## SUMMERVILLE WOMEN'S MEDICAL GROUP, P.C.
## Patient Information

Doctor_____ Medical/Primary Care Doctor_____

Name_____
First Middle Maiden Last

Address_____

City_____State_____Zip Code_____

Home # (____)_____Work # (____)_____Cell # (____)_____

Age_____Date of birth_____Social Security #_____

Single_____ Married_____ Separated_____ Divorced_____ Widowed_____

Patient's Place of Employment_____

Husband, Parent or Guardian'sName_____
(Please circle above relationship to you) First Middle Last

**H, P or G** Birthdate_____**H, P, or G SS#**_____**H, P, or G** Cell# (___)_____

**H, P or G** Place of Employment_____**H,P, or G** Work #(____)_____

Primary Insurance Co. Name_____Insured's Name_____

Certificate/Policy #_____Group #_____Phone # (_____)_____

Secondary Insurance Co. Name_____Insured's Name_____

Certificate/Policy #_____Group #_____Phone # (_____)_____

EMERGENCY CONTACT: _____(____)_____
Name Relationship Telephone

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*AUTHORIZATION FOR RELEASE OF INFORMATION:* I authorize the release of any information needed to process an insurance claim. I permit a copy of this authorization to be used in place of the original. I also request payment of insurance benefits, on assigned claims, to **Summerville Women's Medical Group, P.C.** **IF YOUR INSURANCE CHANGES, NOTIFY US IMMEDIATELY! CLAIMS THAT REMAIN UNPAID AFTER 45 DAYS, WILL AUTOMATICALLY BECOME PATIENT RESPONSIBILITY.**

_____
Signature Date

May we leave messages regarding tests results at the number(s) provided ? Yes___ No___

**2016**

2/22/13

## NOTICE OF PRIVACY PRACTICES

### THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
### *PLEASE REVIEW IT CAREFULLY.*

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

**For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

**For Health Care Operations.** We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts. WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; public health risks; and worker's compensation.

### NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

**Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

**Right to Request Removal from Fundraising Communications.** You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact [Name of Privacy Officer], [Practice phone number], [Practice Address] All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

**[Practice Administrators: If you choose to have patients or their personal representatives sign this Notice, please use the lines below. Otherwise, the lines below should be removed.]**

**I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.**

_____ _____

**Patient or Patient's Personal Representative** **Date**

SUMMERVILLE WOMEN'S MEDICAL GROUP, P.C.
*Obstetrics and Gynecology*

2300 WRIGHTSBORO ROAD
AUGUSTA, GEORGIA 30904
(706) 737-3948
FAX (706) 737-4035

EVAN C. BAHR, M.D., F.A.C.O.G.

J. HENRY OLIVER, M.D., F.A.C.O.G.

I acknowledge, by signing below, that I have received the "Notice of Privacy Practices".

_____ _____

Patient or Patient's Representative Date

In addition, I authorize this office to discuss or release medical information, from my medical records in this office, to the following people. This will remain my legal authorization unless I complete an amended form at a future visit.

| | |
|---|---|
| _____ | _____ |
| Name | Relationship |
| _____ | _____ |
| Name | Relationship |
| _____ | _____ |
| Name | Relationship |
| _____ | _____ |
| Name | Relationship |
| _____ | _____ |
| Name | Relationship |

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# Financial Policy

## Office Visits

**We require payment at the time of service for all office visits.** We accept cash, personal checks, Visa and Mastercard. We do not file claims for office visits unless we are a Preferred Provider under a Managed Care Contract. Our receptionist will give you a receipt that contains all the information needed by your insurance company. This receipt can be attached directly to your insurance claim form. Many insurance policies will reimburse you for the laboratory procedures and office procedures. It is to your advantage to submit each office visit to your insurance company.

## Insurance

**Please provide our office with your current insurance information.** As a courtesy to you, we will file a claim to your insurance company for hospitalizations and surgery.

Please inform our office about special programs in your insurance policy regarding second opinions, pre-admission certification and length of stay guidelines. Failure to comply with these requirements could reduce the amount the insurance company will pay for the procedure and increase your financial responsibility. If you do not know, call your insurance agent or see the secretary who handles the insurance for your company.

Prior to elective surgery, we will provide you with an estimate of the surgical fee and an estimate of your insurance coverage and what your estimated co-payment will be. We require that your co-payment be taken care of, in full, within 60 days following your surgical procedure. A deposit for your co-payment will be required by or on the day of your pre-operative visit.

Even though an insurance claim has been filed by our office, you will receive a statement each month if your account has a balance due. This office cannot accept responsibility for collecting your claim or for negotiating a settlement on a disputed claim. You are responsible for payment of your bill.

Your insurance policy is a contract between you and your insurance company. You pay the monthly premiums to the insurance company in return for medical coverage. The insurance company has no relationship with our office. Only you can negotiate the

settlement of a disputed claim. **Payment of our fees in a timely manner is the patient's responsibility.**

Our fees are set to be within reasonable and customary guidelines for this community. Insurance companies as a part of their business practice, often establish usual and customary rates below a physician's actual costs. The amount of reimbursement from your insurance policy may not cover the total cost of your medical care. **Any difference between what your insurance pays and our charge is the patient's responsibility. Any services that may be considered as "non-covered" services by your insurance provider will become your responsibility to pay.**

**No Insurance**

If you need elective surgery and have no private insurance, **our office is willing to work with you to arrange a reasonable payment schedule.**

**Medicare**

As a service to you, our office will submit to Medicare the claim for all office visits and procedures in addition to hospital claims. The Medicare patient is responsible for the deductible and a 20% co-payment. **We require that the payment for the deductible and the 20% co-payment be made at the time of service.**

**Surgical/Obstetrical Accounts**

You will receive a statement from our office every 30 days. **Accounts must be paid in full within 60 days of the service rendered, unless prior arrangements have been made.** If we do not receive full payment of our bill (or prior arrangements made) within 60 days, we will initiate collection action.

We realize that medical expenses are usually unexpected and can create hardships. We encourage open communication regarding your ability to pay your bill. Insurance often does not pay in a timely manner or does not pay the full amount of our fee.

**Collection Fees**

I hereby agree that in the event of default in payment of any amount due and if this account is placed in the hands of a collection agency or attorney, I will pay an additional charge equal to the cost of collection agency fee, attorney fee and court cost incurred and permitted by laws covering my transactions.

**If you have any questions or we can be of assistance regarding our services and financial policies please call us.**

**Patient's Signature**_____ **Date**_____

# PATIENT HISTORY FORM

Name_____ Date of birth_____
Race/Ethnic Background _____
Reason for today's visit_____
Drug Allergies_____

## Current Medications

| Drug Name | Dosage | Doctor |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Past History of Illnesses

| Please answer with X | Now | Past | ? | Comments |
|---|---|---|---|---|
| Severe headaches | | | | |
| Eye problems | | | | |
| Hypertension (High blood pressure) | | | | |
| Anemia | | | | |
| Phlebitis | | | | |
| Rheumatic fever | | | | |
| Heart problems | | | | |
| Stroke | | | | |
| Severe chest pain | | | | |
| Shortness of breath | | | | |
| Varicose veins | | | | |
| Epilepsy/Seizures | | | | |
| Counseling | | | | |
| Memory loss | | | | |
| Anxiety/Depression | | | | |
| Asthma | | | | |
| Lung disease | | | | |
| Pneumonia | | | | |
| Bronchitis | | | | |
| Thyroid problems | | | | |
| Weight changes | | | | |
| Liver disease | | | | |
| Mononucleosis | | | | |
| Hepatitis/Jaundice | | | | |
| Gallbladder disease | | | | |
| Abdominal pain | | | | |
| Rectal bleeding | | | | |
| Hemorrhoids | | | | |

Name

| | | | | |
|---|---|---|---|---|
| Constipation | | | | |
| Diabetes | | | | |
| Cancer | | | | |
| Easy bruising | | | | |
| Osteoporosis | | | | |
| Arthritis | | | | |
| Skin rash | | | | |
| Kidney disease | | | | |
| Bladder problems | | | | |
| Hirsuitism (abnormal hair growth) | | | | |
| Tuberculosis | | | | |
| HIV/AIDS | | | | |
| Blood clots | | | | |
| Eating disorders | | | | |
| Collagen vascular disease (Lupus, etc.) | | | | |
| Chickenpox | | | | |
| Reflux | | | | |
| Hiatal Hernia | | | | |
| Ulcers | | | | |
| Broken bones | | | | |
| Bowel problems | | | | |
| Blood transfusions | | | | |

Are you a Jehovah's Witness? Y N

## Family History

| | Current health problems | If deceased, cause of death and age at death |
|---|---|---|
| Mother | | |
| Father | | |
| Maternal Grandmother | | |
| Maternal Grandfather | | |
| Paternal Grandmother | | |
| Paternal Grandfather | | |
| Sibling | | |
| Sibling | | |

## Gynecological History

| I have: | Y | N | Comments |
|---|---|---|---|
| vaginal discharge, irritation, or itching | | | |
| urinary frequency, urgency, or leakage | | | |
| pain/discomfort with menstrual period | | | |
| pain/discomfort during intercourse | | | |
| A history of sexually transmitted diseases | | | |
| A history of pelvic inflammatory disease | | | |
| A history of abnormal pap smears | | | |
| hormonal disorders | | | |
| menopausal symptoms | | | |
| infertility problems | | | |

Did your mother take DES during her pregnancy? Y N

Name_____

Last pelvic exam _____ Reason:_____

Last pap smear _____ Result:_____

## Menstrual History

Date of last menstrual period _____ Normal? Y N

Age of first menses_____

Cycle Length_____ Duration_____

Flow? Light___ Moderate___ Heavy___

Discomfort is: Minimal___ Moderate___ Severe___

Bleeding occurs: between periods___ after intercourse___

Irregular periods? Now Past If necessary, explain_____

Have menstrual problems ever interfered with work/school/sports? Y N If yes, please explain _____

_____

## Contraceptive History

| | Now | Past | How long used | Problems? |
|---|---|---|---|---|
| Birth control pills/patches/ring | | | | |
| IUD | | | | |
| Diaphragm with jelly/cream | | | | |
| Condom | | | | |
| Jelly/Cream/Foam alone | | | | |
| Rhythm/ Natural | | | | |
| Withdrawal | | | | |
| Suppositories | | | | |
| Sterilization (male or female?) | | | | |
| Depo-Provera | | | | |
| Norplants/Implanon | | | | |
| Other | | | | |

Are you dissatisfied with or would you like to change your present method? Y N

What is your partner's attitude towards birth control? _____

_____

## Obstetrical History

Pregnancies_____ Elective Terminations_____ Miscarriages_____ Premature births (>37 wks)_____

Live births_____ Living children_____

| # | Birth date | Birth weight | Baby's sex | Weeks pregnant | Type of delivery | Complications? |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |

Notes:_____

_____

_____

_____

_____

Name_____

## Breast History

Do you perform regular breast self-examinations? Y N
Have you noticed problems with your breasts? Y N If yes, please describe_____
_____
Have you noticed: abnormal discharge____ tenderness/pain_____ lump_____
Do breast problems seem to be related to menstrual cycle? Y N N/A If yes, please describe ___
_____
Currently breast feeding? Y N
Do you have a history of an abnormal mammogram? Y N If yes, please describe_____
_____
Date of last mammogram_____
Do you have a family history of breast cancer? Y N If yes, please describe_____
_____
Do you have a history of breast surgery? Y N If yes, please describe_____
_____

## Social History

Smoking? Y N If yes, packs per day?_____ years?_____
Alcohol? Never___ Rarely___ Moderately___ Daily____
Recreational drug use? Y N If yes, please describe_____
Exercise? Never___ Rarely___ Moderately___ Daily____

It is your responsibility to maintain your health, and we recommend that you schedule regular gynecological exams, pap smears, and mammograms. We try to minimize your waiting time, but our specialty is unpredictable by nature...please bear with us.

Signature of Patient_____ Date_____