

## **Instructions – Please Read**

### **Completing Forms:**

- Print all forms on SINGLE sided WHITE paper.
- Write clearly in black or blue ink.
- Answer all questions. Circle or Check öYesö or öNoö where appropriate.
- Bring all forms with you to your scheduled appointment (Do not fax or mail them to the office).

### **Medical Records from previous physicians:**

If other physicians or facilities have medical information about you that you believe is important for your current pregnancy, please contact that physician/facility to request those records. You should allow 7-10 business days for that office to fulfill your records request. **DO NOT** have that office mail or fax your records to our office. Have that office send you your records directly and bring a copy of them to your scheduled appointment. Examples of useful medical records are listed below:

- Previous obstetrical records
- Genetic test results
- Ultrasound reports
- IVF/IUI records
- Pap Smear results
- Blood work results
- Other records you believe would better assist your physician manage your healthcare and pregnancy.

### **At your Appointment:**

If you have printed and completed the forms from our website, arrive to your appointment 10-15 minutes prior to your scheduled time. If you have not completed the forms from our website, please arrive 30 minutes prior to your scheduled appointment.

- Bring all your completed forms to the appointment
- Bring all medical records from other physicians to the appointment
- Bring photo identification (drivers license or passport)
- Bring your insurance information and insurance card.
- Bring a valid credit card (MasterCard or Visa)
- Bring your questions that you have for your physician

## Obstetrical Welcome Letter

### **Congratulations and welcome to our obstetrical practice!**

We and our staff share in your joy. During the next several months, our primary goal will be to assist you with the smooth delivery of a healthy infant.

Throughout the course of your obstetrical care, the association of the physicians will provide you with continuous care. Although you will choose one of us as your primary obstetrician, we recommend that you schedule appointments with all of doctors so that you meet and feel comfortable with all of us. There are always two doctors available for office visits Monday through Friday. One of us is always on call for labor and delivery emergencies 24 hours a day, including weekends. We are all affiliated with New York University (NYU) Medical Center, and all deliveries will be at NYU ó Tisch Hospital.

Partners are encouraged to participate in all aspects of obstetrical care, from the office visits to the delivery room. If this is your first pregnancy, we urge you and your partner to participate in a childbirth preparation class. These classes should optimally start after the 30<sup>th</sup> week.

During your pregnancy you will see the doctor once every month up to 28 weeks of gestation, every two weeks up to 36 weeks and then weekly until delivery. If you have a problem please do not hesitate to call. Please let the receptionist know what you are calling about so that we can attend to urgent matters promptly. Routine and non-urgent calls may be returned after office hours and in some cases the following day. If you have a medical emergency after office hours, our voice mail message will give you the answering service number (212) 774-1637. Please do not call this number during regular business hours.

Please visit our website ([www.lexobgynnyc.com](http://www.lexobgynnyc.com)) for many of the questions that might arise during your pregnancy.

We look forward to providing you with care during this special period in your life.

Sincerely,

Lexington OB/GYN  
Physicians and Staff

## WELCOME TO LEXINGTON OB/GYN, P.C.

Thank you for selecting our practice! We will strive to provide you with the best possible healthcare. To help us meet your entire healthcare needs, please fill out this form completely in ink.

**PATIENT INFORMATION (CONFIDENTIAL)**

MD: \_\_\_\_\_ # \_\_\_\_\_ Operator \_\_\_\_\_

Name (as appears on your insurance card)

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Maiden name (if applicable): \_\_\_\_\_ Birthdate: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Social Security #: \_\_\_\_\_ Marital Status: [ ] Single [ ] Married [ ] Other \_\_\_\_\_

Address: (Street) \_\_\_\_\_ Apartment #: \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Home #: (\_\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_\_) \_\_\_\_\_

Work #: (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

**SPOUSE'S INFORMATION:** No spouse

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Birthdate: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer &amp; Address: \_\_\_\_\_

Work #: (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ Cell #: (\_\_\_\_\_) \_\_\_\_\_

**RESPONSIBLE PARTY:** Self  Spouse

Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Birthdate: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

Home #: (\_\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_\_) \_\_\_\_\_

Work #: (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_ E-mail: \_\_\_\_\_

Employer &amp; Address: \_\_\_\_\_

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I authorize payment of medical benefits to Lexington OB/GYN, P.C. when assignment has been taken. I have read and agree to the office financial policy and agree to all terms and conditions and revisions of those terms and conditions. I authorize Lexington OB/GYN, P.C. to use or disclose any information for treatment, payment and health care operations. I authorize that the physicians and/or employees of Lexington OB/GYN, P.C. can contact me via all electronic formats (such as telephone, e-mail, fax, etc) or leave me a message if they are unable to contact me directly. I have read or received a copy of the Notice of Privacy Practices.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's relationship: \_\_\_\_\_

Please provide information on ALL MEDICAL INSURANCE POLICIES you are covered under. If you have multiple carriers, please make sure each carrier is aware of the other. An insurance policy where the patient is the subscriber is generally PRIMARY.

Primary Insurance Information

**Insurance Carrier:** \_\_\_\_\_

**Identification #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Insurance Claims Address:** \_\_\_\_\_

**Insurance Telephone #:** \_\_\_\_\_

**Subscriber Name:** \_\_\_\_\_

**Subscriber's Social security #:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Relationship to patient:**  Self  Spouse  Mother  Father  Domestic Partner  Other \_\_\_\_\_

**Subscribers Address:** \_\_\_\_\_

Secondary Insurance Information

**Insurance Carrier:** \_\_\_\_\_

**Identification #:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Insurance Claims Address:** \_\_\_\_\_

**Insurance Telephone #:** \_\_\_\_\_

**Subscriber Name:** \_\_\_\_\_

**Subscriber's Social security #:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Relationship to patient:**  Self  Spouse  Mother  Father  Domestic Partner  Other \_\_\_\_\_

**Subscribers Address:** \_\_\_\_\_

I understand and agree that;

- Failure to complete and give accurate information may result in a delay or a denial of payable benefits and may cause unexpected expenses to me. Lexington OB/GYN will not re-file a claim 30 days from the date of service;
- Knowingly or intentionally providing false insurance information may be deemed insurance fraud.
- If my insurance does not make payment within 45 days, I will be responsible to pay the balance in full;
- Regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered as per the financial policy;

I authorize;

- Payment to Lexington OB/GYN when assignment has been taken;
- Lexington OB/GYN to initiate a complaint or appeal to my insurance carrier or to the Insurance Commissioner of New York State or other states, if appropriate;
- Lexington OB/GYN, P.C. to use or disclose any information for treatment, payment and health care operations.

I have read and agree to the office financial policy and agree to all terms and conditions and revisions of those terms and conditions. I have read or received a copy of the Notice of Privacy Practices. I certify that the above information is correct and understand that I am obligated to provide this information.

**Patient Name (Print):** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patients Signature:** \_\_\_\_\_

**Guardian/Responsible Party Name (Print)** \_\_\_\_\_

**Guardian/Responsible Party signature:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

# Lexington • Ob Gyn

## Financial Policy & Agreement

Thank you for selecting Lexington OB/GYN as your healthcare provider. Our commitment is to provide the very best healthcare to our patients while recognizing the need to limit services to only those medically necessary. The responsibility for payment of fees for these services is the direct obligation of the patient. Any financial payment you may receive from private insurance or government agencies is a matter strictly between you and the insurance carrier or government agency.

You must realize that your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO or your employer. While we will try to be helpful, and we may participate in the plan, your health benefit plan determines your coverage, any requirements for prior authorizations or referrals and establishes the limit on your coverage for medical services. We cannot know the benefits and exclusions of each patient's policy. It is the patient's responsibility to know and understand her coverage and benefits.

For insurance plans we participate with, we will seek to obtain verification of your eligibility, however, even when such eligibility and/or benefits are verified, your insurance plan will not guarantee the accuracy of their confirmation of coverage or benefits, and that you are eligible and that your benefits are in force. Therefore, it is our policy to obtain your credit card number and authorization to assume acceptance of financial responsibility, should your insurance plan not honor the claim we submit for the services we provide to you.

### **Billing your Insurance Carrier:**

This practice will invoice you or your insurer. If a bill, not disputed by the guarantor of the bill, patient or by the insurer in accordance with New York State (NYS) regulation, and is not paid within 45 days, we will transfer the balance to your responsibility. Please be advised that in NYS a health insurer is required by regulation to pay its claims within 45 days, therefore, should your insurer fail to do so, they are in violation of the regulations of the State of New York, and you should contact the NYS Department of Insurance, as you may have a recourse against your insurer for their failure.

### **Billing Information:**

Please be sure that we have your most current demographic and insurance information at all times. It is your responsibility to provide us with this information. As soon as your information changes, notify us in **writing** immediately, so we can make the appropriate changes in our billing system and continue your care. You will be responsible for any charges billed to the wrong insurance carrier as a result of not providing us with correct insurance information and we will not re-file a claim to the correct insurance after 30 days of the service date.

### **Well Women (Preventive) and Problem Focused exams:**

A well women exam is when a healthy patient is seen to screen for various illnesses and diseases; this is considered preventive medicine. A problem visit is one where the patient has a specific concern, symptom or complaint. We are required to submit claims based on the services you receive. If we provide both a well women and a problem focused exam then both services may be billed. Depending on your insurance coverage, some or all of the cost may have to be billed to the patient. We recommend you contact your insurance carrier prior to each visit and inquire about the type of benefits you have. Once a claim has been submitted to your insurance carrier, the office will not change the coding in order to circumvent an insurance denial as this may be considered insurance fraud.

### **Referrals/Authorizations:**

Should your insurance carrier require a referral or authorization, it is your responsibility to obtain or request one prior to your appointment. Please note some insurance carriers will not allow your OB/GYN physician to issue a referral. In this case, you will need to consult your primary care physician (PCP). The office will not issue referrals or authorizations for services already performed.

### **Bills from Laboratories, Hospitals and Other Healthcare Providers:**

If your medical care requires a pap smear, blood work, a culture or a biopsy, the specimen is generally sent to an outside laboratory or hospital for analysis. When this occurs you may receive a separate bill from that laboratory. If you receive medical care during a hospital inpatient or outpatient encounter, you may receive separate bills from the hospital, the anesthesia department and other healthcare providers involved in your care. Any questions related to these bills cannot be answered by this office and will need to be directed to the billing entity.

### **Telephone consultations:**

Your insurance benefits do not include telephone consultations as a covered benefit. A telephone consultation is a request by the patient for clinical advice related to a new or distinct medical condition and is not part of the follow up to a condition under active treatment in the office. Telephone consultations are also charged if the patient requests and authorizes a discussion of the patient's condition, treatment, or any other clinical matter with a relative or other physician not part of the active treatment of the patient. No charges are incurred in our response to follow up questions to the office visit or to discuss lab results.

**Form Completion:**

Should you require specialized forms for employment, school, disability, or for any other purpose, you must assume the cost of preparing these forms. Should you request that this office discuss the contents of any form, a telephone consultation charge will be required. The patient must authorize such communications in writing. Forms requested for completion must be provided at least 1 week before the due date. The charge for basic form completion is \$25.00. This charge will change based on the complexity and time involved.

**Returned Checks:**

If you make a payment by check to the office and it is returned to us for any reason, you will incur a fee of \$35.00. Additionally, no appointments or services will be provided for non-emergent care, until the balance is paid in full.

**Appointment Cancellation, No show and Rescheduling Policy:**

Any appointments for New GYN patients, Initial Obstetrical patients and office procedures that are not cancelled by 10:00am two (2) business days in advance will result in a \$100.00 charge billed to your account. Any appointments for follow up GYN visits or obstetrical rechecks that are not cancelled by 10:00am two (2) business days in advance will result in a \$50.00 charge billed to your account. Any cancellation or rescheduling of a scheduled surgical procedure without a valid medical reason will incur a \$200.00 cancellation fee. Cancellation fees are not covered by insurance.

**Copayments:**

Copayments are contractual obligations between you and your insurance carrier. Compliance rules set forth by federal and state governments require us to collect copayments. All patients are expected to pay their copayments at the time of the visit. If you fail to pay your copayment you will be assessed a \$25.00 processing fee.

**Non-covered charges:**

A non-covered service is any service that is denied by your insurance carrier due to benefit descriptions or limitations, policy exclusions, or pre-existing waiting periods. Non-covered services will be the responsibility of the patient and payment is due at the time of service.

**Replacement Prescriptions:**

This practice provides prescriptions that are medically necessary and appropriate in your treatment. If you are on a long-term medication, our physicians will typically prescribe a sufficient quantity to last until your next visit. If you are running out of medicine, it is likely because you need to make a follow-up appointment. It is your responsibility to promptly fill the prescription. Should the prescription become lost, or you have moved to a new pharmacy, and a replacement is necessary, there is a \$25 fee that must be paid before the replacement prescription is provided.

**Rebilling Fees:**

Your insurance carrier will notify both you and our office with an Explanation of Benefits (EOB) if there is a balance due that is your responsibility. At that time a statement will be sent to you. If the balance is not settled in full within 30 days, or arrangements to settle the balance have not been set up with our financial department, a \$10.00 rebilling fee will be incurred. Additional \$10.00 rebilling fees will be incurred for each 30 day period that the balance remains unpaid.

**Past due accounts:**

It is our intention to maintain all patient accounts in our office. However, if your account becomes past due the office will take the necessary steps to collect this debt. We have the options of sending your account to a collection agency or to an attorney, reporting your account to a credit reporting agency or submitting a claim to the appropriate court. In the event your account is turned over to our Collection Agency, you will be responsible for all collection fees (33% will be added to your account balance) and all legal fees (court costs will be added to your balance) that our office incurs through the process utilized to collect the outstanding delinquent balance.

**Fees:**

The fees/charges quoted above are subject to change at any time.

I have read this document and I understand my fiscal responsibilities. I agree to all the terms and conditions and any revisions to those terms and conditions

Patient's name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor's name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor's relationship to patient: \_\_\_\_\_

# Lexington • Ob Gyn

## OBSTETRICAL FINANCIAL POLICY

The global obstetrical fee is \$7000.00 for a single delivery and \$8500.00 for twin deliveries. The global obstetrical fee includes all routine prenatal office visits, delivery (vaginal or cesarean), postpartum hospital care and a six-week follow-up visit in the office. The obstetrical fee is the physician's fee only. The hospital will charge you separately for its services. The obstetrical fee does not include charges for office or hospital visits that are for conditions not associated with normal pregnancy. The following services which we may provide are also charged separately:

<u>Procedure</u>	<u>Fee(\$)*</u>	<u>Procedure</u>	<u>Fee(\$)*</u>	<u>Procedure</u>	<u>Fee(\$)*</u>
Tubal Ligation	2500.00	Cord Blood Collection **	400.00	Ultrasounds	200.00+
Amniocentesis	500.00	Bio Physical Profile	300.00	Toxoplasmosis S&H	55.00+
External Version	750.00	Non Stress Tests	125.00	Disability form completion	25.00+
Circumcision	500.00	Blood drawing	20.00	Other form/letter completion	25.00+

\* Fees are subject to change at any time.

\*\* Cord blood collection is not a covered benefit as it is not deemed medically necessary by insurance carriers.

For patients who have insurance plans we do not participate with, the obstetrical fee is to be paid in full prior to your estimated due date. We encourage you to meet with our financial manager who will be able to answer your financial and insurance questions and concerns. The financial manager will also discuss your payment options.

For patients who have insurance plans we do participate with, the office will contact your insurance carrier and verify your obstetrical benefits. Based on your benefits, we will be able to calculate your estimated financial responsibility. You may receive a letter from the office detailing your benefits, estimated financial responsibility and your payment options.

You are responsible to notify your insurance carrier of your pregnancy. You generally need the following information of your name, your identification number, your date of birth, your estimated delivery date, anticipated delivery type (vaginal or cesarean delivery), physician's name and the hospital's name. Failure to notify your insurance carrier may result in a reduction or denial of payable benefits and a greater financial responsibility for you.

If you require forms or letters to be completed during your care (such as employment or disability), the office will require your written authorization prior to releasing any information. The "Medical Release" form can be found on our website. Please note that there is a fee for each request and the office requires 7-10 business days to complete each request.

In the event, that our office does not participate in your entire pregnancy, the global obstetrical fee will be pro-rated. If you transfer from the practice for any reason during your obstetrical care, you must immediately inform the office **in writing**, so we can make the appropriate changes and submit claims to your insurance carrier within the filing deadline. If a claim is denied by your insurance carrier for missing the filing deadline and you did not provide written notification, you will become fully financially responsible for the entire claim amount.

I have read this document and I understand my fiscal responsibilities. I agree to all the terms and conditions and any revisions to those terms and conditions

Patient's name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor's name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor's relationship to patient: \_\_\_\_\_

## Referrals and Pre-certification Policy

We recognize the need for a definite understanding between you and your physician concerning healthcare. Our commitment is to provide the very best healthcare to our patients while recognizing the need to limit services to only those medically necessary.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO or your employer. While we will try to be helpful, and we may participate in the plan, your health benefit plan determines your coverage, any requirements for prior authorizations or referral and establishes the limit on your coverage for medical services.

It is the patient's responsibility to know if your insurance has specific rules or regulations, regarding referrals and pre-certifications, limits on outpatient charges, specific physicians and/or hospitals to use.

To obtain a referral or a pre-certification, please contact the office at (212) 686-8686 option 3.

### Radiological tests (Ultrasounds/Sonograms/Bio-physical profiles/Echocardiograms):

If you are referred for a radiological test by one of our physicians, you will need a **REQUISITION** form. This form notifies the specialist what test is to be performed and the reason for the test. Please keep this form safe and take it with you to your appointment. If you lose or forget the requisition form, you may be billed a \$25.00 administration fee for a replacement.

Your insurance carrier may also require you to obtain an insurance referral for each radiological test. Some plans limit how many ultrasounds you can have. Once you reach that limit (generally 3) you will require pre-certification.

Pre-certification is a much more involved process, in which the office needs to substantiate that the test is medically necessary.

For a referral, we require 4 business days to process your request.

For a pre-certification, we require 7 business days to process your request.

**Please be advised that if you have a radiological test without first obtaining a referral and/or a pre-certification, you may be held financially responsible. Please also be advised that the office will not issue a referral or pre-certification for a service already performed or back date a referral or pre-certification.**

I have read this document and I understand my responsibilities. I agree to all the terms and conditions and any revisions to those terms and conditions

Patient's name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor's name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor's relationship to patient: \_\_\_\_\_

# Lexington • Ob Gyn

## ALL PATIENTS MUST COMPLETE

Dear Patient:

We value you as a patient and appreciate that you have entrusted us with your health care needs.

As you know, there are charges for each of the medical care services that we will provide to you and your newborn. The co-payments, deductibles and co-insurance amounts that we are obligated to collect from you are determined by the type and extent of health benefit coverage that your health benefit plan provides. Our office will be pleased to work with your health benefit plan in verifying your eligibility and benefits and requirements for prior authorizations or referrals, but please be aware that your health plan does not guarantee the accuracy of its confirmation of coverage or benefits. Since you are ultimately responsible for payment of the medical services provided to you, it is our policy to obtain your credit card number and authorization to process a claim for payment should your health plan not honor the claim we submit for the services provided to you.

Your health benefits, including your responsibility for co-payments, deductibles, and co-insurance is a decision made by your employer, not this office or your health plan.

In providing credit card information below, you authorize payment by credit card should your account or your newborns account fall into arrears greater than 30 days or for services in the absence of coverage by your health benefit plan (Including, but not limited to, co-payments, co-insurance, deductibles, and/or uncovered services).

Patient's Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Payment Method:  Visa  Mastercard

Account Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year

V-code: \_\_\_\_\_ ( 3 digit security code- usually on the reverse side of the card)

Credit Card Billing Address:

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Card Member's Name: \_\_\_\_\_

Card Member's signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appointment Cancellation Policy

Our goal is to provide quality medical care in a timely manner. When you make an appointment, we reserve a significant amount of time for your visit/procedure. In order to do so, we have had to implement an appointment cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care. Failure to keep or to arrive on time for scheduled appointments jeopardizes the ability of our office to provide you and other patients the appropriate care. In order to be respectful of the medical needs of the community, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone else who is in need of treatment. It is our goal to contact each patient to confirm their appointments. We do this as a courtesy to the patient. **Our inability to contact you does not relieve you of your responsibility to keep scheduled appointments.** If it is necessary to cancel or reschedule your appointment, we require that you call by 10:00am two (2) business days in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

*Cancellation charges are not covered by insurance and are due and payable prior to any future appointments.*

- (1) If you cancel or reschedule your appointment by 10:00am two (2) business days in advance there is no charge.
- (2) Any appointments for New GYN patients, Initial Obstetrical patients and office procedures that are not cancelled by 10:00am two (2) business days in advance will result in a \$100.00 charge billed to your account.
- (3) Any appointments for follow up GYN visits or obstetrical rechecks that are not cancelled by 10:00am two (2) business days in advance will result in a \$50.00 charge billed to your account.
- (4) If you schedule an appointment within the cancellation period and then cancel or no show, you will still be held responsible for the above cancellation fee.

Our aim here is to open otherwise unused appointments for our patients, not to collect missed appointments fees. It is unfortunate that we must create this policy, but we want our patients to understand that late cancellations and no-shows are not taken lightly. Please be respectful of the staff's and other patients' time. Patients should be aware of the costs associated with using a limited resource like healthcare and try to use medical resources judiciously. Repeated missed appointments or late cancellations are disruptive to the optimal delivery of care to you and other patients. As a result, 3 late cancellations or missed appointments may result in your physician sending you a letter discharging you from the practice.

Patient's name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor's name (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guarantor's relationship to patient: \_\_\_\_\_

**RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM**

I have received a copy of Lexington OB/GYN's Notice of Privacy Practices.

Patient Name (Print): \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

**OFFICE USE ONLY:**

I have made a good faith effort to obtain an acknowledgement of receipt of the Notice of Privacy Practices of Lexington OB/GYN. I requested the patient \_\_\_\_\_  
(PATIENT NAME)  
to sign the acknowledgement on \_\_\_\_/\_\_\_\_/200\_\_\_\_, but the patient refused.

Receptionist name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HIV\* RELATED INFORMATION

Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing a release. You can ask for a list of people who can be given confidential HIV related information without a release form.

If you sign this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form and you can change your mind at any time.

If you experience discrimination because of release of HIV related information, you may contact the New York State Division of Human Rights as (212) 870-8624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

Name of person whose HIV related information will be released:	_____
Name and address of person signing this form (if other than above):	_____ _____
Relationship to person whose HIV information will be released:	_____
Name and address of person who will be given HIV related information:	New York University Medical Center 530-560 First Avenue New York, NY 10016 Labor & Delivery Floor
Reason for release of HIV related information:	Antenatal Care and Labor and Delivery Management
Time during which release is authorized:	Duration of obstetrical care

My questions about this form have been answered. I know that I do not have to allow release of HIV related information, and that I can change my mind at any time. **Please be advised, that if you decline, you and your newborn child will be required to have your blood drawn at the hospital for HIV/AIDS testing.**

I authorize and consent to Lexington Ob/Gyn disclosing HIV *related information* to labor and delivery at New York University Medical Center for labor management.

**I DO NOT authorize and do not give my consent to Lexington Ob/Gyn to disclose HIV related information to labor and delivery at New York University Medical Center for labor management.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\* Human Immunodeficiency Virus that causes AIDS.

# PRENATAL DIAGNOSIS SCREENING QUESTIONNAIRE

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Will you be age 35 or older when the baby is due? Yes  No

**Ethnicity:** (please check all that apply):

	Mother	Father
Caucasian	<input type="checkbox"/>	<input type="checkbox"/>
Northern European	<input type="checkbox"/>	<input type="checkbox"/>
French Canadian	<input type="checkbox"/>	<input type="checkbox"/>
Greek / Italian	<input type="checkbox"/>	<input type="checkbox"/>
Ashkenazi Jewish	<input type="checkbox"/>	<input type="checkbox"/>
African American	<input type="checkbox"/>	<input type="checkbox"/>
Asian	<input type="checkbox"/>	<input type="checkbox"/>
Puerto Rican	<input type="checkbox"/>	<input type="checkbox"/>
Hispanic	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>

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<b>Do you, the baby's father or anyone in either family have any one of the following?</b>			<b>Physician Notes</b>
Birth defect of the spine or brain?	Yes	No	_____
Down Syndrome?	Yes	No	_____
Sickle Cell trait or disease?	Yes	No	_____
Congenital heart defect?	Yes	No	_____
Chronic Anemia?	Yes	No	_____
Hemophilia or other blood disorder?	Yes	No	_____
Muscular dystrophy?	Yes	No	_____
Cystic fibrosis?	Yes	No	_____
Nervous system disease, seizures?	Yes	No	_____
Mental retardation?	Yes	No	_____
Other genetic disorders or birth defects?	Yes	No	_____

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewing Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT INTAKE HISTORY**

**Please fill out as completely as possible. Check "Yes" or "No" where appropriate**

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date of service: \_\_\_\_\_  
 Referred by: \_\_\_\_\_ AGE: \_\_\_\_\_ (New form needed in 3 years)

**GYNECOLOGIC HISTORY:**

Age periods began:	# of days from one period to the next:	# of days of bleeding:
If postmenopausal, age at menopause:	Have you taken estrogen replacement? <input type="checkbox"/> yes <input type="checkbox"/> no	
Have you ever had:	<b>YES</b>	<b>NO</b>
		<b>MD NOTES</b>
Abnormal pap smear?		
Cervical/uterine polyps?		
Uterine Fibroids?		
Ovarian cysts?		
Endometriosis?		
Tubal infection/pelvic inflammatory disease (PID)?		
Sexually transmitted disease (STD)?		If yes, check: <input type="checkbox"/> gonorrhea <input type="checkbox"/> chlamydia <input type="checkbox"/> syphilis <input type="checkbox"/> herpes <input type="checkbox"/> warts (HPV) <input type="checkbox"/> other
DES exposure?		
Infertility?		
Gynecologic cancer?		
Breast problem/biopsy?		
Other gyn problems?		
Are you currently sexually active?		
How many sexual partners have you had in your life?	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-10 <input type="checkbox"/> 11+	
Age of first sexual relationship?	<input type="checkbox"/> under 16 years old <input type="checkbox"/> 16 years and over	
What is your sexual orientation?	<input type="checkbox"/> heterosexual <input type="checkbox"/> homosexual <input type="checkbox"/> bisexual	
Current birth control method(s)?	<input type="checkbox"/> condom <input type="checkbox"/> diaphragm/cap <input type="checkbox"/> pill <input type="checkbox"/> IUD <input type="checkbox"/> spermicide <input type="checkbox"/> other <input type="checkbox"/> none	
Past birth control method(s)?	<input type="checkbox"/> condom <input type="checkbox"/> diaphragm/cap <input type="checkbox"/> pill <input type="checkbox"/> IUD <input type="checkbox"/> spermicide <input type="checkbox"/> other <input type="checkbox"/> none	

**PERSONAL PAST HISTORY OF ILLNESSES:**

	<b>YES</b>	<b>NO</b>	<b>MD NOTES</b>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Heart mummur/mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	
Irregular/rapid heartbeat (arrhythmia)	<input type="checkbox"/>	<input type="checkbox"/>	
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
Other lung disease	<input type="checkbox"/>	<input type="checkbox"/>	
Reflux / Hiatal Hernia / Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	
Gallbladder disease / stones	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis / liver disease	<input type="checkbox"/>	<input type="checkbox"/>	
Other gastrointestinal / bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney infections / stones	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches / migraines	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures / epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Blood clots / phlebitis in legs/lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis / joint disease / injury	<input type="checkbox"/>	<input type="checkbox"/>	
Collagen vascular disease (lupus / scleroderma / etc)	<input type="checkbox"/>	<input type="checkbox"/>	
Bone disease / fractures / osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Skin disease	<input type="checkbox"/>	<input type="checkbox"/>	
Eye disease	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Depression / anxiety / other psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

**OBSTETRICAL HISTORY:**  NOT APPLICABLENumber of pregnancies:  Full term  Pre-term  Miscarriages  Abortions  Living children

Year	Wks Pregnant	Vaginal/Forceps/Vacuum/C-section	Hrs in labor	Sex	Birth weight	Complications?
1.						
2.						
3.						
4.						

**SURGICAL HISTORY:**  NOT APPLICABLE **HOSPITALIZATIONS:**  NOT APPLICABLE

Operation Type	Year	Reason	Year

**IMMUNIZATIONS/TESTS:** Infection/Vaccine Year Year

Measles (Rubeola)		Hepatitis A		Pneumococcal vaccine	
Mumps		Hepatitis B		Tuberculosis (Tb) test	
German Measles (Rubella)		Tetanus booster			
Chicken Pox (varicella)		Flu Vaccine			

**MEDICATIONS** (incl. vitamins, herbs, over the counter drugs)**ALLERGIES:****MD****NOTES:**

<input type="checkbox"/> NONE	1.		<input type="checkbox"/> NONE	
2.	3.		1.	
4.	5.		2.	
6.	7.		3.	

**FAMILY HISTORY:**

Mother: <input type="checkbox"/> Living	Illnesses:	<input type="checkbox"/> Deceased	Age at death:	Cause:
Father: <input type="checkbox"/> Living	Illnesses:	<input type="checkbox"/> Deceased	Age at death:	Cause:
Siblings: #Living	Illnesses:	# Deceased	Age at death / cause:	
Children: # Living	Illnesses:	# Deceased	Age at death / cause:	

ILLNESSES	YES	NO	RELATIVE & AGE	MD NOTES
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>		
Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>		
Blood clots in legs / lungs	<input type="checkbox"/>	<input type="checkbox"/>		
Collagen vascular disease (lupus, etc)	<input type="checkbox"/>	<input type="checkbox"/>		
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>		
Psychiatric disease	<input type="checkbox"/>	<input type="checkbox"/>		
Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>		
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>		
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>		
Uterine cancer	<input type="checkbox"/>	<input type="checkbox"/>		
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>		
Other cancer	<input type="checkbox"/>	<input type="checkbox"/>		
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>		
Other	<input type="checkbox"/>	<input type="checkbox"/>		

**SOCIAL HISTORY:**

Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Live with partner <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Highest level school completed: <input type="checkbox"/> High school <input type="checkbox"/> College <input type="checkbox"/> Graduate	
Occupation:	
Have you ever smoked: <input type="checkbox"/> No <input type="checkbox"/> Yes # of packs/day # of years	
- if yes, do you currently smoke: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Alcohol: # of drinks per day or # of drinks per week	
Recreational drug use: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you ever been abused or threatened by anyone: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Regular exercise: # of times per week	

# Lexington • Ob Gyn

## REVIEW OF SYSTEMS

Do you currently have any problems related to the following systems? Please circle **Yes** or **No** to each question.

<b>1. Genitourinary</b>			<b>7. Respiratory</b>		
Abnormal bleeding	Y	N	Wheezing	Y	N
Painful Periods	Y	N	Frequent cough	Y	N
Premenstrual symptoms	Y	N	Shortness of breath	Y	N
Painful intercourse	Y	N	Spitting up blood	Y	N
Abnormal vaginal discharge	Y	N	<b>8a. Skin</b>		
Itching of genital organs	Y	N	Rash	Y	N
Menopausal symptoms	Y	N	Sores	Y	N
Blood in urine	Y	N	Moles	Y	N
Painful urination	Y	N	Dry Skin	Y	N
Strong urgency to urinate	Y	N	<b>8b. Breasts</b>		
Frequent urination	Y	N	Pain in breasts	Y	N
Involuntary loss of urine	Y	N	Nipple discharge	Y	N
Urinate more than once per night	Y	N	Lumps	Y	N
Other	Y	N	<b>9. Musculoskeletal</b>		
<b>2. Constitutional</b>			Muscle or joint pain	Y	N
Weight gain or loss	Y	N	Osteopenia	Y	N
Fever	Y	N	Osteoporosis	Y	N
Fatigue	Y	N	<b>10. Neurologic</b>		
Chills	Y	N	Dizziness	Y	N
Other	Y	N	Numbness	Y	N
<b>3. Eyes</b>			Seizures	Y	N
Double vision	Y	N	Frequent/severe headaches	Y	N
Blurred vision	Y	N	Severe memory loss	Y	N
Pain	Y	N	<b>11. Psychiatric</b>		
Other	Y	N	Depression	Y	N
<b>4. Ear, Nose and Throat</b>			Frequent crying	Y	N
Ear infection	Y	N	Severe anxiety	Y	N
Ringing in ears	Y	N	<b>12. Endocrine</b>		
Sinus problems	Y	N	Hair loss	Y	N
Sore throat	Y	N	Excessive thirst	Y	N
Mouth sores	Y	N	Hot flashes	Y	N
Other	Y	N	Heat/cold intolerance	Y	N
<b>5. Cardiovascular</b>			Tired/sluggish	Y	N
Chest pain or pressure	Y	N	<b>13. Hematologic/Lymphatic</b>		
Painful breathing	Y	N	Frequent bruises	Y	N
Rapid/irregular heart beat	Y	N	Swollen glands	Y	N
Swelling of legs	Y	N	Cuts do not stop bleeding	Y	N
Other	Y	N	<b>14. Allergic/Immunologic</b>		
<b>6. Gastrointestinal</b>			Hay fever	Y	N
Abdominal pain	Y	N	Drug allergies (please list)	Y	N
Frequent diarrhea	Y	N			
Nausea / vomiting	Y	N			
Heartburn / indigestion	Y	N			
Bloody stool	Y	N			
Other					

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Other allergies (please list) Y   N

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

