ORANGE COAST OBGYN

Consent Release Form for Medical Information

Patient Name: _____
(Please print patient name)

Date of Birth: _____

Doctor: _____

Internist/Family Practice Physician: _____
(First name) (Last name)

Telephone #: _____

Preferred Pharmacy Name: _____

Preferred Pharmacy Phone #: _____

Email address: _____

May we discuss your medical information with any other person or family member?
Yes or No (Circle One)

Name: _____
(Please Print Name) (Relationship)

May we leave a detailed message (including abnormal results) on your voice mail?
Yes or No (Circle One)

Voice Mail #: _____

_____ Date: _____

ORANGE COAST OBGYN

Financial Policy

We are pleased that you have chosen our practice to serve your health care needs. The following is a statement of our financial policy. We ask you to read and sign below prior to any treatment.

Insurance Billing
Your insurance policy is a contract between you and your insurance company. **It is your responsibility to know your benefits and how they apply to your treatment.** We bill your insurance as a courtesy to you, but please be aware that not all services provided may be covered by your insurance plan. If your insurance company has not paid your account within 90 days the balance will be transferred to you. We accept CASH, CHECKS, VISA, MASTERCARD, and AMEX.

Cash patients
All services must be paid in full at the time of treatment.

Administrative Fees

- **All co-pays will be collected at the time of service, prior to seeing your provider.** If co-payment is not made you will not be seen.
- All Medical Records requests are subject to a $25 preparation fee plus/minus shipping.
- A fee of $25 will be applied to all returned checks.
- A fee of $25 dollars per form will be collected for completing all Disability, Worker's Compensation, Employer Leave, and other forms. These forms will not be submitted until the fee is paid.
- A fee of $35 will be charged for office visits cancelled without 24 hours advance notice.

OB Deposits
Before the end of your pregnancy, our billing office will verify your OB benefits and discuss your financial responsibility with you. Your balance is due within 30 days of delivery. You may make payments toward your obstetrical care before delivery to help prepare for any financial burdens.

Surgery Deposits
We charge only for professional services provided by the physician at our office. You may also receive a bill from the hospital, surgery center, anesthesiologist, assistant surgeon, or pathology department. They will bill your insurance directly. When your surgery is scheduled the scheduler will provide you with your estimated financial responsibility. This is usually 3-5 days prior to your surgery. The estimated responsibility will be collected as a deposit at the time of your pre-op appointment. **If you cancel surgery with less than 24 hours notice your deposit will be nonrefundable.**

I hereby attest that the insurance information I have provided is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits. I will be financially responsible for all charges that are not covered by my insurance plan.

Patient's signature:_____

Date:_____

Patient Name:_____

HIPAA Policy

HIPAA POLICY REGARDING USE AND DISCLOSURE OF PHI FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS INCLUDING SPECIAL HIPAA RULES REGARDING USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR MARKETING PURPOSES

SCOPE OF POLICY:
All offices of Orange Coast OBGYN are covered by this policy:

What Personnel Are Covered by this Policy? This policy applies to health care providers, clinical and all employees who assist these providers in performing tasks related to health care.

PURPOSE OF POLICY: The purpose of this policy is to set forth the standards for the use of a patient's or subject's (the "Individual") Protected Health Information (PHI) for treatment, payment, and health care purposes.

DEFINITIONS:
Covered Entity: health plan; healthcare clearinghouse; or a health care provider who transmits any Health Information in electronic form in connection with a transaction covered under the HIPAA regulations.

Health Information: Any information whether oral or recorded, in any form, that is created or received by Orange Coast OBGYN that related to an Individual's past, present, or future physical health, or to the payment of such health care.

Health Care Operations: Any of the following activities of the Orange Coast OBGYN Covered Component to the extent that the activities are related to the functions of the Orange Coast OBGYN Covered component that make it a health plan, health care provider or a health care clearinghouse:

- (a) health care protocol development (excluding research protocol development)
- (b) case management and health care coordination;
- (c) contacting health care providers and patients with information about treatment alternatives;
- (d) accreditation, certification, licensing or credentialing activities;
- (e) conduction or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.

Individually Identifiable Information: Health Information, including demographic information, that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.

Marketing: Marketing is:

(1) An arrangement between a Covered Entity and any other entity pursuant to which the Covered Entity discloses PHI to the other entity, in exchange for direct or indirect remuneration, for the other entity or its affiliate to make a communication about its own services that encourages the recipient of the communication to use;

(2) Making a communication about a service that encourages the recipient of the communication to use the service unless the communication is made:

- (a) to describe a health related service (or payment for such service) that is provided by, or included in a plan of benefits provides by the Covered Entity that is making the communication (including communications about entities that are participating in a health care provider network or health plan network, or about replacement of or enhancement to a health plan; and health related services available only to a health plan enrollee that add value to, but are not part of a plan of benefits);
- (b) for treatment of the Individual;
- (c) for case management or care coordination for the Individual;
- (d) to direct or recommend alternative treatments, therapies, health care providers or setting of care to the Individual
-

Protected Health Information (PHI): Individually Identifiable Health Information that is transmitted by electronic media or transmitted or maintained in any other form or medium.

POLICY:

General Rule: The Orange Coast OBGYN Covered Component may use and disclose PHI for Treatment, Payment and Health Care Operations purposes without first obtaining a written authorization (that contains all HIPAA-required elements) from the Individual who is the subject of the PHI, provided that the use or disclosure falls within one of the following categories:

- (a) the Orange Coast OBGYN Covered Component may use or disclose an Individual's PHI for it own Treatment, Payment or Health Care Operations;
- (b) the Orange Coast OBGYN Covered Component may disclose an Individual's PHI for the treatment activities of a health care provider;
- (c) the Orange Coast OBGYN Covered Component may disclose an Individual's PHI to another Covered Entity or a health care provider for the payment activities of the entity that receives the PHI;
- (d) the Orange Coast OBGYN Covered Component may disclose an Individual's PHI to another covered entity for the Health Care Operations of the entity that receives the PHI if each entity either has, or had, a relationship with the Individual; the PHI pertains to the relationship; and the disclosure is for quality assessment, quality control or peer review purposes or for the purpose of health care fraud, and about detection or compliance.

Consent: Although the Orange Coast OBGYN Covered Component is not required to obtain an Individual's authorization for the use of PHI for the treatment, payment and health care operations purposes in order to comply with HIPAA, it is permitted under HIPAA to obtain an individual's consent to such uses/disclosures.

PROCESS/PROCEDURE:

Consent for Treatment: The Orange Coast OBGYN Covered Component should continue to obtain a signed consent for treatment for each Individual who receives health care services. This consent for treatment may contain a consent to the use and disclosure of the Individual's PHI for treatment, payment and health care operations purposes; however, for uses and disclosures of PHI for the HIPAA purposes outlined above under the General Rule, a HIPAA authorization is not required.

APPLICABILITY OF MINIMUM NECESSARY AND ACCOUNTING RULES:
Minimum Necessary Rule: The Minimum Necessary Rule does not apply to disclosures made for treatment purposes. The Minimum Necessary Rule does apply to any other uses and disclosures permitted under this policy that are not made to the Individual or made pursuant to the written authorization of the Individual.

Accounting Rule: The Orange Coast OBGYN Covered Component is not required to keep records accounting for the disclosure of PHI used for Treatment, Payment and Health Care Operations purposes permitted under the policy, or for disclosures made to the Individual or pursuant to the written authorization of the Individual. Records of all other disclosures permitted hereunder must be maintained in order to provide an Individual with an accounting of such disclosures upon her request. These records must be maintained for a period of six years following the date of the disclosure.

HEALTH INFORMATION EXCHANGE:
This practice is participating in the Hoag Health Information Exchange (HIE), an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law, that protects your privacy. Through the HIE, your participating providers will be able to access information about you that is necessary for your treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation.

If you choose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), We will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to others through the HIE.

To opt out of the HIE, please contact the Hoag Director of Health Information Exchange in writing at One Hoag Drive, Newport Beach, CA 92663, or by telephone at 949/764-8722.

I acknowledge receipt of HIPAA privacy policy:

_____ _____

Signature Date

ORANGE COAST OBGYN

Insurance Waiver

I have chosen to receive medical services from Dr. _____.
I understand that my insurance benefits cannot be verified at this me.

I understand I am responsible for all deductibles, copayments and non-covered expenses, and other out -of-network expenses incurred by seeking services by a non-preferred/out-of-network provider. I am also aware that any outside services (labs, ultrasounds, mammograms, hospital care, etc.) ordered by the physician are also subject to out-of-network reimbursement depending on my individual plan according to my insurance carrier.

_____
Patient Signature

_____
Print Name

_____
Date

ORANGE COAST OBGYN

PATIENT INFORMATION

PLEASE PRINT CLEARLY DATE: _____

PATIENT INFORMATION

Patient's Name: _____ Age: _____

Date of Birth: _____ Social Security #: _____

Driver's License #: _____ ☐Single ☐Married ☐Widowed ☐Divorced

Address: _____

Cell #: (____)_____ Home #:(____)_____ Work #: (____)_____

AT WHICH NUMBERS MAY WE LEAVE DETAILED MESSAGES INCLUDING HEALTH INFORMATION, TEST RESULTS, ETC. AT THE NUMBERS ABOVE?
☐CELL ☐WORK ☐HOME

Email Address: _____

Occupation: _____ Employer: _____

Employer's Address: _____

SPOUSE'S INFORMATION

Spouse's Name: _____ Date of Birth: _____

Spouse's Social Security#: _____ Employer: _____

Spouse's Occupation: _____ Phone #: (____)_____

PHARMACY/REFERRING PHYSICIAN INFORMATION

Pharmacy Name: _____ Phone #: (____)_____

PCP/REFERRED BY: _____ Phone #: (____)_____

MEDICAL INSURANCE INFORMATION

Name of Insurance Company: _____ Effective Date: _____

Insured's Name: _____ Relationship: _____

ID #: _____ Group #: _____

Secondary (if any):
Name of Insurance Company: _____ Effective Date: _____

Insured's Name: _____ Relationship: _____

ID #: _____ Group #: _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____
Relationship: _____ Phone #: (____)_____

ASSIGNMENT & RELEASE

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO PAID DIRECTLY TO **ORANGE COAST OBGYN**. I AM FINANCIALLY RESPONSIBLE FOR NONCOVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY MEDICAL CLAIMS.

Patient Signature: _____ Date: _____

PARENTS/GUARDIANS OF MINOR CHILDREN

I hereby authorize treatment of: _____ FOR MY MINOR CHILD BY **Orange Coast OBGYN**.

Parent/Guardian Signature: _____ Date: _____

ORANGE COAST OBGYN

HEALTH HISTORY QUESTIONNAIRE

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

Reason for visit: _____

_____

_____

PLEASE LIST:

Current Medications	Drug Allergies & Reactions

GYNECOLOGICAL HISTORY:

Age you began menstruating: _____ First day of last period: _____

Menstrual flow: ☐Regular ☐Irregular ☐Painful/Cramps Length of cycle: _____ Days of flow: ____

Menopausal? ☐Yes ☐No If yes, what age did you begin menopause? _____

PREGNANCY:

Year	# of weeks at delivery	Hours of labor	Weight	Sex	Delivery type (Vaginal or C-section)	Location of delivery	Complications

Current birth control method: _____ Name of pill: _____(if on pills)

Date of last pap smear: _____ ☐Normal ☐Abnormal

Have you had an abnormal pap smear before? ☐Yes ☐No

Have you ever had a sexually transmitted disease? ☐Yes ☐No If yes, please list date and type:

_____

_____

Date of last mammogram: _____ Result: ☐Normal ☐Abnormal

Date of last colonoscopy: _____ Result: ☐Normal ☐Abnormal

Are you a smoker? ☐Yes ☐No If yes, how many packs daily? _____ If quit, how long ago? _____

Do you drink alcohol? ☐Yes ☐No If yes, how many drinks per week? _____

Do you use drugs? ☐Yes ☐No If yes, what type? _____

What is your exercise routine? _____ Frequency & type: _____

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS?

	Yes	No		Yes	No		Yes	No
Lung Disease			Cardiovascular			Systemic		
Bronchitis			High Blood Pressure			Diabetes		
Emphysema			Heart Attack			Thyroid		
Asthma			Heart Murmur			Arthritis		
Sinusitis			Circulation Disorder			Kidney/Bladder		
Cold or Respiratory Infections			Heart Disease			Stomach/Bowel		
Pneumonia			Clotting/Bleeding Disorder			Hepatitis		
Shortness of Breath			Chest Pain			Seizure Disorder		
Lung Disease			Stroke			Muscle Weakness		
Cancer			Anemia			Glaucoma		

LIST ALL PRIOR SURGERIES:

_____

_____

FAMILY HISTORY:

Condition	Mother	Father	Sibling	Other	Condition	Mother	Father	Sibling	Other
Breast Cancer					Alcoholism				
Ovarian Cancer					Kidney Disease				
Uterine Cancer					Thyroid Disease				
Other Cancer					Mental Illness				
Osteoporosis					Diabetes				
Heart Disease					High Blood Pressure				

PLEASE LIST ANY OTHER SIGNIFICANT MEDICAL ISSUES NOT LISTED ABOVE:

_____

_____

ORANGE COAST OBGYN

Genetic Questionnaire

These questions will help in the care of your pregnancy. Your answers may indicate whether certain test would be helpful in evaluating the health of your unborn baby.

How old will you be when your baby is born? _____ Ethnicity? _____

Have you, the father of the baby, or anyone in either of your families ever had any of the following disorders? Please circle "YES" or "NO"
Please specify for each "YES" answer, the problem and the relationship of the affected person

• Mental retardation	YES NO
• Down Syndrome or any other chromosome abnormality	YES NO
• Birth Defects (I.e. cleft lip or palate, limb defects)	YES NO
• Spina Bifida (open spine), anencephaly	YES NO
• Hydrocephalus (water on the brain)	YES NO
• Congenital blindness or deafness	YES NO
• Blood disorders (anemia's)	YES NO
• Cystic Fibrosis	YES NO
• Epilepsy or seizures	YES NO
• Heart defects	YES NO
• Bleeding disorders (hemophilia, blood clots, pulmonary embolism)	YES NO
• Huntington's Chorea	YES NO
• Kidney problems	YES NO
• Mental illness	YES NO
• Muscular Dystrophy	YES NO
• Myotonic Dystrophy	YES NO
• Neurofibromatosis	YES NO
Have you had three or more miscarriages?	YES NO
Are you using alcohol, tobacco, or taking any drugs?	YES NO
Is there any history of twins or triplets in either of your family?	YES NO
Are you concerned about any other problem your baby might have?	YES NO

Other: _____

_____ _____
Patient Name Date