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

ALLERGIES:

	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

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)_____

- ❖ 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
- ❖ This authorization permits the practice to use and/or disclose the following identifiable health information about me: All medical care needs _____ 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:

_____
_____
_____

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

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*