WOMEN WELLBEING OBGYN

REGISTRATION FORM

PLEASE COMPLETE ALL REQUIRED INFORMTION

CONTAINING ASTERISK (*)

* PATIENTS NAME: _____ SSN: _____-_____-_____ DOB: _____

(IF MINOR) PARENTS NAME: _____

* ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

* PHONE: _____ EMAIL: _____

* PHARMACY: _____ PHONE: _____ CITY: _____ ZIP: _____

* STATUS: SINGLE MARRIED DIVORCE WIDOWED LEGALLY SEPERATED

* RACE: _____ ETHNICITY: _____ LANGUAGE: _____

EMPLOYER: _____ ADDRESS: _____ OCCUPATION: _____

SPOUSE'S NAME: _____ DOB: _____ SSN: _____-_____-_____

SPOUSE'S EMPLOYER: _____ OCCUPATION: _____

BUSINESS ADDRESS: _____ WORK PHONE: _____

* PRIMARY INSURANCE INFORMATION: _____

* INSURED NAME: _____ DOB: _____ SSN: _____-_____-_____

* ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

* ID NUMBER: _____ GROUP NUMBER: _____

* RELATIONSHIP TO PATIENT: ____ SELF _____ DEPEPNDENT IS THE PATIENT A STUDENT? _____

SECONDARY INSURANCE INFORMATION: _____

INSURED NAME: _____ DOB: _____ SSN: _____-_____-_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

ID NUMBER: _____ GROUP NUMBER: _____

RELATIONSHIP TO PATIENT: ____ SELF _____ DEPEPNDENT IS THE PATIENT A STUDENT? _____

PATIENT RELEASE:

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS CORRECT. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION AS NECESSARY TO PROCESS MY CLAIM(S) TO MY INSURANCE COMPANY OR THEIR AGENCIES (INCLUDING MEDICARE) FOR FILING AND PAYMENT OF MEDICAL CLAIMS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED ON ALL BALANCES OWED TO THE PROVIDER THAT ARE PAST DUE. I PERMITE A COPY OF THIS RELEASE TO BE USED IN PLACE OF THE ORIGINAL.

** PATIENT/LEGAL REPRESENTATIVE SIGNATURE:* _____ *DATE:* _____

BILLING POLICY

Welcome to Women Wellbeing OBGYN. In order to better serve you with your insurance coverage we are providing you with our billing policy. I understand that the practice will file claims for services rendered to my insurance carrier for your primary insurance plan. Copays are due at the time of your appointment and there are no exceptions to this. We accept most insurances; however, it is your responsibility to ensure we participate with your insurance plan. You must present your current active insurance at the time of your visit. We do not back bill. It is ultimately the patient's responsibility to understand their health coverage. Your employer should have a copy of your Benefits Guidebook or call your insurance company if you need detailed information about your coverage.

I acknowledge that I am responsible for any balances that may be due to Women Wellbeing OBGYN due to any/all of the following:

- Co-insurance, copays and yearly deductibles
- Non-covered services
- Out of network charges
- Surgical Assistants not covered by your insurance company
- Terminated coverage
- No insurance coverage
- No referral obtained from primary care physician
- Failure to respond to insurance carrier correspondence (COB)

I authorize treatment of the person named above and agree to pay all fee charges for such treatment. I agree to leave a deposit for my visit if my deductible is larger than $1000 unless it is a preventive visit without any additional radiology or procedure. Deposit amount will be determined by the type of visit as well as any additional procedure and radiology that may be required.

I understand that I will receive a statement for any balance due after my carrier has processed the claim. I understand and am agreeable that the balance of my statement will be paid in full to Women Wellbeing OBGYN within 30 days. If I am unable to pay the entire amount, I am responsible to immediately, upon receipt of statement, call the office 516-519-8488 to arrange a payment plan. Please be advised that there is a no-show fee, if you cancel less than 24 hours from your appointment time, you will be charged $50. I understand that if I pay by check to Women Wellbeing OBGYN and the check is returned by the bank for non-sufficient funds, I will be charged the amount of the check plus $30 processing fee. I also understand that I will no longer be able to pay by check for any monies owed to Women Wellbeing OBGYN. I understand that failure to pay my balance and/or arrange payments and follow that payment agreement will result in collection agency action, including payment of collection agency fees and/or discharge from practice.

PLEASE NOTE: Each visit is documented in your medical record and 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 securing reimbursement from an insurance company is inappropriate and considered insurance fraud.

We are committed to giving the best care to our patients; and in doing so we ask your cooperation in meeting your financial responsibility.

Patient Signature:_____ Date:_____

What brings you in?

_____

_____

_____

Concerns?

_____

PCP:

_____

Family History

Father: Alive ☐ Deceased ☐

Mother: Alive ☐ Deceased ☐

Cancer	YES □	NO □
Genetic disease	YES □	NO □
Diabetes	YES □	NO □
Hypertension	YES □	NO □

Social History

Smoking	YES □	NO □
Alcohol	YES □	NO □
Substance Abuse	YES □	NO □

Allergy History

Medications:

Foods:

Latex: YES □ NO □

What Medications Are You Currently Taking?

ASPIRIN	YES □	NO □
COUMADIN	YES □	NO □
PLAVIX	YES □	NO □
CORTICOSTERID	YES □	NO □

LIST ANY OTHER MEDICATIONS CURRENTLY BEING TAKEN:

Past Medical History

	YES	NO		YES	NO		YES	NO
Hypertension	□	□	Constipation	□	□	Arthritis	□	□
Diabetes	□	□	Bowel Disease	□	□	Depression	□	□
Heart Disease	□	□	Hepatitis A,B,C	□	□	Kidney Disease	□	□
Arrhythmia	□	□	Gallstones	□	□	Urinary Tract Infection	□	□
Asthma	□	□	Epilepsy	□	□	Stroke	□	□
Lupus	□	□	Cancer	□	□	Anemia	□	□
Thyroid	□	□	Osteoporosis	□	□	Breast Disease	□	□
			OTHER:			Blood Transfusion	□	□

Surgical History

	YES	NO		YES	NO
Heart Surgery	□	□	Myomectomy	□	□
Thyroid Surgery	□	□	Hysterectomy	□	□
Appendectomy	□	□	Ovarian/or Tubal Surgery	□	□
Cholecystectomy	□	□	Cesarean Section	□	□
Sterilization	□	□	Other:		
Colonoscopy	□	□	Hospitalization:		
Breast Surgery	□	□			

GYN History

1.Date of last period: 2.Age first period began: 3.Length of period: 4.Number of days between periods: 5. Have you had bleeding between periods? 6. Period amount? Heavy Mild Normal 7. Have you had extreme menstrual pain? 8.Present method of birth control: 9.Date of last PAP test: 10. History of cysts? 11. History of fibroids?	10. Have you had hot flashes? 11. Have you ever had sex? 12.Number of sexual partners: 13. Sexual Partners: M F Both 14. Have you had painful intercourse? 15.Have you ever had an abnormal PAP test: 16. Do you have abnormal vaginal discharge? 17. Date of Last Mammogram? 18. Have you had sexual transmitted diseases? If yes, which one? _____ _____ 19. Do you or family members have problems with anesthesia? 20. HPV Shot? Y N

OB History

1. Are you currently pregnant? 2.Number of pregnancy: 3. Have you had history of ectopic pregnancy? 4.Number of children: 5. Have you had any complications prior pregnancy?	**Previous Pregnancies:** Full Term: PREMATURE: ABORTION: MISCARR.: NOW LIVE: VAGINAL DELIVERY: CESAREAN DELIVERY: FORCEPS: VACUUM DELIVERY: BIRTH WEIGHT:

BLADDER QUESTIONS

1. Frequency of urination:	Y	N
2. Painful urination:	Y	N
3. Does urine leak when you rush/hurry to the toilet?	Y	N
4. Do you leak with sneezing, coughing, laughing or exercising?	Y	N
5. Is your urinary stream/flow weak, prolonged or slow?	Y	N
6. Do have blood in the urine?	Y	N

BOWEL QUESTIONS

1. History of Constipation:	Y	N
2. Do you leak stool when you don't mean to?	Y	N
3. Do you have bleeding during bowel movements?	Y	N
4. Do you have pain during bowel movements?	Y	N

FAMILY HISTORY OF CANCER

TYPE:	YES	NO	WHO	AGE
BREAST	Y	N		
UTERINE	Y	N		
OVARIAN	Y	N		
CERVICAL	Y	N		
COLON	Y	N		
OTHER:				

WOMEN WELLBEING OBGYN
HIPAA PRIVACY NOTICE CONSENT FORM

I understand and have been provided with Women Wellbeing OBGYN's Notice of Privacy Practices that provides a more complete description of information uses and disclosures. Women Wellbeing OBGYN reserves the right to make changes to their Privacy Notice and revised copies are available. By signing this form I acknowledge that I have been afforded the opportunity to consider Women Wellbeing OBGYN's Notice of Privacy Practices prior to signing this consent and making healthcare decisions.

I authorize Women Wellbeing OBGYN to release medical and financial information, including any or all reports,records, bill for services rendered or opinions found in my medical chart, with respect to treatment to any alternative healthcare giver.

Women Wellbeing OBGYN maintains patient medical records on paper, on microfilm and/or electronic media which may be accessible to any physician or healthcare provider participating in my current or future care. Medical records are disclosed according to applicable NY State and Federal laws, and the provisions of this consent.

HIPAA AUTHORIZATION TO DISCUSS YOUR MEDICAL INFORMATION:
Patient ONLY **OR**

You may disclose my medical information to:

_____	_____	_____
Please Print Name	Relationship	Phone Number

EMERGENCY CONTACT: MEDICAL INFO IS NOT RELEASED TO THIS PERSON. (HOWEVER, THIS PERSON CAN BE THE SAME AS YOUR HIPAA AUTHORIZED CONTACT.)

_____	_____	_____
Emergency Contact	Relationship	Phone Number

I acknowledge that I have received a copy of Advanced Care's Notice of Privacy Practices.

_____	_____
Signature of patient legal guardian	Date

WOMEN WELLBEING OBGYN

NOTICE OF PRIVACY PRACTICES

OUR OBLIGATIONS: We are required by law to: Maintain the privacy of protected health information. Give you this notice of our legal duties and privacy practices regarding health information about you. Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: The following describes the ways we may see and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer. For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. For payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment. For Health Care Operations. We may use and disclose Health Information for health care operations purposes. Theses uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities. Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you. Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort. Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS: As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law. To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat. Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transportation. Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military. Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These provides benefits for work-related injuries or illnesses. Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law. Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information. Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the Information requested. Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime. Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties. National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations. Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to

provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT: Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. Disaster relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES: The following uses and disclosures of your Protected Health Information will be made only with your written authorization: 1. Uses and disclosures of Protected Health Information for marketing purposes; and 2. Disclosures that constitute a sale of your Protected Health Information. Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you: Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment of your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to WOMEN WELLBEING OBGYN. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review. Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to your or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Heath Information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record. Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information. Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing to WOMEN WELLBEING OBGYN. Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to WOMEN WELLBEING OBGYN. Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to WOMEN WELLBEING OBGYN. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out of pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. Out-of-Pocket Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to WOMEN WELLBEING OBGYN. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests. Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please request a copy from WOMEN WELLBEING OBGYN.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Heath Information we already have as well as any Information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Practice Manager. All complaints must be made in writing. You will not be penalized for filing a complaint.