Pacific Gynecology Specialists, PC

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Authorization to Leave Personal Health Information by Alternate Means

Patient Identification

Name ____
First Middle Last

Date of Birth ________________________
Month/Date/Year

Authorization

I hereby authorize Pacific Gynecology Specialists to leave detailed, personal health information by the following means: (please complete all that apply)

- ☐ Voicemail message on my home phone number ______________________ (Area code and phone number)
- ☐ Voicemail message on my work phone number ______________________ (Area code and phone number)
- ☐ Voicemail message on my cellular phone ______________________ (Area code and phone number)
- ☐ Voicemail message at a different location ______________________ (Area code and phone number)
- ☐ Verbal message with my spouse/SO _____________ (Name) ____________________ (Area code and phone number)
- ☐ Verbal message with other family member _____________ (Name) ____________________ (Area code and phone number)
- ☐ **Preferred Pharmacy**____________________ (Name) _____________ (Location) ____________________ (Area code and phone number)

With my signature below, I acknowledge and understand that this information will be kept in my medical records and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more of the telephone numbers and/or contacts listed above.

____

Signature of Patient or Legally Authorized Signature **Date Signed**

Pacific Gynecology Specialists, PC

PLEASE PRINT CLEARLY AND ANSWER COMPLETELY DOCTOR:

PATIENT INFORMATION

NAME (First) ________________________ (M.I.) ______(Last) _____________________________Email:________________________

STREET ADDRESS___________________________________ CITY/STATE/ ZIP____

HOME PHONE______________________________________ SOCIAL SECURITY NO.____________________________________

DATE OF BIRTH______________________ AGE____________ PRIMARY CARE PHYSICIAN_____________________________

REFERRING PHYSICIAN________________________________ PHONE NUMBER_______________________________________

EMERGENCY CONTACT (NAME AND PH #) ____

PATIENT'S EMPLOYER_________________________________ OCCUPATION____

EMPLOYER'S ADDRESS ________________________________ WORK PHONE____

SPOUSE/PARTNER INFORMATION

NAME ____ DATE OF BIRTH ______________________________________

EMPLOYER ____________________________________ OCCUPATION ____

SOCIAL SECURITY NO. ___________________________ WORK PHONE ____

PERSON RESPONSIBLE FOR BILL IF NOT PATIENT

PATIENT'S RELATIONSHIP TO RESPOSIBLE PARTY

NAME____ □ SPOUSE □CHILD □DEPENDENT

ADDRESS______________________________________ CITY/STATE/ZIP ______________________________________

HOME PHONE __________________________________ DATE OF BIRTH ______________________________________

SOCIAL SECURITY_______________________________

EMPLOYER_____________________________________ OCCUPATION ____

EMPLOYER'S ADDRESS___________________________ WORK PHONE____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY_______________________________________ EFFECTIVE DATE ___________________________

ARE YOU THE SUBSCRIBER? □YES □NO SUBSCRIBER'S NAME ____

INSURANCE GROUP NO._________________________ POLICY NO.____

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY _____________________________________ EFFECTIVE DATE___________________________

ARE YOU THE SUBSCRIBER? □YES □NO SUBSCRIBER'S NAME ____

INSURANCE GROUP NO. _________________________ POLICY NO. ______________________________ _____________

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the physicians of Pacific Gynecology Specialists, P.C. I also authorize the release of any medical information necessary to process these clams. I understand that regardless of insurance coverage, I am responsible for my account.
The above information is complete and accurate to the best of my knowledge

____ ____

PATIENT OR GUARANTOR'S SIGNATURE DATE

Pacific Gynecology Specialists, PC
PATIENT HEALTH HISTORY PAGE 1 OF 3

PATIENT NAME: ____ DATE OF BIRTH ______________________________

HEIGHT: ____ WEIGHT: ____________________________________

What medicines are you allergic to?: ____

____

____

Current Medications you are taking (**Name** of medicine, What is the **Dose,** How **often** do you take it):

____

____

____

____

Serious Illness you have now or have had in the past- Please circle all that apply:

Anemia	Bronchitis	Depression	Hepatitis	Osteoporosis
Angina	Cancer	Glaucoma	High Cholesterol	Pneumonia
Arthritis	Cataracts	Heart Attack	High Blood Pressure	Thyroid Disease
Asthma	Colon Polyps	Heart Disease	Irritable Bowel	Tuberculosis
Blood Clots	Diabetes	Heart Murmur	Kidney Infections	Seizures

Other serious or chronic illnesses not listed above:

____

____

____

Surgeries- What **type** of surgery, **when** was the surgery, **where** did you have it done:

____

____

____

____

How many times have you been pregnant? _________________ How many live births have you had? _____________________

When was your last Pap Smear? ________________________ Was it normal? YES NO

If no, please explain: ____

Have you ever had an abnormal Pap Smear? **YES NO** **I**f yes, when? ____

Who is your internist or family doctor? Name: ____________________________________ Phone #:_______________________

Pacific Gynecology Specialists, PC
PATIENT HEALTH HISTORY PAGE 2 OF 3

How old were you when you started your period? ____

Any problems with your menstrual cycle? YES NO If yes, please explain: ______________________________________

If you have used birth control pill, how many years in total did you use them? ______________________________________

Have you had any breast problems? (Cysts, lump, etc) YES NO

If yes, please explain: ____

Do you get frequent bladder or kidney infection? YES NO

If yes, please explain: ____

Are you currently sexually active? YES NO

If yes, do you have any pain or bleeding with intercourse? YES NO

Do you, or have you had any sexually transmitted diseases? YES NO

If yes, please explain: ____

When was your last mammogram? _________________________ Was it normal? YES NO

If no, please explain: ____

When was your last colonoscopy? __________________________ Was it normal? YES NO

If no, please explain: ____

When was your last bone density test? ______________________ Was it normal? YES NO

If no, please explain: ____

Last CT scan? ___________ Where ______________ Ultrasound? _______________ Where? _________________

Last EKG? _______________ Where? _____________ Chest X-Ray? _____________ Where? _________________

Do you leak urine or stool? YES NO If yes, please explain: ____

Do you wear glasses or contact lenses? YES NO If yes, which do you wear? _____________________________

Do you have dentures? YES NO If yes, upper / lower / partial / full ? ______________________________________

Do you wear hearing aids ? YES NO If yes, left ear / right ear / both ears ? _________________________________

Are you on medicine for diabetes? YES NO Are you on any blood thinners? YES NO

Do you have any history of heart problems? YES NO If yes, please explain:______________________

Pacific Gynecology Specialists, PC
PATIENT HEALTH HISTORY PAGE 3 OF 3

Do you smoke? YES NO How long have you smoked? _______________ How much do you smoke? _______________

Do you consume alcohol? YES NO If yes, please explain (type, quantity, frequency): ____________________________
____

Do you exercise? YES NO If yes, please explain (type, frequency): ____
____

FAMILY HISTORY of cancer:

Mom's side of the family? YES NO If yes, please list who and what type of cancer: ______________________________
____
____

Dad's side of the family? YES NO If yes, please list who and what type of cancer:______________________________
____
____

Additional FAMILY HISTORY:

Any heart disease? YES NO If yes, please explain: ____
____

Any Diabetes? YES NO If yes, please explain: ____
____

Any Osteoporosis? YES NO If yes, please explain: ____
____

Any Alzheimer's Disease or Dementia? YES NO If yes, please explain: ______________________________________
____

Any Thyroid Disease? YES NO If yes, please explain: ____
____

Do you have any religious beliefs that may affect surgery should you require it? (example: Jehovah Witness) YES NO
If yes, please explain: ____
____

Patient Signature: ____ Date: _______________

Pacific Gynecology Specialists, PC

DISCLOSURE/AGREEMENT

Date: ________________

Patient's Name: ____

Reason for today's visit:

- ☐ Routine Preventive Exam (I have no medical complaint or significant problem/abnormality of which I am aware).
- ☐ Routine Exam for Reproductive Assessment
- ☐ I have a problem/complaint that I wish evaluated/treated by the doctor

My chief complaint is: ____

____

Please check one:

- ☐ My insurance plan covers Preventive Medicine Services.
- ☐ My insurance plan doesn't cover Preventive Medicine Services.
- ☐ I don't know if my insurance plan covers Preventive Medicine Services.

I recognize that I am responsible for providing my insurance coverage information to Pacific Gynecology at the time of service. If I do not have this information with me, I recognize it is my responsibility to provide a Billing Representative with the information within 5 business days from the time of service.

I agree to pay for any and all medical services I receive from the doctors/providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf. However, if my insurance company denies payment for any reason (e.g. non-covered services, insurance does not pay preventive medicine visits, my failure to secure a referral from my primary care physician), I will pay for it upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.

I further agree and understand that this office can only code and file claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

____ _______________

Signature of Patient or Responsible Party **Date**

Pacific Gynecology Specialists, PC

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my medical providers *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my medical provider has the right to the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is use or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ________________________________ Date:_____________________

Signature: ____________________________________

For Office Use Only:
We were unable to obtain patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

□ The patient refused to sign
□ Communication barriers
□ Emergency situation
□ Other

Pacific Gynecology Specialists, PC

Insurance and Financial Information for All Patients

Health Insurance

You may be wondering how much your treatment at Pacific Gynecology Specialists will cost and how much of that cost will be paid by your health insurance. This will vary, depending on the type of coverage you have and whether or not your insurance company has a contract with Pacific Gynecology Specialists.
For example:

- If your health insurance company has a contract with Pacific Gynecology Specialists such as Regence Blue Shield or Premera Blue Cross does, you will generally only pay co-pays for doctor's visit and prescriptions.
- If your health insurance company does not have a contract with Pacific Gynecology Specialists, then your insurance will pay a percentage of what it considers reasonable charges for each doctor's appointment, test and procedure. You will be responsible for the remaining balance.
- If you belong to an HMO, such as Group Health, your insurance may not pay for care at Pacific Gynecology Specialists, unless an HMO doctor gives you a referral for a treatment or a procedure that is not available at that HMO. You must have the written referral with you on your appointment day in order for Pacific Gynecology Specialists to see you.
- If you have no health insurance coverage, you will need to make plans in advance to handle your bill. A Patient Financial Service Representative will give you an estimate of the total cost of your treatment, and then work out a payment plan for you.
- If you have questions about paying for your treatment, call (206) 965-1708 and a Patient Financial Service Representative will help ensure that financial arrangements are settled prior to your arrival at Pacific Gynecology Specialists. The staff will work with you and your insurance company to obtain the highest possible benefits for your care.

Working with Financial Services

If you have health insurance, Patient Financial Services will contact your insurance carrier(s) prior to your first appointment to verify your coverage. We will also obtain any necessary pre-authorizations or pre-certifications. Although we are happy to assist you, it is your responsibility to obtain a referral from your primary care provider if you are enrolled in a managed care or HMO plan.

Please make sure that you provide us with the following information:

- Your name, address and telephone number(s)
- The name(s) and phone numbers of your insurance carrier(s), as well as your group number, policy number and the subscriber's name
- Copies of your insurance card(s) front and back and/ or medical assistance card.

Self–Pay Patients

If you do not have insurance coverage our Patient Financial Service Representative will give you an estimate of the anticipated cost of your treatment, including facility and physician charges.

A deposit, equal to the full amount of the estimate, must be paid to or immediately upon your arrival. Please be aware that our estimate/deposit may vary from the actual charges due to a number of factors. You are responsible for all charges incurred throughout your treatment. If the actual charges exceed your initial deposit, we may request additional deposits as needed. If, after your accounts have been paid in full, there are funds remaining from your deposit, we will provide a refund.

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Billing information

Pacific Gynecology Specialists will bill your primary and secondary insurance on your behalf for both facility (if done here at Pacific Gynecology Specialist) and professional services. We will work directly with your insurance company to obtain full benefits and to respond to requests for additional medical information. Most health insurance plans do not cover the full amount of facility and physician charges. You will be required to pay and co-payments, deductibles, coinsurance or non-covered charges.

Payment options

For your convenience, we accept the following methods of payment for co-pays and account balances

:

- Visa
- MasterCard
- Electronic wire transfer of funds
- Irrevocable letter of credit
- Cashier's check
- Personal checks

For billing questions or concerns, please call our Financial Service Representative at (206) 965-1708.

Signature: ____

Date: ____