PATIENT INTAKE HISTORY

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

Name:	Date of birth:	Today's date:
Referred by:	Primary care MD:	

GYNECOLOGIC HISTORY

Menstrual history:			
Age periods began:	# of days from one period to next:	# of days of bleeding:	Age @ menopause:

Gynecologic problems: Have you ever had:		MD notes
Abnormal pap smear	Y N	
Cervical/uterine polyps	Y N	
Uterine fibroids	Y N	
Ovarian cysts	Y N	
Endometriosis	Y N	
Tubal infection/pelvic inflammatory disease (PID)	Y N	
Sexually transmitted disease (STD)	Y N	
GONORRHEA CHLAMYDIA SYPHYLIS HERPES		
WARTS/CONDYLOMA/HUMAN PAPILLOMA VIRUS (HPV)		
Infertility	Y N	
DES exposure	Y N	
Gynecologic cancer	Y N	
Breast problem/biopsy	Y N	
Other GYN problem (SPECIFY)		

Sexual/contraceptive history:
Are you currently sexually active? Y N
How many sexual partners have you had in your life? 0 1 2-4 ≥5 Age @ first intercourse: ≤16 yrs >16 yrs
What is your sexual orientation? HETEROSEXUAL HOMOSEXUAL BISEXUAL
Current birth control method: CONDOM DIAPHRAGM/CAP PILL IUD SPERMICIDE OTHER NONE
Past method(s): CONDOM DIAPHRAGM/CAP PILL IUD SPERMICIDE OTHER NONE

OBSTETRIC HISTORY

Total # of pregnancies: Full term: Preterm: Miscarriages: Abortions: Living children:

Year	Weeks pregnant	Vaginal/forceps Vacuum/cesarean	Hrs in labor	Sex	Birth weight	Complications

PERSONAL PAST HISTORY OF ILLNESSES

Illness		
High blood pressure	Y N	
High cholesterol	Y N	
Stroke	Y N	
Heart murmur/mitral valve prolapse	Y N	
Irregular/rapid heartbeat (arrhythmia)	Y N	
Heart attack	Y N	
Asthma	Y N	
Tuberculosis	Y N	
Reflux/hiatal hernia/ulcer	Y N	
Bowel disease	Y N	
Gallbladder disease/stones	Y N	
Hepatitis/liver disease/jaundice	Y N	
Kidney disease/stones	Y N	
Diabetes	Y N	
Thyroid disease	Y N	
Migraines	Y N	
Seizures/epilepsy	Y N	
Blood/bleeding disorder	Y N	
Blood clots/phlebitis in legs/lungs	Y N	
Arthritis/joint disease	Y N	
Autoimmune disease	Y N	

Bone disease/osteoporosis	Y N	
Skin disease	Y N	
Eye disease	Y N	
Cancer	Y N	
Depression/anxiety/other psychiatric disorder	Y N	
Other medical illness	Y N	
Injuries/fractures	Y N	
Have you ever had a blood transfusion?	Y N	

SURGICAL HISTORY / HOSPITALIZATIONS

Year	Type of operation	Year	Reason

IMMUNIZATIONS:

Measles: titers / vaccine	Varicella: disease / vaccine
Mumps: titers / vaccine	Hepatitis B: titers / vaccine
Rubella: titers / vaccine	Other:

MEDICATIONS (including over-the-counter drugs, herbs, etc.) / ALLERGIES

vitamins?	calcium?	penicillin?	

FAMILY HISTORY

Mother: LIVING DECEASED cause: age:	Father: LIVING DECEASED cause: age:
Siblings: # living: # deceased: causes/ages:	
Children: # living: # deceased: causes/ages:	

Family history of illnesses (*blood relatives,* including immediate family, grandparents, aunts/uncles, cousins)

		INDICATE HOW RELATED TO YOU/AGE @ DIAGNOSIS (IF KNOWN)
High blood pressure	Y N	
High cholesterol	Y N	
Stroke	Y N	
Heart disease	Y N	
Diabetes	Y N	
Thyroid disease	Y N	
Seizures/epilepsy	Y N	
Blood/bleeding disorder	Y N	
Blood clots in legs/lungs	Y N	
Autoimmune disease	Y N	
Osteoporosis	Y N	
Psychiatric disease	Y N	
Drinking problems	Y N	
Alzheimer's disease	Y N	
Breast cancer	Y N	
Ovarian cancer	Y N	
Uterine cancer	Y N	
Colon cancer	Y N	
Other cancer	Y N	
Other disease	Y N	

SOCIAL HISTORY

Marital status:	MARRIED LIVE w/ PARTNER SINGLE WIDOWED DIVORCED	
Highest level of school completed:	HIGH SCHOOL COLLEGE GRADUATE	
Occupation:	Ethnicity:	
Have you ever smoked?	Y N	# of packs per day: # of years:
Do you currently smoke?	Y N	
Do you drink alcohol?	Y N	# of drinks per day: or # of drinks per week:
Do you use recreational drugs?	Y N	
Have you ever been abused or threatened by anyone?	Y N	
Do you exercise regularly?	Y N	# of times per week:

Date		Date					
Patient signature:		MD signature					

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 & Address: ____

Work #: (______) _________________________ Ext ______ Cell #: (______) ________________________

RESPONSIBLE PARTY: ☐ **Self** ☐ **Spouse**

Name: Last: ____________________________ First: ______________________________ Middle: _______________

Birthdate: _______/________/_________ Social Security #: ______________________________________

Address: ____

Home #: (______) ____ Cell #: (______)___________________________

Work #: (______) ___________________________ Ext ________ E-mail: __________________________________

Employer & 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 (see reverse side) 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: ____

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Financial Policy & Agreement

We recognize the need for a definite understanding between you and your physician concerning healthcare and the financial arrangements for this medical care. 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.

Updating Information:
Please be sure we have the most current demographical and insurance information at all times. It is your responsibility to provide us with this information. The information you provide us must match the information you provide the insurance carrier. Filing insurance claims with the wrong information delays processing and increase patient's financial responsibility. Please note if you fail to provide us with correct insurance information, we will not re-file a claim to the correct insurance after 30 days and the balance will become your financial responsibility.

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. 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.

It is also your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals from primary care physicians, pre-certification, limits on outpatient charges, specific physicians and/or hospitals to use. You should be knowledgeable of any deductibles, co-payments and/or coinsurance. You agree to accept responsibility for co-payments, deductibles, and medical care and other services that are provided to you which are not specifically covered by your insurance plan or not covered due to the absence of authorizations/referrals you are obligated to obtain under your insurance plan. The services, plans, and benefits under your insurance plan may be subject to and governed by applicable contracts and government regulations. This agreement is not intended to conflict with or circumvent the provisions of such contracts and regulations, including any provision regarding grievance procedures that maybe available to you.

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.

Well women vs. Problem 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. Some insurance carriers only provide benefits for prevention while other may only provide benefits for problems. 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.

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 care, you will need to consult your primary care physician (PCP). The office will not issue a referral or authorization for a service already performed or back date a referral or authorization.

Bills from Hospital and Labs:
When you have a pap smear, any type of blood work or a culture or biopsy, the specimen is generally sent to an outside lab or hospital for analysis. When this occurs you may receive a separate bill from that 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 consultation are also charged if the patient requests and authorizes a discussion of the patients 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. Charges range from $75.00 to $200.00.

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.

Missed Appointments:
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.

Surgical Cancellations:
Any cancellation or rescheduling of a scheduled surgical procedure without a valid medical reason will incur a $200.00 cancellation fee which is not covered by insurance.

Replacement Prescriptions:
This practice provides prescriptions that are medically necessary and appropriate in your treatment. 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 fee:
This practice will invoice you or your insurer. If a bill, not disputed by the guarantor of the bill, patient or by your insurer in accordance with NYS regulation, and is not paid with 45 days of receipt by the payer, a re-billing fee of $10 will be added to the bill. That rebilling fee is not a covered benefit and will become 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 fails 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.

Statement:
It is your responsibility to make all co-payments at the time of service. You know the co-payments in you health benefit plan. Should you fail to make co-payments at the time of the visit, this practice will invoice you for that co-payment, and a $10 statement fee will be added as the cost of handling and billing for this obligation of yours.

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.

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: ______________________________

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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. 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 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 to 7 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: ______________

Please provide information on all 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 always 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 the insurance payment is delayed over 90 days, I will be expected 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 compliant or appeal to my insurance carrier or to the Insurance Commissioner of New York State;
- 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: ____

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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.

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 Name (printed): ______________________________

Patient signature: ______________________________

Date: ______________________________

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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: ____