

CONFIDENTIAL PERSONAL DATA SHEET

LAST NAME: _____ FIRST: _____ MIDDLE: _____

MAIDEN: _____ AGE: _____ DATE OF BIRTH: _____ / _____ / _____

SOCIAL SECURITY # _____ - _____ - _____ EMAIL _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME _____ CELL _____ WORK PHONE _____

EMPLOYER _____

OCCUPATION _____

EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP _____

PRIMARY CARE PHYSICIAN _____

PRIMARY CARE PHYSICIAN ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHARMACY _____

ADDRESS _____

Ethnicity: (choose one) Hispanic Latino Non Hispanic Other Undetermined

Race: (choose one) Caucasian African American Other Undetermined

Primary Language: _____ Martial Status: _____

The Notice of Privacy Practices is posted in our office for your review. A copy may be provided for you upon request. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan, and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment, obtain payment from third party payers and conduct normal health care operations such as quality assessments and accreditation. I certify that the above information is correct and I request services.

X _____ Date
Signature of patient or person acting on patient's behalf

PATIENTS MEDICAL HISTORY

LAST NAME: _____ FIRST: _____ MIDDLE: _____ MAIDEN: _____ DOB: _____

Gravida (Total Pregnancies): ___ **Para:** Full term: ___ Preterm: ___ Miscarriages: ___ Ectopics: ___ Abortions: ___ Living: ___

Age at 1st menstrual period: _____ **Age at 1st childbirth:** _____

CURRENT MEDICATIONS: Please list ALL medications you currently take along with the dosage and reason. Please bring a current list of medications to every office appointment.

<u>MEDICATION</u>	<u>DOSAGE</u>	<u>REASON</u>	<u>MEDICATION</u>	<u>DOSAGE</u>	<u>REASON</u>
1. _____			6. _____		
2. _____			7. _____		
3. _____			8. _____		
4. _____			9. _____		
5. _____			10. _____		

ALLERGIES: Please list allergies and your reaction.

<u>ALLERGY</u>	<u>REACTION</u>	<u>ALLERGY</u>	<u>REACTION</u>
1. _____		4. _____	
2. _____		5. _____	
3. _____		6. _____	

PAST SURGICAL HISTORY: Please list the type of surgery & the date of the surgery.

1. _____	Date _____	4. _____	Date _____
2. _____	Date _____	5. _____	Date _____
3. _____	Date _____	6. _____	Date _____

FAMILY HISTORY: Please list relationship to the family member and check mark if they have/had any of the medical conditions listed below. If the family member has/had cancer please provide name of cancer and age of diagnosis.

<u>RELATIONSHIP</u>	<u>MATERNAL/PATERNAL</u>	<u>HYPERTENSION</u>	<u>DIABETES</u>	<u>HEART DISEASE</u>	<u>CANCER</u>	<u>OTHER</u>

PATIENT'S SIGNATURE: _____ **DATE:** _____

ALTOONA OB/GYN ASSOCIATES, INC.
FINANCIAL POLICY

We provide you with the best possible care and service. We consider your understanding of our financial policies an essential element of your care and treatment. We find that communication with our patients regarding our policies assists us in providing the best service possible. The following is our Financial Policy, which we require you to read and agree to prior to your treatment.

PLEASE INITIAL EACH AREA

Insurance

We participate in most insurance plans. We will file claims for all services we provide in the office and at UPMC Altoona. If you are not insured by a plan that we participate with, payment in full is expected at each visit. Please remember that insurance coverage is a contract between you and your insurance company. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage.

Medicare (If applicable)

We are a participating Medicare provider. Medicare as well as your secondary insurance (if any) will be billed for you. However, that does not mean that all the services are covered. Patients are responsible for paying their annual unmet deductible. You are also responsible for any co-insurance, which is usually 20% of the allowed amount for a service.

Non-Covered Services (If applicable)

Medicare and some Medicare Advantage plans will only cover your yearly exam and pap smear **every other year.** If this happens, it is your responsibility to pay for our services. We will make every effort to inform you of what services may not be covered by your insurance plan, but you will still be responsible for all the balances.

Patient Billing

All copayments must be paid at the time of service. **Any additional services may incur additional charges along with the charge for your yearly exam.** If a balance is due after receiving the explanation of benefits from your insurance company, you will be sent a billing statement. We ask that all balances are paid in full no later than 90 days from the date of service. If the balance remains unpaid after 90 days, your account will be forwarded to a collection agency. Please notify our billing office if you are unable to pay your bill in full. Special payment arrangements may be available.

Claim Submission

We will submit your claim to your insurance company. However, your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Any unpaid balance not covered by your insurance is your responsibility.

Copy Fee

We will provide copies of patient records at the patients' request. Copies of records may be subject to a per page fee as follows: 1-20 pages are \$1.60 per page; 21-60 pages are \$1.19 per page and 61+ pages are \$0.41 per page. (fees are subject to change)

Forms Fee

Forms including FMLA, Disability, etc. may take 7-10 business days to be processed and are \$20 per form. (fee is subject to change)

Canceled/Missed Appointment Fee

If you cannot keep your appointment time, please call our office at least 24 hours prior to your scheduled appointment time. If you fail to give us notice of your missed appointment, you will be responsible for a \$25 missed appointment fee. This charge is not covered by your insurance company and will be your responsibility. If you arrive late for your appointment, we may need to reschedule your appointment in fairness to other scheduled patients. Repeated missed or late appointments may result in dismissal from our practice.

Surgeries

When a surgical procedure is scheduled, we will give you an estimate of the amount you may be responsible to pay. This amount will be collected prior to the procedure being performed unless payment arrangements are made. Additional payments or refunds may be required after the insurance has processed your claim. Your insurance company will issue an EOB, explanation of benefits, indicating the responsible amount.

Minor Patients

The parent or guardian accompanying a minor will be financially responsible for payment of services. Young adults (age 18 and over) and emancipated minors are legally responsible for their account.

I have read and understand the financial policy of this practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Patient name (please print)

Signature of Patient/Guarantor

Date of birth

Date

Altoona Ob/Gyn Associates, Inc
HIPAA & Emergency Contact Information

Patient authorization for use and disclosure of Protected Health Information (PHI) from the practice

By signing this form at the bottom,

I _____ authorize
Please Print Name _____ DOB _____

Altoona Ob/Gyn Associates, Inc., to use and/ or disclose certain PHI about me to:

1) Name _____
Please Print Name _____ Relationship _____

Phone: (Cell) _____ (Home) _____ (Work) _____

Check all that apply to person listed above:

release PHI pick up medical items/papers from office emergency contact

2) Name _____
Please Print Name _____ Relationship _____

Phone: (Cell) _____ (Home) _____ (Work) _____

Check all that apply to person listed above:

release PHI pick up medical items/papers from office emergency contact

3) Name _____
Please Print Name _____ Relationship _____

Phone: (Cell) _____ (Home) _____ (Work) _____

Check all that apply to person listed above:

release PHI pick up medical items/papers from office emergency contact

If other, specifically describe the information to be used or disclosed, such as date(s), level of detail to be released or origin of information:

This authorization will expire upon death or until revoked in writing

Our office may contact you with appointment and medical information through cell, home, or work number with your HIPAA appointed person.

Signature of Patient/Guarantor: _____

Today's date: _____