



Account # _____

Request for Confidential Communication of Protected Health Information

Patient Information:

Legal Name: _____ Preferred Name: _____ DOB: _____

Mailing Address: _____

City/State/Zip: _____

Race	Ethnicity
<input type="checkbox"/> White	<input type="checkbox"/> Hispanic/Latino
<input type="checkbox"/> Asian	<input type="checkbox"/> Not Hispanic/Latino
<input type="checkbox"/> Other	<input type="checkbox"/> Declined
<input type="checkbox"/> Black/African American	
<input type="checkbox"/> American Indian/Alaskan Native	
<input type="checkbox"/> Native Hawaiian/Pacific Islander	
<input type="checkbox"/> Declined	

SSN: _____ Primary Number

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Email: _____

Billing Information (if different than above):

Name: _____ Relationship to Patient: _____

Mailing Address: _____

City/State/Zip: _____

If we are contacted by someone that you know personally (example: parent, spouse, friend), may we release information to them? (Please select only one option)

- No, I prefer no information is released.
- Yes, information can be given to the alternate contact below:

Name: _____

Relationship: _____ Phone: _____

Information to be released to alternate contact (please check any that apply):

- Medical information (including but not limited to information about STDS, pregnancy, and birth control)
- Appointment dates/times
- Financial information about my account
- Other (please specify): _____

Emergency Contact (Please select only one option):

- Please use the alternate contact person above as my emergency contact.
- The following person may be contacted in case of an emergency:

Name: _____

Relationship to Patient: _____ Phone: _____

I understand this authorization will remain in effect until I revoke or change it. I may do this at any time by contacting OB GYN Associates in writing.

Patient Signature: _____ Date: _____

Office use only:

- ____ Employee Initials
- PBM Consent
 - Photo
 - Changes updated in GW
 - Portal Invite
 - Copy Flag



OB GYN Associates
2769 Heartland Drive, Suite 201
Coralville, IA 52241

Account #: _____

Patient Acknowledgement and Consent

Welcome to OB GYN Associates of Iowa City and Coralville! We are committed to providing you with the best possible health care. The following information is provided to ensure you are aware and understand our policies.

Patient Liability We encourage you to become familiar with your health insurance plan. Each carrier has specific guidelines regarding coverage and benefits. It is **your** responsibility to understand the guidelines set by your insurance carrier. If you have benefit or coverage questions, please contact your insurance company directly. As a courtesy to our patients, we verify benefits for certain procedures. **A quote of benefits is not a guarantee of benefits or payment.** Your claim will process according to your plan. If a discrepancy exists between the benefits quoted and final payment of the claim, the terms of your insurance plan will override. We recommend you also contact your insurance carrier to check benefits.

Insurance Information We require complete and accurate insurance information in order to bill your insurance. If accurate information is not given to OB GYN Associates, the patient will be responsible for any balance. In accordance with your insurance contract, payment is required at time of service.

Appointment No-Show/Cancellation When cancelling an appointment, we require advance notice of 24-hours. If the appointment is not cancelled 24-hours in advance or you do not show up for a scheduled appointment, after **three late cancels or no-shows**, you will be charged a \$25.00 no-show/late cancellation fee. This fee is not billable to your insurance and you will be responsible for the balance due. We reserve the right to discharge patients from OB GYN Associates for habitual abuse of this policy.

Returned Checks The charge for a returned check is \$25.00. This charge is not billable to your insurance and you will be responsible for the balance due.

Minors A parent or legal guardian must sign the Patient Acknowledgement and Consent form. The parent or legal guardian that accompanies the minor patient to the clinic will be responsible for any payment as outlined above. It is the responsibility of the parent or legal guardian to forward any bills to other responsible parties.

Self-Pay Patients (No Insurance) Payment is due in full prior to services being rendered. If you are unable to pay at the time of your visit, your appointment will be cancelled and rescheduled at a time when payment can be made.

Collections If we have not received a payment on your account after sending 3 statements and no effort is made to make alternative payment arrangements with OB GYN Associates, your account may be turned over to an outside collections agency. This balance must be paid in full in order to continue your care with OB GYN Associates.

I hereby authorize OB GYN Associates to release necessary medical information to my insurance carrier to process all claims and hereby assign to OB GYN Associates all payments for medical services rendered. I understand I am responsible for all amounts not covered by insurance. I further understand that copays and coinsurance are due at the time of service.

I have been offered a copy of the Notice of the Privacy Practices of OB GYN Associates. OB GYN Associates reserves the right to modify the privacy practices outlined in the Notice of Privacy Practices.

I understand OB GYN Associates uses electronic prescribing. My prescriptions will be sent and my medication information may be obtained through OB GYN Associates electronic prescribing functionality.

I understand OB GYN Associates will report any vaccines administered throughout my care to IRIS (Immunization Registry Information System).

Patient Signature: _____ Date: _____
(Legal Guardian/Patient Representative - required if patient is minor or adult unable to sign)

Relationship to Patient: _____

OB GYN Associates

Patient Health History

Office Use Only:

Ht _____ Wt _____
 BP _____ Pulse _____

Today's Date _____ Preferred Pharmacy _____
 Name _____ Date of Birth _____ Age _____
 Employer _____ Referred By _____ Marital Status _____
 Reason for Visit _____ Partner's Name _____

CURRENT MEDICATIONS (Prescription & over the counter, i.e.. vitamins, etc.) _____ _____ _____	MEDICATION ALLERGIES or NONE _____ _____ _____	VACCINES <input type="checkbox"/> HPV <input type="checkbox"/> Tetanus <input type="checkbox"/> Flu <input type="checkbox"/> MMR EXERCISE <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Days/week
---	--	---

MENSTRUAL HISTORY: 1st Day of Last Period _____ Postmenopausal Hysterectomy
 # of days between periods _____ Length of period _____

PREGNANCY HISTORY					
# of pregnancies	# of full term births	# of premature births	# of miscarriages	# of induced abortions	# of living children

BELOW DETAILS NOT NEEDED IF NO FUTURE PREGNANCIES ARE PLANNED								
Born M/D/Y	# of wks pregnant	Hrs in labor	Birth weight	Baby's sex	Type of Delivery	Pain medication	Complications	Baby's Name

GYN HISTORY

Birth Control Method _____

Are you satisfied with your birth control? Yes No

Date of last pap smear _____

Have you ever had an abnormal pap? Yes No
 When? _____

Have you ever had a colposcopy or LEEP? Yes No

Have you ever had an STD or PID? Yes No
 Which STD? _____ When? _____

Are you sexually active? Yes No

Do you have pain with intercourse? Yes No

Do you have any urinary problems? Yes No

Do you have any breast problems? Yes No

Do you have problems with vaginal discharge? Yes No

Have you had:

A mammogram? Yes No When? _____

A bone density scan? Yes No When? _____

A colonoscopy? Yes No When? _____

Your cholesterol checked? Yes No When? _____

PERSONAL MEDICAL HISTORY

No known medical history

High blood pressure

High cholesterol

Heart disease or murmur

Blood clot/Pulm. Embolus

Stroke

Diabetes (what type?) _____

Thyroid problems

Cancer (what type?) _____

Depression/Anxiety

Osteoporosis

Asthma

Migraine

Other _____

SUBSTANCE USE

Alcohol Y N
 Amt _____/week

Tobacco

Current every day
 Current some days
 Never
 Former
 Quit Date: _____

Street Drugs Y N

Month/Year	Surgery	Complications

FAMILY MEDICAL HISTORY

Please indicate which Relative (M, F, S, B, GMA, GPA, etc.)

No known medical history _____

High blood pressure _____

Heart disease or murmur _____

Blood clot/Pulm. Embolus _____

Stroke _____

Diabetes _____

Cancer (what type?) _____

Other _____

To the best of my knowledge, I have answered every question accurately and completely. I will inform my physician of any change in my health history.

Patient/Guardian Signature

Date

FOR OFFICE USE ONLY

Labs	Screening	Dx
Lipid	<input type="checkbox"/>	_____
TSH	<input type="checkbox"/>	_____
Free T4	<input type="checkbox"/>	_____
FSH	<input type="checkbox"/>	_____
Glucose	<input type="checkbox"/>	_____
CBC	<input type="checkbox"/>	_____
CBC w diff	<input type="checkbox"/>	_____
CMP	<input type="checkbox"/>	_____
BMP	<input type="checkbox"/>	_____
Hct	<input type="checkbox"/>	_____
Hgb	<input type="checkbox"/>	_____
PRL	<input type="checkbox"/>	_____
Prog	<input type="checkbox"/>	_____
Quant HCG	<input type="checkbox"/>	_____
A1C	<input type="checkbox"/>	_____
Blood STD	<input type="checkbox"/>	_____

Radiology	Screening	Dx
Mammo	<input type="checkbox"/>	_____
Dexa	<input type="checkbox"/>	_____
Colonoscopy	<input type="checkbox"/>	_____
TVUS	<input type="checkbox"/>	_____
Breast U/S	<input type="checkbox"/>	_____

Pap	Screening	Dx
Pap	<input type="checkbox"/>	_____
HPV	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Reflex	_____
GC/Chlam	<input type="checkbox"/>	_____
Trich	<input type="checkbox"/>	_____

Biopsy	Screening	Dx
Endometrial	<input type="checkbox"/>	_____
Cervix	<input type="checkbox"/>	_____
Vulvar	<input type="checkbox"/>	_____

Injection
<input type="checkbox"/> DMPA
<input type="checkbox"/> Tdap
<input type="checkbox"/> Flu
<input type="checkbox"/> Gardasil

Misc
<input type="checkbox"/> UPT
<input type="checkbox"/> Hemocult
<input type="checkbox"/> Wet Prep
<input type="checkbox"/> KOH

Cultures
<input type="checkbox"/> Urine
<input type="checkbox"/> Yeast
<input type="checkbox"/> HSV

New Rx: _____ Pharmacy: _____