Thyroid problem Hair Loss
Psychiatric	Depression Anxiety
Neurologic	Numbness Tingling Fainting Seizures Dizziness
Hematologic	Easy Bruising Prolonged Bleeding Enlarged Glands
Other:	

Patient Signature:	Date:
Physician Signature:	Date Reviewed:

109 Valley Rd. Montclair, NJ 07042
www.wombkeepers.com
Fax: 973-655-9665 Phone: 973-655-9662 staff@wombkeepers.com

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. IT ALSO SHOWS AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND RETAIN FOR YOUR RECORDS.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We, are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint

For more information about HIPAA or to file a complaint, contact:

The U.S. Department of Health and Human Services
Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 Tel. (202) 619-02570

109 Valley Rd. Montclair, NJ 07042
www.wombkeepers.com
Fax: 973-655-9665 Phone: 973-655-9662 staff@wombkeepers.com

PATIENT DISCLOSURE INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request that confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual home.

I wish to be contacted in the following manner (check all that apply)

[ ] Home Phone:______________________ [ ] Okay to leave message
[ ] Cell Phone: ______________________ [ ] Okay to leave message
[ ] Other Phone:______________________ [ ] Okay to leave message

I authorize Wombkeepers Obstetrics and Gynecology to release my protected health information to the following individual:

Name:____________________________________ Relationship:____________________

HIPAA ACKNOWLEDGEMENT

With my consent, Wombkeepers may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO), as further detailed in the Notice of Privacy Practices.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Wombkeepers reserves the right to revise its Notice of Privacy Practices at anytime and patients may request to receive any revisions in person or in writing.

With my consent, Wombkeepers may call my home or other designated location and leave a message, on voice mail or in person, in reference to any items that assist in my care or as necessary for payment. Wombkeepers may also mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With my consent, Wombkeepers may E-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Wombkeepers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Wombkeepers use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing this document I acknowledge that I have read and/or received a copy of the Wombkeepers Obstetrics and Gynecology HIPAA Notice of Privacy Practices. I have also read the contents of this form. I consent to the use and disclosure of my protected health information by Wombkeepers in order to carry out treatment, healthcare procedures and payment. I have had the opportunity to ask questions and all my questions have been answered.

Printed Name:	Signature:	Date:
Witnessed by:	Signature:	Date:

109 Valley Rd. Montclair, NJ 07042
www.wombkeepers.com
Fax: 973-655-9665 Phone: 973-655-9662 staff@wombkeepers.com

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Your clear understanding of our practice financial policy is important to our professional relationship. We make every effort to keep our fees reasonable while at the same time covering the cost of the services we provide. Payment of your bill is considered part of your overall treatment. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies.

Fees and Payments
Fees are standard and based on the complexity of your visit. Payment in full is required at the time of your visit and can be made with cash, personal check, Visa, MasterCard, or Discover.

Insurance co-payments are due at the time of service. We will not bill your secondary insurance for co-payments. If you are unable to pay your co-payment at your visit, your appointment may need to be rescheduled. If it is necessary that you be seen, a $25.00 Copay Service charge will be added to your account

While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Your insurance is a contract between you, your employer and the insurance company, we are not party to that contract. Before your visit, contact your insurance company to verify that we are participants in your plan, and that the services you intend to receive are covered. In order for us to file a claim, you must present a CURRENT copy of your insurance at each visit and communicate any changes in your personal information.
Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurance companies select certain services that they will not cover, therefore we can't guarantee payment of all claims by your insurance company. Some common examples of non-covered services are contraception and infertility. Additionally, some plans do not cover preventative or obstetrical services. Reduction or rejection of your claim does not relieve you of your financial responsibility.

PLEASE NOTE: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on coverage by Insurance Companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and is considered insurance fraud.

Required at Check-In

- Verify Personal Contact Information
- Present Current Copy of Insurance Card
- Present Current Picture ID
- Payment of any Outstanding Balance
- Payment of Today's Visit

We will verify your coverage at each visit. If we are unable to do so, you will be considered self pay and will be responsible for your visit.

Self-Pay
In order to address the needs of our patients without insurance and patients with coverage limitations, we offer a 30% discount off our standard fees. This discount acknowledges the lower cost involved in billing and collections when a claim does not need to be submitted to a third party payer. In order to qualify, payment needs to be made IN FULL prior to or on completion of your visit or procedure. Any remaining balance is not eligible for a discount. This discount applies to all medial services provided and is offered only at time of service. This policy does not apply to any miscellaneous charges or services through the Maternity Wellness Center.

109 Valley Rd. Montclair, NJ 07042
www.wombkeepers.com
Fax: 973-655-9665 Phone: 973-655-9662 staff@wombkeepers.com

Medicare and Medicaid
We gladly accept Medicare patients and will bill our services at the allowed rate. Medicare regulations require that you sign an Advanced Beneficiary Notice (ABN) at every visit. This form helps to explain which services Medicare may not cover and may be your responsibility. Lab work will require a separate ABN signature.
We gladly accept patients with Medicaid, United HealthCare Community Plan. Your current card must be presented at each visit.

Annual Exams and Mammography
Please verify that your insurance will cover these preventative services before making your appointment. Depending on your age and the plan, these services may not be covered. Also, some insurance companies are very strict in enforcing time limits between visits and may not cover your visit if you are even one day early.

Family Medical Leave Act and Disability Paperwork
If your employer requires Family Medical Leave Act (FMLA) or Disability paperwork to be completed by your provider, we offer two options:

- A form created by our practice that meets the needs of both employer and patient. Patients may request this form to be filled out at any time to clarify their current condition. The turnaround time for this form is 5 -7 business days and there is no charge for this.
- Forms directly from your employer requiring additional information take considerable time for the staff to complete. We are happy to complete these forms for you; however there is a 5-7 business day turnaround and a charge of $25.00, payable in advance. If there is denial of coverage and an appeal has to be completed, an additional $25.00 fee will be charged.

Medical Records
In order to be in compliance with New Jersey State law and HIPAA regulations, we charge a per page charge, payable in advance, if you would like a copy of your records sent to you or another physician. This per page fee policy is available upon request. As always, if a collaborating physician (primary care or specialist) requests portions of your record to assist in your care, there is no charge.

Miscellaneous Charges
Returned Check Charge : Non Sufficient Funds (NSF) checks are subject to a $25.00 fee (in addition to fees from your bank).

Collections Charge: Accounts that are not paid within 60 days from due date may be sent to an External Collection agency and reported to the Credit Bureau. In addition to your outstanding balance, a 33% surcharge may be added to cover our costs. In addition, you may be removed from the practice.

Lab Charges: Depending on your insurance, you may get a separate bill from the lab facility that performs your lab work. These charges should be discussed directly with the Lab facility.

Refunds: Patient Refunds are processed on the last Friday of the month. Any account that has outstanding claims will not be eligible for a refund.

I certify that I have read and understand this financial policy and that I have had the opportunity to ask questions and all questions have been answered.

Name:	Signature:	Date:
Staff:	Signature:	Date:

109 Valley Rd. Montclair, NJ 07042
www.wombkeepers.com
Fax: 973-655-9665 Phone: 973-655-9662 staff@wombkeepers.com