WOMEN'S OB/GYN of RAMAPO, PLLC

Providing Quality Care for Women from Menarche through Menopause

Dr. Kareen Saunders

PATIENT REGISTRATION FORM

Last Name: (please print clearly)	First Name:	Middle:	Marital Status: (circle one) Single / Mar / Div / Sep / Widow

Maiden/Former Name:	Birth Date: / /	Age:	Social Security No.:	Student Status: (✓ one) ❑ Full-time ❑ Part-time ❑ N/A

Home Address:	City:	State:	Zip Code:
Mailing Address: (if different)	City:	State:	Zip Code:

Home Phone No.: ( )	Cell No.: ( )	Employer Phone No.: ( ) Ext.	Work Status: (✓ one) ❑ Full-time ❑ Part-time ❑ N/A

Employer Name & Address: (please print clearly)

Please tell us who referred you to Dr. Saunders:	❑ Dr. ______________________________________	❑ Insurance Plan	❑ Hospital
❑ Family ______________________	❑ Friend ______________________	❑ Advertisement	❑ Yellow Pages ❑ Website ❑ Other

INSURANCE INFORMATION			
Name of Primary Insurance:	Member/Subscriber ID#:	Secondary Insurance (if applicable):	Member/Subscriber ID#

Insurance Subscriber: (✓ one) ❑ Self ❑ Spouse ❑ Parent ❑ Other	***Subscriber** Last Name: (if not self, please provide all * information)	*** Subscriber** First Name:	*** Subscriber** Birth Date: / /

IN CASE OF EMERGENCY			
Name/Relationship	Home Phone No. (if different): ( )	Work Phone No.: ( ) Ext.	Cell No.: ( )

PHARMACY INFORMATION		
Pharmacy Name	Pharmacy Address	Pharmacy Phone#

LABORATORY PREFERENCE IF NO LABORATORY IS CHOSEN WE WILL SEND ANY SPECIMENS TO ANY LABORATORY THAT PARTICIPATES WITH YOUR INSURANCE		
❑Quest	❑ BioReference	❑ LabCorp

CONTACT INFORMATION (CHECK ALL THAT APPLY TO THE MANNER OF WHICH YOU WOULD LIKE TO BE CONTACTED.			
❑ **Home**	❑ **Work**	❑ **Written Communication**	❑ **Other**
❑ Ok to leave Message with details ❑ Leave message with call back number	❑ Ok to leave Message with details ❑ Leave message with call back number	❑ Ok to mail to home address	

AUTHORIZATION TO PAY BENEFITS & RELEASE INFORMATION		
The above information is true to the best of my knowledge. **I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance or non-covered services**. I also authorize Women's OBYGN of Ramapo, PLLC to release any information acquired in the course of my treatment to process insurance claims.		
Patient/Guardian Signature:	Print Name:	Date:

Patient: The following questions are confidential, please answer as completely as possible	Doctor's Comments:

1. What is the primary reason for your visit today: (✓ one)

- ❑ Annual exam/check-up with or without PAP test
- ❑ Emergency Office Visit
- ❑ Consultation
- ❑ Other ____

Doctor's Comments: ____ ____ ____

2. Menstrual / Menopause History:

First day of <u>last</u> menstrual period? ____________________ (date)

Your age when you had your first menstrual period? ___________ (age)

Are your periods usually: ❑ Regular ❑ Irregular

Your periods last ________ days and occur ________ per month

Bleeding is: ❑ Heavy ❑ Moderate ❑ Light

Do you have bleeding between periods? ❑ Yes ❑ No ❑ Sometimes

Do you have cramps/pain with your periods? ❑ Yes ❑ No ❑ Sometimes

Do you have pain or bleeding with intercourse? ❑ Yes ❑ No ❑ Sometimes

When did you begin Menopause? ________________________

Doctor's Comments: ____

3. Contraceptive History:

What is your current method of birth control? (✓ all that apply)

❑ None ❑ Tubal Ligation ❑ Birth Control Pills ❑ Diaphragm ❑ Condom

❑ Natural Family Planning/Rhythm ❑ IUD ❑ Depo Provera Injections

❑ Plan Future Pregnancy ❑ Abstinence ❑ Vasectomy

Have you ever had a problem with any of the above contraceptives? ❑ Yes ❑ No

If yes, please explain: ____

Doctor's Comments: ____

4. Pregnancy History: (please indicate the number of pregnancies & complete the chart)

#of Pregnancies: ____ Miscarriages ____ Abortions: ____ Preterm: ____ Stillbirth _____

Year	#Months	Vaginal/ Cesarean	Boy/Girl	Complications/Problems?

Doctor's Comments: ____

5. Surgical History/Hospitalization: (non-pregnancy related)

Year	Hospital	Type	Reason	Complications

Doctor's Comments: ____

6. Social History:

Tobacco Use: ❑ Never ❑ Yes-packs per day?: ______ How many years? _________

Alcohol Use: ❑ None ❑ Yes-drinks per week: ________ Type? __________________

Caffeine Use: ❑ None ❑ Yes-amount per day: ________ Type? ____________________

Exercise: ❑ None ❑ Yes-Hours per week: ________ Type? ___________________

7. Medication/Allergies:

Are you allergic to any of the following:

❑ Penicillin ❑ Sulfa ❑ Codeine ❑ Morphine ❑ Aspirin ❑ Tylenol ❑ Latex

❑ Other: ____

Are you currently taking any medication, supplements or herbals? ❑ Yes ❑ No
If "YES", please list them:

Name	Dose (mg)	Frequency	Reason

____
____
____
____
____
____
____
____

8. Screenings: (Please indicate the month and year for each)

When was your last pap smear: _________________ (mm/yy)

When was your last mammogram: ______________ (mm/yy)

When was your last colonoscopy: ________________ (mm/yy)

When was your last cholesterol testing: _______________ (mm/yy)

When was your last DEXA (osteoporosis screening): _____________ (mm/yy)

____
____
____
____

YOUR HEALTH HISTORY: Do you have or have you ever had any of the following (please check appropriate boxes)?

Migraine Headaches		Blood clots		Blood Transfusion		Freq. Bladder		Genital Warts	
Frequent Headaches		Bleeding Disorder		Hemorrhoids		Kidney stones		Problems Sleeping	
Head Injury		Changing Moles		Colon Polyps		Interstitial cystitis		Depression	
Frequent dizziness		Melanoma		Arthritis		Poor Bladder Control		Psychiatric History	
Seizure disorder		Eczema		Adult Fractures		Abnormal Pap		IV Drug Use	
Sinus Problems		Psoriasis		Scoliosis		Colposcopy		Cancer	
Hearing Problems		Acne		Neck/Back Problems		Laser of the cervix		If Yes, Type?	
Pneumonia		Ulcer		Osteoporosis		Cryosurgery of			
Tuberculosis		Indigestion		Anemia		LEEP of the cervix			
Asthma		Chronic		Excessive bruising		Cone Biopsy		Year Diagnosed?	
Emphysema		Chronic Diarrhea		Leukemia		Uterine Fibroids		Treatment	
High Cholesterol		Liver Disease		Thyroid Disease		Irregular Periods		Radiation	
Heart Murmur		Hepatitis A		Diabetes		Missing Periods		Chemotherapy	
Heart Disease		Hepatitis B		Hypoglycemia		Chlamydia		Any Other Pertinent	
Abnormal Heartbeat		Hepatitis C		Pituitary Disease		Gonorrhea		History?	
High Blood Pressure		Drug Addiction		Kidney Infections		Genital Herpes			

FAMILY HISTORY: Please check the box and write in the family member who had any of the following:

Breast Cancer			High Blood Pressure			Alzheimer's		
Ovarian Cancer			Heart Attack			Mental Illness		
Uterine Cancer			Stroke			Thyroid		
Colon Cancer			Diabetes			Other:		
Other:			Osteoporosis					

Contract of Financial Responsibility and Informed Consent

In agreeing to be responsible for your medical care, Women's OB-GYN requires that you be responsible for your financial obligations to us. Please read each paragraph and sign where indicated to acknowledge your understanding and acceptance. If you are a minor (under 18 years of age), your parent or legal guardian must accept financial responsibility on your behalf.

1. I agree that I will pay for all services provided to me by Women's OB-GYN at the time of service, unless my services are covered by a contracted insurance.
2. I understand that my insurance company or health plan may require me to pay co-payment, co-insurance or deductibles. I agree
3. I understand that if, upon 60 days after billing and /or insurance filing, my contracted insurance has not paid, I will be required to contact them to find out why the claim has not been paid, and am responsible for any outstanding balance.
4. I understand that if, 60 days after billing, I fail to pay any balance due on my account (unless this balance is still out to a contracted insurance), further action may be taken on my account, unless other previous arrangements have been made and approved by Women's OB-GYN.

Please make sure you are informed of your insurance benefits. Notice to our patients regarding payment:
If you are self-pay- full payment of services rendered is required at the time of service. **CURRENT INSURANCE CARDS MUST BE PRESENTED AT THE TIME OF SERVICE**. If we are contracted with your insurance-full payments of co-pay's, co-insurance, or deductibles are required at the time of service. **We will bill your insurance-as a courtesy to you. Please understand any balance is ultimately your responsibility.** If we are not contracted with your insurance-full payment of services is required at the time of your visit. We will provide you with the appropriate paperwork so that you may file your claim with your insurance carrier for reimbursement.
OB Patients:
We will bill your insurance, whether we are contracted or not, for your global package-as a courtesy to you. The above information does apply to services not covered in your OB contract. Please be familiar with what this includes. Non-global problems visits are billed separately.
Pre-authorization Requirements:
I accept the responsibility to obtain all referrals form other physicians, or preauthorization's from insurances to be in compliance with my insurance or medical coverage. This includes finding out whether my insurance company needs preauthorization for ultrasounds, procedures, D.E.X.A. scan's (bone density), medications, or IUD'S. If I have questions, I will contract my insurance for clarification. If any procedures do need to be preauthorized I take responsibility to do that, or ask my nurse for assistance. If this in not done, I will be responsible for payments.
Annual Exams:
Some insurance companies do not cover preventive care visits. **Due to insurance fraud issues, we cannot change the reason for your visit after you have left the office.** We contract with many insurance carriers to offer you discounted services and specialty care, but we do not know what your specific plan covers. Our office will not make calls to your insurance company for this purpose. Please let us know whether you are being seen for a problem or a routine physical exam, so that we may proved you with appropriate care and avoid insurance disappointments.
Record Release:
We do charge a fee to release records of $35.00, unless the doctor has referred you elsewhere. We only release records for visits and test done through this office.
Account Balances:
All past due balance, or collection accounts must be paid in full at the time you come in for your appointment. You may call to set up payment arrangements, but these must be reasonable and paid in a timely manner. All arrangements must be made in advance.
Cancellations:
In order to provide the best possible service and availability to ALL our patients, should you need to cancel your appointment; we ask that you please do so at least 24 Hours in advance. Keeping your appointments is your responsibility.

Signature__________________________________ Print Name:_________________________ Date:_________________
(Patient/Parent of Minor

YOUR RIGHTS REGARDING YOUR HEALTH INSURANCE

You are permitted to request that restrictions be placed on certain uses and disclosures of your protected Health information by WOBGYN to carry out treatment, payment or healthcare operations. Restriction requests must be in writing. We are not mandated to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers involved with your treatment. In addition, restrictions would not apply when we are required by law to disclose certain healthcare information. You have the right to review and /or obtain a copy of your healthcare records, with the EXCEPTION of psychotherapy notes, or information complied for the use in civil, criminal or a administrative action or proceeding. WOBGYN may deny access under other circumstances, in which case you have the right to have the denial reviewed. You may also request that WOBGYN not send information to a particular address or location or contact you at a specific location, perhaps at your place of employment. In the event that this location would be the only way or means for us to contact you, or if the situation required urgent contact involving continually of care or a matter of urgent necessity, the restriction would not apply. Again, all restriction requests must be in writing. Disclosures of your protected health information are recorded. We are not required to record disclosures made pursuant to a signed consent or authorization. You have the right to request and receive a copy of this notice. You have the right to file a complaint with WOBGYN and or the Secretary of Health and Human Services. To file a complaint with WOBGYN, contact our office manager or Dr. Saunders. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to provide an Authorization for other uses and Disclosers: WOBGYN will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosures of your Health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your Health insurance for the reasons described in the authorization. Please note: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our office.

ACKOWLEDGEMENT OF RECEIPT TO NOTICE OF PRIVACY PRACTICES AND CONSENT

I ________________________________ acknowledge that I have received a copy of WOBGYN Notice of Privacy Practices for review. This notice describes how my healthcare information may be used and disclosed and the rights I may have regarding my protected healthcare information.

______________________________________ ___________________

Signature of Patient or Designated Representative Date

____

Relationship of Representative