

Southpointe OBGYN, LLC

PATIENT INFORMATION (PLEASE PRINT)					
Last Name:		First Name:		Middle Name:	
Address (NO PO BOX):			City:	State:	Zip Code:
Home #:		Work #:		Cell #:	
Date of Birth:		Social Security # (Required):		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Employer:			Employer Address:		
Email Address:			How did you hear about us?		
Referring Physician:			Primary Care Physician:		
Pharmacy Name & Location:			Pharmacy Phone Number:		
INSURANCE INFORMATION					
Name of <u>Primary</u> Insurance:			Name of <u>Secondary</u> Insurance:		
Subscriber Name:		Relationship to Patient:	Subscriber Name:		Relationship to Patient:
ID #:	Group #:		ID #:	Group #:	
Subscriber DOB:		Subscriber Social Security #:		Subscriber DOB:	Subscriber Social Security #:
EMERGENCY CONTACT INFORMATION					
Last Name:		First Name:		Relationship to Patient:	
Address:			City:	State:	Zip Code:
Home #:		Cell #:		Work #:	
AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS					
<input type="checkbox"/> I authorize Southpointe OBGYN, LLC to release any and all information (including verbal, copies, of medical records and x-rays) concerning my medical care to the following individuals:					
_____		_____		_____	
Name		Relationship		Phone Number	
_____		_____		_____	
Name		Relationship		Phone Number	
<input type="checkbox"/> I DO NOT authorize Southpointe OBGYN, LLC to release any information concerning my care to any individual (other than the healthcare professionals involved with my care).					
Signature of Responsible Party:				Date:	

PLEASE READ AND SIGN BACK PAGE

Southpointe OBGYN, LLC

MEDICAL INFORMATION			
Patient Name:		Date of Birth:	Age:
MEDICAL HISTORY			
First day of last period:	Do you have regular monthly periods? <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do your periods come?	Age at first period?
Periods are: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	How many days does your period last?	Cramps are: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Drug Allergies:		Current Birth Control: Are you happy with this birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had a sexually transmitted disease?			
<input type="radio"/> Yes <input type="radio"/> No			
Age at first intercourse?	Number of partners (lifetime):	Sexual Preference: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual	
Have you had a new sexual partner since your last exam? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you desire testing for STD's? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Last Pap Smear: ____/____	Have you ever had an abnormal Pap? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please give year and any procedures:	
Last Mammogram: ____/____	Have you ever had an abnormal Mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please give year and any procedures:	
How many total pregnancies have you had:	How many did you deliver?	How did you deliver?	Number of miscarriages: _____ Number of elective terminations: _____
Hospitalizations/Surgeries (list all <u>except</u> for pregnancy):			Date of Surgery
Do you currently: <input type="checkbox"/> Exercise regularly <input type="checkbox"/> Diet - What type? _____ <input type="checkbox"/> Drink alcohol - How much? _____ <input type="checkbox"/> Use recreational drugs? <input type="checkbox"/> Smoke cigarettes: ____ packs/day	Current Medications (please list ALL)/ Herbal/ Calcium Supplements:		Do you do monthly breast exams? <input type="checkbox"/> Yes <input type="checkbox"/> No

Southpointe OBGYN, LLC

FAMILY HISTORY									
Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Please check all that apply under the appropriate family member:									
Disease	Self	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother/Sister	Other
Alcoholism									
Anemia									
Arthritis									
Asthma/ Lung Problems									
Birth Defects									
Bleeding Problems									
Blood Clots									
Bloody Stools/ Colon Polyp(s)									
Breast Cancer									
Cervical Cancer									
Colon Cancer									
Depression									
Diabetes									
Heart Disease									
High Cholesterol									
High Blood Pressure									
UTI's									
Kidney Disease									
Liver Disease									
Loss of Urine									
Mental Illness									
Osteoporosis									
Ovarian Cancer									
Seizures									
Stomach Ulcers									
Stroke									
Thyroid Disease									
Tuberculosis									
Uterine Cancer									
Other (please explain):									

Southpointe OBGYN, LLC

1. Payment Policy

Insurance. We participate in most health insurance plans, including Medicare. If you are not insured by a plan we do business with or are not insured, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. **Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.** If any disputes/disagreements between your insurance plan and you regarding if and when you were/are covered should arise, payment in full by you will be required regardless of your dispute/disagreement.

Medicare Part B Patients. We participate with Medicare Part B. Medicare does not cover all healthcare services. In the event a service is needed that Medicare Part B will/does not cover, you will be advised prior to providing the service that it is not covered by Medicare and provided with an Advanced Beneficiary Notice. This document is required by Medicare and will explain what the service is that is not covered and why it is not covered by Medicare allowing you to make an informed decision on whether or not you still require the service in question. By signing this form, you hereby authorize Southpointe OBGYN, LLC to release information required by the Social Security Administration or its intermediaries for purposes of medical claims. Additionally, you hereby agree and assign the benefits payable for covered services to Southpointe OBGYN, LLC and/or its healthcare providers.

Co-payments and Deductibles. All co-payments and deductibles must be paid at the time of service. Co-payment is for specialist services. This arrangement is part of your contract with your insurance carrier and our contract with your insurance carrier. Failure on our part to collect co-payments and deductibles from patients can be considered fraud and is a violation of our contract and your responsibility with your insurance plan. Please help us in upholding both of our contractual obligations by paying your co-payments at the time of service.

Non-Covered Services. Please be aware that some or perhaps all of the services you receive may be non-covered or not considered reasonably necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. An example of some items that may not be covered is medical supplies and equipment and copies of your medical records.

Proof of Insurance. All patients must fully complete our patient information form before seeing a healthcare provider. We must obtain a copy of a photo identification and a current, valid health insurance card that provides coverage for the date(s) for which you are provided a service by us.

Claims Submission. If you have an insurance plan which we participate with, we will submit your claims to the insurance plan and assist you in any way we reasonably can to help get your claims paid. Your insurance plan may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. **Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.**

Payment Arrangements. Payment arrangements/Payment plans can only be made at the time services are provided.

Nonpayment. If any balance due by you is over 90 days past due, you will receive a statement stating that this is your final notice and that payment in full must be received immediately. If said balance remains unpaid, we may refer your account to a collection agency.

Collection Agency. In the event an unpaid balance by you is referred to a collection agency, you hereby agree to pay 18% interest per annum, plus attorneys fees which are hereby stipulated to be 33 1/3% of the outstanding balance, plus court costs in addition to the outstanding balance whether or not suit is filed.

2. Acknowledgement - Receipt of Notice of Privacy Practices

The privacy and protection of your patient information is of the utmost importance to Southpointe OBGYN, LLC. As required by federal HIPAA Regulations, a Notice of Privacy Practices must be provided by all healthcare providers to their patients. At Southpointe OBGYN, LLC you will be offered a copy of the Notice of Privacy and a copy is posted in the waiting room. Southpointe OBGYN, LLC reserves the right to modify the privacy practices outlined in the notice.

I have read and understand the above payment policy and by signing below, agree to abide by its guidelines. I have received or have been offered a copy of the Notice of Privacy Practices for Southpointe OBGYN, LLC and by signing below, acknowledge the same.

_____ / _____ / _____
Signature of Patient/Legal Guardian

Date

Relationship to Patient (If Applicable)

Southpointe

OBGYN, LLC

In the effort to serve all of our patients equally, fairly and to the best of our ability, we ask that you review and understand our Patient Policies and Procedures.

Policies and Procedures Agreement

Patient Information and Insurance Cards: Your personal information sheet and insurance card are an important part of your medical record. It is your responsibility to make sure that you update this information at each visit to keep your record current. As this may seem inconvenient, it is necessary to keep your insurance and contact information updated to insure you receive proper care.

Late Policy: Every effort is made to keep our physicians schedules on time; therefore if you are more than **15** minutes late, we will reschedule your appointment to the next available with a physician in the office; however, there is no guarantee that you will be seen immediately or by the originally scheduled physician. If all the physicians' schedules are full you will be asked to reschedule your appointment to a later date.

Missed/Cancelled Appointments, Procedures or Surgeries: Every effort is made to accommodate our patients request for appointment, procedure or surgery dates/times; therefore, it is important that **you** make every effort to keep your scheduled appointments. Cancellations or less than 24 hours for missed office appointments/no-show appointments will be subject to a fee of **\$50.00**. Cancellations of less than 7 days for procedures or surgeries are subject to a fee of **\$150.00**. Please be advised that chronic missed appointments may result in dismissal from our practice.

Fee for Completion of Forms, Reports, and Letters: This is a non-insurance covered service which requires time from administrative and nursing staff as well as the doctors; therefore, a fee of **\$15.00** will be charged for the completion of forms or the writing of letters. Once the **\$15.00** fee is paid for the first form, each form thereafter will be **\$5.00** per form. ***Forms include all forms, reports and letters.

Transferring of Records: All patients must sign a records release form to have their records copied or to send them to another provider or organization. Copies will be provided to the patient for a **\$10.00** administrative fee PLUS **\$0.50** per page up to 50 pages and **\$0.25** per page thereafter. There is no fee to transfer records directly to another provider or organization.

Payment for Services for Patients with Insurance: According to your health insurance plan you are responsible for paying your co-payment at the time of service. Co-pays that are not paid at the time of service will be billed with an additional **\$10.00** fee. This fee is necessary to cover administrative and supply costs when billing for co-pays. If we participate as providers with your health plan we will bill your insurance company for your visit. If we are not contracted with your insurance company, you are responsible to pay for your visit after the services are rendered. Southpointe OBGYN, LLC files your insurance as a courtesy. We ask that if your account remains unpaid after 45 days that you contact your insurance company for payment.

Tricare Insurance: If you have **Tricare PRIME** you are required to have a referral from your PCM for services other than your annual (Pap, Breast Exam, and Birth Control).

Payment for Services for Patients without Insurance: You will be responsible for payment by cash, check or credit card on the day of service. On bills with extensive procedures and by approval of our billing department and office manager, you may set up a payment plan with our office.

Returned Checks: There is a **\$50.00** fee for any checks returned by your bank.

PATIENT SIGNATURE _____

DATE _____

PRINTED NAME _____