

**CONFIDENTIAL PERSONAL DATA SHEET**

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ MIDDLE: \_\_\_\_\_

MAIDEN: \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

SOCIAL SECURITY# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ E-MAIL \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PRIMARY \_\_\_\_\_ SECONDARY \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_

OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

PRIMARY CARE PHYSICIAN ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHARMACY \_\_\_\_\_

ADDRESS \_\_\_\_\_

Ethnicity: (circle one) Hispanic, Latino, Non Hispanic, Other or Undetermined

Race: (circle one) Caucasian, African American, Other or Undetermined

Primary Language: \_\_\_\_\_ Marital 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 \_\_\_\_\_  
Signature of patient or person acting on patient's behalf

\_\_\_\_\_  
Date

**FINANCIAL INFORMATION AND AUTHORIZATION**

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ MIDDLE: \_\_\_\_\_

MAIDEN: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

**FINANCIAL TYPE** (check all those that apply)

Commercial  Blues  Medicare  Medicaid  \*Self Pay

\*If self pay, amount needs paid at time of service unless prior arrangements have been made

**INSURANCE** We will need to scan your insurance cards for our records

Primary Insurance \_\_\_\_\_ Insurance ID# \_\_\_\_\_ Group# \_\_\_\_\_

Insured's Name \_\_\_\_\_ Employer \_\_\_\_\_ Co-pay \_\_\_\_\_

Claims Mailing Address (on back of card) \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Insurance ID# \_\_\_\_\_ Group# \_\_\_\_\_

Insured's Name \_\_\_\_\_ Employer \_\_\_\_\_ Co-pay \_\_\_\_\_

Claims Mailing Address (on back of card) \_\_\_\_\_

**SPOUSE/RESPONSIBLE PARTY NAME (POLICYHOLDER OF INSURANCE)**

Spouse/Responsible Party Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Social Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Address \_\_\_\_\_

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

Primary \_\_\_\_\_ Secondary \_\_\_\_\_ Work Phone \_\_\_\_\_

**MY FINANCIAL RESPONSIBILITY**

I certify that the above information is correct. I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductible's applicable, co-payments or non-covered services as may be required by my insurance plan.

X \_\_\_\_\_  
Signature of patient or person acting on patient's behalf

\_\_\_\_\_  
Date

**RELEASE OF MEDICAL INFORMATION AUTHORIZATION**

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment.

X \_\_\_\_\_  
Signature of patient or person acting on patient's behalf

\_\_\_\_\_  
Date

**PATIENT'S MEDICAL HISTORY**

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ MIDDLE: \_\_\_\_\_ MAIDEN: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

**CURRENT MEDICATIONS:** Please list ALL medications you take and all dosages of each and how many tablets are taken each day. You are required to bring a list of your medications with you EACH visit.

MEDICATION	DOSAGE	REASON	MEDICATION	DOSAGE	REASON
1. _____			6. _____		
2. _____			7. _____		
3. _____			8. _____		
4. _____			9. _____		
5. _____			10. _____		

**ALCOHOL:**     DO NOT USE                     1-2 DRINKS/WK.                     4-5 DRINKS/WK.

**TOBACCO:**     DO NOT USE  
 SECOND HAND SMOKE:     YES     NO  
 CURRENT TOBACCO USE    YEAR TOBACCO USE BEGAN \_\_\_\_\_ PACKS PER DAY \_\_\_\_\_  
 FORMER TOBACCO USE    YEAR TOBACCO USE ENDED \_\_\_\_\_

DO YOU USE RECREATIONAL DRUGS?     YES     NO

<b><u>ALLERGIES:</u></b>	ALLERGY	REACTION
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

**PAST SURGERIES:** TYPE OF SURGERY AND DATE

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

HAVE YOU EVER BEEN TESTED FOR HEPATITIS C     YES     NO                    RESULTS:  POSITIVE     NEGATIVE

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE

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

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

**Names are in addition to yourself**

By signing this form, I authorize Altoona Ob/Gyn Associates, Inc., to use and /or disclose certain PHI about me to:

1) Name \_\_\_\_\_  
Please Print Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone number (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

2) Name \_\_\_\_\_  
Please Print Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone number (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

❖ This authorization permits the practice to use and/or disclose Protected Health Information (PHI) about me: All medical care needs \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Other \_\_\_\_\_

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

❖ I would like the above-named person(s) to pick up medical items, including prescriptions, from the office if I am unable to \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

❖ This authorization will expire upon death or until revoked in writing

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

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**Emergency Contact Person**

(If contact is same as above, please indicate by writing "same as above")

1) Name \_\_\_\_\_  
Please Print Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone number (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

2) Name \_\_\_\_\_  
Please Print Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone number (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Patient name (print) \_\_\_\_\_ DOB \_\_\_\_\_

Patient signature \_\_\_\_\_ Today's date \_\_\_\_\_

**ALTOONA OBGYN ASSOCIATES, INC.**  
**FINANCIAL POLICY**

We are dedicated to providing 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 \$1.55 per page; 21-60 pages are \$1.15 per page and 61+ pages are \$0.39 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*