BAYSIDE WOMEN'S HEALTH
PATIENT DEMOGRAPHICS

Chart#:______________ Date:________________

Demographic Information

Name: ______________________________ / ________________________ /__________________ /______________________________
Last First Middle Maiden

Mailing Address: ____ / ______________________ /_____ /____________
Address City State Zip Code

Home #:______________________________ Work #:____________________________ Cell #:______________________________

Consent to Text? □ Yes □ No Consent to Call? □ Yes □ No Email Address: _____________________________________

SSN: __________________________ Marital Status: ________________________ Race: __________________________

Date of Birth: ______________________ Age: __________ Employer: ____

Spouse Information

Name of Spouse: _____________________________________ DOB: ______________________ SSN: ___________________________

Employer: ____ Work #: ____________________ Cell #: ________________________

Insurance Information (Please notify front desk of additional insurance plans.)

Primary Ins Co.: __________________________________ Contract # _______________________________ Group # _______________

Subscriber's Name: ______________________________ Subscriber's DOB: _______________ Subscriber's SS# _________________

Secondary Ins Co.: _______________________________ Contract # _______________________________ Group # _______________

Subscriber's Name: ______________________________ Subscriber's DOB: _______________ Subscriber's SS# _________________

Referral Information

Were you referred by another physician? □ Yes □ No If yes, please list physician's name:_____________________________

Primary Care Physician: ____ Phone number: ____________________________

Emergency Contact Information

Name: ____ Relationship: ______________________ Phone #: __________________

Name: ____ Relationship: ______________________ Phone #: __________________

Pharmacy Information

Name: ____ Phone #: ____________________________________

Address: ____ / _________________________ /_________ /______________
Address City State Zip Code

By signing below, I certify that the above information is correct. I will contact Bayside Women's Health immediately with any changes.

____ ________________________
Patient Name (printed) Date

____
Signature of Patient

BAYSIDE WOMEN'S HEALTH
NEW PATIENT MEDICAL HISTORY

Name:	**Date:**	**Chart #:**

MENSTRUAL HISTORY: **Age Started:**_______________	
Regular ___ **Irregular**___ | **Length of Flow:** ______**(Days)** | **Cramps**____ **Clots**____ **Headaches**____	
Date of last Pap Smear: __________________ **Normal** _____ **Abnormal**_____	**History of Abnormal Pap Smears?** _____________________________________

PERSONAL MEDICAL HISTORY/MAJOR ILLNESSES:									
NONE		Hepatitis		Crohn's		BL Transfusion		Sickle Cell	
Heart		Asthma		Ulcers		Epilepsy		Phlebitis	
Arthritis		Cancer		STD		High BP		Varicose Veins	
Migraines		Diabetes		Thyroid		Anemia		Other	

<u>SURGICAL HISTORY:</u> **Date:**	**Type of Operation:**

PREGNANCY HISTORY: (List the # of times you have had the following. *including currently*)									
Pregnant		Full-term Delivery		Stillborn		Premature Delivery		Miscarriage	
Abortion		Living Children		Infant Death		C-Section		Other	

List <u>ALL</u> Pregnancies IN ORDER: (Include abortions, miscarriages, etc.)

Sex:	**Birth Weight:**	**Date of Birth:**	**RhoGAM:**	**Complications Before or After Delivery:**

BAYSIDE WOMEN'S HEALTH
MEDICATION LIST

Name:	Date:	Chart #:

**Please list all prescription and over-the-counter medications as well as any herbal supplements that you take.

MEDICATION NAME:	DOSE:	FREQUENCY:

BAYSIDE WOMEN'S HEALTH
ANNUAL MEDICAL INTAKE FORM

Patient Name: ____________________________________ **Chart #:** _________________________ **Date:** ______________________

To help your doctor during today's health exam, please complete items 1 through 16.

1. Age: _____ Marital Status: S M D W SEP.

When was the *FIRST DAY* of your last period? __________

What method of birth control do you use? ______________

2. Number of times you have been pregnant: _____________

Number of living children: _____________________

Are you planning a pregnancy in the next 6-12 months? YES NO

3. When was your last Pap Test? ________________

Have you ever had an Abnormal Pap? YES NO

***If yes, When?* ___________

Did you have any of the following?

Colpo/Biopsies	YES	NO
LEEP/CRYO	YES	NO
Surgery	YES	NO

4. Do you have any of the following:

A. Problems with present method of birth control	YES	NO
B. Bleeding between periods	YES	NO
C. Pain with sex	YES	NO
D. Any problem with interest in or enjoying sex	YES	NO
E. A new or enlarging lump in breast	YES	NO
F. Change in size/firmness of stool	YES	NO
G. Blood clots (leg, lung, etc.)	YES	NO
H. Headaches	YES	NO
I. Pain in joints	YES	NO
J. Pain in chest	YES	NO
K. Pain in abdomen	YES	NO
L. Trouble falling or staying asleep	YES	NO
M. Often feeling down, depressed or hopeless in the past month	YES	NO
N. Often having little/no interest in hobbies/daily activities during the past month	YES	NO
O. Is conflict in your family or relationships, sometimes handled by pushing, hitting, or cruelty?	YES	NO
P. High blood pressure	YES	NO

5. Do you have a parent, grandparent, brother or sister with history of the following:

A. Cancer	YES	NO
B. Heart attacks	YES	NO
C. High Blood Pressure	YES	NO
D. Diabetes	YES	NO

***If yes to any of the above please list them below:*

Relation: _______________ Type: __________________

Relation: _______________ Type: __________________

Relation: _______________ Type: __________________

Relation: _______________ Type: __________________

6. Have you *EVER* used tobacco? YES NO

***If yes, please continue below:*

A. Number of packs/day: ______________

B. Number of years smoked: ___________

C. Year quit: ___________

7. Do you drink alcohol? YES NO

***If yes, please continue below:*

A. How much? (OCC) (MOD) (HEAVILY)

B. Have you ever felt you should decrease your drinking? YES NO

C. Has anyone ever seemed concerned about your drinking? YES NO

D. Have you ever felt guilty about your drinking? YES NO

8. Do you drink caffeine? YES NO

***If yes how much?* ___________ *(Cups per day)*

9. Do you currently use illegal drugs? YES NO

10. Which of the following are included in your diet:

Grains/Starches	a lot	some	none
Vegetables	a lot	some	none
Dairy	a lot	some	none
Meats	a lot	some	none
Sweets	a lot	some	none

11. Do you exercise regularly? _________________

Activity: ______________________

Days per week: ________________

12. Have you had your cholesterol level checked? YES NO

13. Have you ever had a colonoscopy? YES NO

***If yes, when:* _____________________

14. Have you ever had a mammogram? YES NO

***If yes, when:* _____________________

Have you ever had an abnormal mammogram? YES NO

***If yes, when:* _____________________

15. If you are 65 or older have you ever had a bone density scan? YES NO

***If yes, when:* ______________________

16. Please describe any problems you are currently having:

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BAYSIDE WOMEN'S HEALTH
AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

In the event that our office is unable to reach you, the patient, directly concerning (but not limited to) test results, pathology reports, and other medical information, it is up to your discretion with whom we may share this information with. Please refer to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with any questions.

I authorize Bayside Women's Health to discuss my account and medical conditions - which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information - with the following persons in order to facilitate and coordinate my care, treatment, and payment. (please check appropriately):

☐ Myself Only

☐ Myself and/or those listed below:

1. Full Name: ______________________
   Relationship: ____________________
   Phone #: ________________________

2. Full Name: ________________________
   Relationship: ______________________
   Phone #: __________________________

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can withdraw this permission by signing a new form at any time. This authorization will remain in effect until I change or revoke it.

____________________________________ ______________________
Patient Name (printed) Date

____
Signature of Patient

Authorization Regarding Messages
(please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments.

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.

____ I authorize you to leave a message with anyone who answers the phone.

____ Messages may only be left with ____

____________________________________ ______________________
Patient Name (printed) Date

____
Signature of Patient

BAYSIDE WOMEN'S HEALTH
FINANCIAL POLICIES/TREATMENT CONSENT

Thank you for choosing our practice. Our providers appreciate your trust in us and the opportunity to care for you. As a part of our practice, we try to offer efficient and helpful billing services. To this end, we ask you to read the following statement of our financial policy and treatment consent. Please sign it prior to any treatment.

FINANCIAL POLICY

Payment is due at the time of service. Co-payment and Deductibles are a contract responsibility between the patient and their insurance company and are non-negotiable as we are required to collect them.

Insured Patients: As a courtesy to you, we will bill your insurance with a copy of your current insurance card. Fees for non-covered services will be collected at the time services are rendered. After receiving your insurer's explanation of benefits (EOB) statement, if there remains an amount due, we will require that it be paid within 60 days. If your insurance coverage should change during the course of treatment, you should notify Bayside Women's Health immediately.

Uninsured Patients: Patients without medical insurance coverage should expect to pay for their treatment in full at each visit. If charges exceed what you can reasonably pay at that visit, please speak to the Front Office Manager to make arrangements for the balance. All uninsured patients are billed based on our Self Pay Fee Schedule. Our Front Office Manager will design a payment plan for you, based on our criteria and your ability to pay. All charges must be paid in full unless you have a signed payment plan. Delinquent accounts that are turned over to outside collections will be charged the full fee for all services.

Pregnancy Related Fees: Fees for pregnancies can vary widely depending on the patient's specific insurance plan. Therefore, Bayside Women's Health may review these fees with you during your 1st trimester. We will inform you in writing of any deductibles, co-insurance and co-pays. The 1st half of the deductible will be due prior to your 20 week ultrasound appointment and the remaining balance due by your 32 week appointment. There may be a time that your insurance does not cover all the care that you receive even though your physician believes it is medically necessary. In these instances, the charges will be reviewed with the physician in an effort to receive payment through your insurance provider. If the charges are still considered non-covered the balance will be released to the patient.

Procedures and Surgeries: Our Front Office team and/or Nurse Manager will provide a Financial Estimate for procedures and surgeries. This will be determined by looking at co-insurance and deductibles on each individual policy. ALL fees (i.e., co-pays, deductibles) will be required before any elective surgery or in-office procedure. A fee of $25 will be incurred for any changes you request within 2 weeks of surgery. Failure to give proper notice of cancellation of your surgery will result in the following fees:

- $100.00 7 days prior to surgery
- $250.00 5 days prior to surgery
- $500.00 48 hrs or less

Outside Pathology or Laboratory Services:
If expertise of an outside lab is needed for a portion of your care, you may receive a bill from that lab for their services.

Delinquent Accounts: Your account will be reviewed if payment is not received after 60 days and will be considered delinquent. We reserve the right to send delinquent accounts to a collection agency. If that is the case, you will be responsible for any costs in connection with collection of a delinquent account. Collection agencies typically charge a 30 – 40% fee of the balance on the account. Non-payment of a delinquent account could affect your ability to schedule future appointments at Bayside Women's Health.

Additional Charges: Returned checks for NSF, Stop Payment, or Account Closed will be subject to a $35.00 fee.

No Show Charge: Any appointment must be cancelled or rescheduled 24 hours or more in advance or a $25 NSF will be charged to your account and must be paid prior to rescheduling.

Change of address: Please update personal information with the business office. If a change of address cannot be found and a statement is returned by mail, the account will be turned over for collection.

TREATMENT CONSENT

Telephone Consent: I give consent to be contacted on my wireless phone number (call or text) regarding billing, collections, and appointment reminders.

Assignment of Benefits: I assign payment of authorized insurance benefits otherwise payable to the policyholder or beneficiary, including without limitation Medicare, Medicaid and Tricare, directly to Bayside Women's Health for any services furnished to me. I further assign to the physician(s) who provide services or their authorized representative(s) such benefits payable for physician/s services.

Authorization for Release of Information: I authorize Bayside Women's Health to release any medical and billing information including but not limited to the following:

a. Insurance Billing – information requested by the insurance company or other third-party payers to support the claim submitted for payment of charges applicable to this account.

b. Medical Necessity and Appropriateness of Services – information requested by any utilization and/or peer review organization associated with the insurer(s) to evaluate the medical necessity and appropriateness of services of this account or to determine benefits for related eservices. This release allows disclosure about the treatment, diagnostic testing or other medical information including psychiatric, alcohol, HIV, drug abuse and /or other confidential information. The recipients are prohibited from any re-disclosure of this information. The undersigned has the right to subsequently revoke this release. That revocation shall not pertain to information previously released. Information requested in good faith by any health care facility or physician for facilitating continuing care and treatment is authorized.

Treatment Consent: I hereby authorize the doctor and the associates/assistants of his/her choice to treat my condition. I understand that possible risks are present in any treatment or procedure that may be performed, and that my physician will explain these prior to initiating any treatment or performing any procedure. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon me. I agree that Bayside Women's Health can request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature: My signature authorizes that I have read the above and understand treatment consent and the financial policy. I understand that it is my responsibility to notify Bayside Women's Health in writing of any changes to this release of information consent. I acknowledge that I have read and understand the Notice of Privacy Practices and that I can obtain a copy upon request. I understand further that Bayside Women's Health and its business associates (including its billing company) may use or disclose my health information in communications with third parties who are involved in or indicate that they are responsible for payment for my healthcare services. I understand that such third parties might include persons who are the policy holders of any policy of insurance covering me. I acknowledge that I am entitled to prevent these communications by objecting to them, and by my signature below, indicate that I DO NOT OBJECT to such communications.

______________________________ ________________

Patient Name (printed) Date

____

Signature of Patient

BAYSIDE WOMEN'S HEALTH
OFFICE POLICIES

Patient Portal

We recommend you signing up for our Patient Portal. You can access it at https://25555.portal.athenahealth.com. Within the portal, you can:

- view, manage and check in for upcoming appointments
- access, print and complete any required forms for upcoming appointments
- access billing statements, view payment history and make payments
- update demographics including phone, email and emergency contacts
- set your notification preferences regarding text, email and phone contacts
- set family access and view current insurance information.

Self Check-In

We now offer patient self check-in prior to your appointment. This decreases your wait time by allowing you to complete forms and update demographic information prior to your visit. Any required forms for upcoming appointments can be viewed once you click on the appointment within the patient portal. **Please continue to SIGN IN at the front desk when you arrive the day of your appointment.** Your provider may have additional questions/forms for you the day of your appointment.

Scheduling Appointments

To schedule an appointment, please call our office Monday-Friday 8:15a-4:45p. Our appointment staff may ask you about the nature of your visit in order to book the most appropriate appointment for you.

Text Message/E-mail Appointment Reminders

If you would like to participate in our email and text message appointment reminder program, please be aware that any charges that apply from your cell phone carrier are your responsibility. If you would like to receive email or text message reminders please provide us with your cell phone number and email address. You may opt out at any time by contacting our office our accessing your patient portal.

No Show Fee

There is a $25.00 No Show Fee for all appointments that are not cancelled/rescheduled at least 24 hours in advance.

Canceling Appointments

If you need to cancel or reschedule your appointment, please call us as soon as possible. This will allow another patient to use your appointment time.

Late Appointments

Please make every effort to be on time for your appointment. We respect the time of our patients and our staff tries to stay on schedule in an effort to reduce wait times. If you arrive late for your appointment, we will attempt to work you in; however, you may be asked to reschedule your appointment.

Emergencies

If you are experiencing a serious or life-threatening emergency, dial 911.
If you are experiencing a medical emergency outside of office hours and need to reach the on-call physician, please call our office at 251-990-6550 and you will be connected to our after-hours call service. They will connect you to the on-call physician.

**We do not refill prescriptions via the emergency line. Please do not call the emergency line if you are not having an urgent medical problem that can wait until normal business hours.*

BAYSIDE WOMEN'S HEALTH
OFFICE POLICIES

Medical Records

You are entitled to copies of your medical records, whether for yourself or another medical provider. You will need to sign a medical record release at our office and present a valid photo ID. Record requests are subject to a $5.00 retrieval fee and are $1 per page the first 25 pages, and fifty cents for each additional page. Please allow up to 5 business days for processing.

Prescriptions

Prescription refills are processed only during our normal office hours. If you would like to order your prescription through a mail order pharmacy, you must obtain a mail order form from your insurance provider and mail or fax the completed form, along with the written prescription directly to your mail order pharmacy.

Narcotics

It is our office policy not to call in narcotic pain medication. We also do not treat chronic pain conditions that require long-term narcotic use. Under no circumstances do we write narcotic pain medications for uses outside the scope of our OB-GYN practice.

Payments

Co-pays, coinsurance, and deductibles are due at the time of service. If you have questions regarding payment arrangements, please contact the office. We accept cash, check, Visa, Discover, and Mastercard.

*There is a $35 fee for returned checks.

FMLA/Short Term Disability Forms

If you have FMLA/Short Term Disability paperwork, please make sure that you complete the *patient sections* of your forms and leave instructions on where they need to be sent. Standard postpartum leave is six weeks following a vaginal delivery and eight weeks after a cesarean delivery. We charge $10.00 per set that must be paid for with cash or check.

**Please allow up to 7 business days for forms to be completed.*

Things to Bring to Every Appointment

Driver's License/Photo ID
Health Insurance Card
Method of Payment
List of All Medications (including strength and dosage)

**If you are unable to present proof of insurance, you will be asked to pay for services as self-pay or reschedule your appointment.*

Insurance

If you have a change in insurance, please inform the front desk when you sign in for your appointment. Our goal is to provide accurate insurance information to our patients; however, it is ultimately the patient's responsibility to ensure that the services received are covered. If your insurance plan requires a referral, it is your responsibility to obtain one from your PCP.

**All copays, coinsurance, and deductibles are due at the time of service.*