New Patient Packet - GYN

SUNFLOWER OB-GYN
at William Newton Hospital

First & Last Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip:_____

Social Security #: _____ Email: _____

Primary Phone Number: _____ Work Phone: _____

_____ (*Please initial*) I agree to allow Sunflower OB/GYN to send me automated appointment reminders via text to the mobile number provided. Mobile Phone: _____

Emergency Contact: _____ Phone: _____

Relationship to patient: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Employer: _____

Race/Ethnic Group: ☐ American Indian/Alaskan ☐ Asian/Pacific Islander
☐ Black/African American ☐ White/Caucasian ☐ Hispanic ☐ Other

Preferred Language: _____

Guarantor Information (if not patient, this person is financially responsible for the account)

Name: _____ Date of Birth: _____

Social Security #: _____ Primary Phone Number: _____

Address: _____ City: _____ State: _____ Zip:_____

Employer: _____ Work Phone: _____

Insurance Information: You <u>MUST</u> attached a copy of your insurance card and ID

Primary Insurance: _____ Secondary Insurance: _____

Policy Number: _____ Policy Number: _____

Group #: _____ Group #: _____

Subscriber Name: _____ Subscriber Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Subscriber Date of Birth: _____ Subscriber Date of Birth: _____

☐ **Check if NO Insurance**

Pharmacy Name and Address: _____

Primary Care Physician: _____ Date of Last Visit: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for services rendered. I understand that I may be asked to complete this form yearly, or more as needed. I authorize the release of any information required for the submission of claims to my insurance company(s).

Name: _____ Signature: _____

Date: _____ Relation to Patient (if applicable): _____

Consent to Communicate

HIPAA Privacy Acknowledgement

Printed Name: _____ Date of Birth: _____

This form allows you to name a person (such as your spouse, partner, other family member or friend) to communicate on your behalf with Sunflower OB/GYN at William Newton Hospital. This is NOT for access to your medical records. This form, when signed, allows Sunflower OB/GYN at William Newton Hospital to communicate with the authorized person(s) regarding your personal information concerning insurance, benefits, payments, treatment or other healthcare information regarding your care.

I hereby give my consent for Sunflower OB/GYN at William Newton Hospital to communicate personal information on my behalf to the authorized person(s) named below. This authorization allows Sunflower OB/GYN at William Newton Hospital to speak with the authorized individual(s) regarding the following: treatment, insurance claims, copays, or other aspects of care. I understand that this is limited to verbal and telephone conversations and does not permit or authorize the release of any written health information to any of the individuals named. I understand that it is my responsibility to let Sunflower OB/GYN at William Newton Hospital know of any changes or to revoke this authorization. I may revoke this authorization at any time in writing to Sunflower OB/GYN at William Newton Hospital. This authorization remains in effect for an unlimited amount of time unless revoked or updated. Any updated signed communication forms will supersede and replace all prior communication forms.

Person(s) authorized to speak with Sunflower OB/GYN at William Newton Hospital:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES AND CODE OF CONDUCT - PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have read and/or received a copy of Sunflower OB/GYN at William Newton Hospital NOTICE OF PRIVACY PRACTICES and CODE OF CONDUCT.

Signature: _____ Date: _____

Relationship of representative (if applicable): _____

Patient Financial Policy

Thank you for choosing Sunflower OB/GYN at William Newton Hospital as your healthcare provider. This policy is being provided to you in order to have a clear understanding of our Patient Financial Policy and is important for our professional relationship. It is your responsibility to provide Sunflower OB/GYN at William Newton Hospital with current insurance information. We may ask for your insurance card, so please have it available each time you come to the clinic. If current information is not obtained at the time of service, it will become your responsibility to pay until current information is provided to the clinic. If you fail to provide this information and timely filing expires, you will be responsible for the outstanding balance.

INSURANCE FILING: Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file the claim for you. However, we will not become involved in disputes between you and your insurance company. If a problem occurs with your claim, you will be asked to contact your insurance company to help resolve the problem. This includes, but is not limited to, questions regarding your deductible, co-insurance and non-covered charges. Sunflower OB/GYN at William Newton Hospital will provide information as needed to assist you with your dispute. Please contact us at 620-222-6261 should you need any documents or information. We want to help you understand your healthcare billing.

CO-PAYMENTS: If your insurance policy calls for a co-pay for office visits, you will be required to pay it at the time of your service.

PATIENT FINANCIAL RESPONSIBILITY: Sunflower OB/GYN at William Newton Hospital expects payment in full within 30 days from your first billing statement. We accept cash, checks, Mastercard, Visa, and Discover.

Please be aware our returned check fee is $30.00.

If you do not have health insurance we expect payment at the time of the service unless other arrangements have been made in advance.

If we anticipate that your insurance company may leave you with a deductible, we may require deposits prior to services being rendered.

PAYMENT OPTIONS: Credit is a form of trust Sunflower OB/GYN at William Newton Hospital has placed in you. Prompt payment is your obligation when you are granted credit, and is vital to the clinic's continued provision of quality health care service to this community. You are responsible for the timely payment of your account. You will receive a monthly statement for services which is due upon receipt. If a payment arrangement is needed, please contact our billing department at 620-222-6261. Timely payments are expected once this agreement is made.

We accept many forms of payment including VISA, MasterCard, American Express, DISCOVER, cash, money orders, or checks.

SELF-PAY PATIENTS: You will be required to pay a deposit on services. Any deposit collected will apply toward your total balance due. If you would like to pay in full at the time of service, a discount may be applicable. Please speak with the staff checking you in if you wish to take advantage of this discount.

WORKER'S COMPENSATION: If your office visit is due to an injury at work that has been reported to and verified by your employer, you may be eligible to have your claim covered by Worker's Compensation insurance. Be sure to inform our receptionist that the injury occurred while on the job. You will need to provide all claim information and complete a form in order for us to file this claim correctly.

ACCIDENTS AND INJURIES: All medical expenses that result from a vehicle accident or public liability are considered the personal responsibility of the patient.

COLLECTIONS PROCESS: If we do not receive your payment in full within sixty (60) days of your first mailed statement, and you have not made arrangements with our office or billing department, your account will be considered delinquent and may be considered for collection action. If your account is placed in collections you will be charged collection fees including but not limited to agency fees, attorney fees and court costs.

FINANCIAL ASSISTANCE: For more information concerning financial assistance programs contact the Billing Office at 620-222-6261.

Please ask if you have any questions regarding our fees, policies or your responsibilities. Please direct questions to our billing office at 620-222-6261.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to Sunflower OB/GYN at William Newton Hospital separately from other Facility or professional bills. I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance, co-pays, or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

Signature for Assignment of Benefits & acknowledgment of Financial Policy:

Signature of patient or responsible party:

_____

Relationship, if other than patient:

_____

Date: _____

Code of Conduct

Clinic and Patient Partnership Agreement

The WNH Physician Clinics have a strong tradition of excellence in patient care. We are committed to providing patient centered care along with the patient's participation. These expectations outline our partnership agreement which is intended to provide compassionate care in an environment that promotes comfort, healing, and mutual respect between the patient and the Clinic team. The first offense of any behavior listed below will result in a verbal warning, second offense will warrant a written warning of the unacceptable behavior, and third offense will result in termination of the patient-physician/nurse practitioner relationship. Physically threatening behavior will result in immediate termination.

+ The Patient and the Clinic (inclusive to the providers, nurses, medical assistants and administrative office staff, etc.) will work together to provide the best possible care for the patient in a respectful environment. This includes communication of the patient's progress during office visits.

+ Any rude, threatening, demeaning comments or behaviors will be addressed by the Clinic, whether in-person or via alternative communication such as telephone or the patient portal. The Clinic will not tolerate any profanity, disruptive behavior or any behavior that interferes with the care of the patient or another patient. Discrimination towards team members, other patients and/or their family members based on race, color, religion, gender identity, sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, or political beliefs will not be tolerated.

+ Any physically threatening behavior demonstrated by the patient in-person, or via alternative communication such as telephone or portal communications, will result in the immediate termination of care by the Clinic. A Clinic team member will immediately contact security and, if needed, local law enforcement.

+ Families are welcomed and recognized as an important part of a patient's care. However, the Clinic will not tolerate profanity, disruptive behavior, or any other behavior that interferes with the care of any patient. Family members that exhibit discriminatory or physically threatening behavior towards any Clinic team member will also have security immediately contacted and, if needed, local law enforcement. The termination of the patient-physician/nurse practitioner relationship will also result.

+ The Clinic does not permit for any alcohol or drug use on the facility's property. Anyone, including families, violating this will be asked to leave the facility. Patients who have a pain management contract with us would also be evaluated for violation of that contract and could lead to termination of the patient-physician/nurse practitioner relationship.

Signature of patient or responsible party:

_____

Relationship, if other than patient:

_____

Date: _____

Thank you for your cooperation.

Medical History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Preferred Pharmacy Name: _____ Pharmacy Location (City): _____

Were you referred by another provider? ☐Yes ☐No

Are your periods regular? ☐Yes ☐No

Date of last menstrual period: _____

Age periods began: _____

How long do periods last? _____

Period flow? ☐Light ☐Normal ☐Heavy

Are you postmenopausal? At what age did you reach menopause? _____

Are you trying to conceive? ☐ Yes ☐ No

Do you have a history of:

Uterine fibroids? ☐Yes ☐No

Endometriosis? ☐Yes ☐No

Ovarian cysts? ☐Yes ☐No

Abnormal vaginal discharge? ☐Yes ☐No

Sexual History:

How many sexual partners have you had in the last year? _____

Have you had more than two partners in your lifetime? ☐Yes ☐No

Are you currently sexually active? ☐Yes ☐No

If no, have you been in the past? ☐Yes ☐No

Do you have a history of STIs (check all that apply):

_____ None
_____ Chlamydia
_____ Gonorrhea
_____ Herpes
_____ HPV/Genital Warts
_____ Syphilis
_____ HIV Hepatitis B/C
_____ Trichomoniasis

Date of last mammogram: _____
Date of last colonoscopy: _____
Date of bone density scan/DEXA: _____
Date of last pap smear: _____
Where was your last pap smear?: _____
Normal/Abnormal?: _____
History of abnormal pap smear?: ☐Yes ☐No
Any treatment done?: ☐Yes ☐No

Current birth control:

_____ None
_____ Natural Family Planning
_____ DepoProvera
_____ Vasectomy/Sterilization
_____ IUD (Skyla, Kyleena, Mirena, Paragard)
Date Placed: _____
_____ Birth Control Pills
_____ Nuvaring
_____ Patch
_____ Condoms
_____ Nexplanon
Date Placed: _____

Medications - Please list all medications and dosage information:

Medication or Supplement/Vitamin Name	Dosage	Frequency
Please list any allergies to food or medication:		

Medical History, cont.

Have you ever had, or do you currently have, any of the following?
If so, please check the diagnosis and list **date of diagnosis** and **date of treatment** to the side.

_____ Anemia
_____ Anxiety
_____ Asthma
_____ Breast lumps
_____ Blood disease (hemophilia, clotting disorder etc...)
_____ Cancer (please specify) _____
_____ COPD (Chronic bronchitis or enphysema)
_____ Depression
_____ Diabetes (type 1 or 2)
_____ Endometriosis
_____ Epilepsy
_____ GERD (Acid reflux)
_____ Heart disease
_____ Hypertension (high blood pressure)
_____ High Cholesterol
_____ Hepatitis (B or C)
_____ Hyperthyroidism
_____ Hypothyroidism
_____ IBS
_____ IBD (Chrons or ulcerative colitis)
_____ Infertility
_____ Kidney disease
_____ Liver disease
_____ Osteoporosis
_____ Ovarian cysts
_____ Physical disabilities
_____ Rheumatologic conditions (Lupus, arthritis...)
_____ Stroke/TIA
_____ Tuberculosis
_____ Uterine fibroids
_____ Other: _____

Past surgical and hospitalization history:

Surgery or hospitalization:	Date AND Locaton:

Family History
Has anyone in your family been diagnosed with or does anyone have a history of the following?
If so, please list who in your family was diagnosed. If it is an extended family member (aunt, uncle, grandparent), indicate whether they are on your mother's or father's side.

Breast Cancer _____
Cervical Cancer _____
Ovarian Cancer _____
Uterine Cancer _____
Colon Cancer _____
Prostate Cancer _____
Pancreatic Cancer _____
BRCA 1 or 2 _____
Diabetes _____
Hypertension (High Blood Pressure) _____
High Cholesterol _____
Heart Disease _____
Any other Cancers or Illnesses? _____
(Please specify which type)

Medical History, cont.

Social history

Tobacco Use? ☐ Yes ☐ No If yes, how many packs per day? _____ How many years? _____

Alcohol Use? ☐ Yes ☐ No If yes, how often? _____

Drug Use? ☐ Yes ☐ No If yes, what type? _____ How often? _____

Number of people in your household? _____ Are you currently employed? ☐ Yes ☐ No

Have you traveled outside the U.S. in the past 6 months? ☐ Yes ☐ No

Highest level of education completed?

☐ High School ☐ GED ☐ Associates ☐ Bachelor's ☐ Master's ☐ PhD

Obstetrical History:

Total # Pregnancies: _____ Full Term: _____ Preterm: _____ Miscarriages/Abortions: _____

Living Children: _____

Past Pregnancy Details:

Delivery	Gestational Age	Weight	Vaginal/C-Section	Complications	Location

For Pregnant Patients Only:

When was the first day of your last menstrual period? _____

Name of the father of the baby? _____ Age of the father of the baby? _____

Do you have any history of gestational diabetes? ☐ Yes ☐ No

Do you have any history of pre-eclampsia (high blood pressure)? ☐ Yes ☐ No

Do you drink caffeine? ☐ Yes ☐ No _____ servings/day

Do you own cats? ☐ Yes ☐ No Who normally cares for the litter box? _____

Do you eat fish on a regular basis? ☐ Yes ☐ No

Do you plan on getting an epidural during labor? ☐ Yes ☐ No

Do you plan on breastfeeding? ☐ Yes ☐ No

Are you planning on sterilization after delivery? ☐ Yes ☐ No

Does anyone in your or the father's family have a history of birth defects? If yes, please list the relation below:

Thalassemia _____ Sickle Cell Disease/Trait _____

Spina Bifida/Anencephaly _____ Hemophilia _____

Congenital Heart Defect _____ Muscular Dystrophy _____

Down Syndrome _____ Cystic Fibrosis _____

Tay-Sachs _____ Huntington's Chorea _____

Mental Retardation/Autism: _____ Are you Ashkenazi Jewish? ☐ Yes ☐ No

Other inherited chromosomal/genetic disorders: _____

Do you want to have any genetic testing done during this pregnancy?: ☐ Yes ☐ No