Memphis Obstetrics & Gynecological Association, P.C.

Patient Information Sheet MRN#: _____

Last Name:	Date: _____
First Name:	**Emergency Contact**
Preferred Name:	Name:
Middle Name:	Relationship:
Former Last Name:	Home Phone:
Sex: **Date of Birth:**	Mobile Phone:
Social Security #:	**Employment**
Address:	Employer:
Address line2:	Employer Phone:
Zip:	Occupation:
City: **State:**	Industry:
Home Phone:	**Guarantor (**one to whom statements are sent**)**
Cell Phone:	Patient's relationship to guarantor:
Consent to text: □ **Yes** □ **No**	Last name:
Work Phone:	First Name:
Patient Email:	Middle Name:
Contact Preference: □**Home** □**Work** □**Mobile** □**Mail** □**Portal**	Date of birth:
Ethnicity: □Non Hispanic or Latino □Hispanic or Latino □Other _____	**Mailing Address** □ Same as patient's address
Preferred Language:	Address:
Race: □American Indian □Asian □Asian Indian	Address line 2:
□Black/African American □European □Filipino □Japanese □Korean	Zip:
Native Hawaiian or Other Pacific Islander □White	City:
Marital Status: □Single □Married □Widowed □Divorced □Separated	State:
How did you hear about us?	Phone:

PRIMARY INSURANCE				
Insurance Name	**Mail to address:**	**City**	**State**	**Zip**
Patient's relationship to policy holder:				
Member/Subscriber id#	Policy/Group #			
Policy holder's name:		DOB:	Sex:	
Policy holder's address:		City:	State:	
Policy holder's Employer:				
SECONDARY INSURANCE				
Insurance Name	**Mail to address:**	**City**	**State**	**Zip**
Patient's relationship to policy holder:				
Member/Subscriber id#	Policy/Group #			
Policy holder's name:		DOB:	Sex:	
Policy holder's address:		City:	State:	
Policy holder's Employer:				

AUTHORIZATION— I certify that I have provided all insurance information to the practice. I understand it is my responsibility to notify the practice of any insurance changes. A photocopy of this statement is considered to be as valid as an original.

Signed: _____ Date: _____

Memphis Obstetrics & Gynecological Association, P.C.

Prenatal History

Name:_____	Last Menstrual Period: _____
Physician: _____	Allergies:_____
Newborn MD:_____	Current Medications:_____
Transfer OB patient? _____	Preferred Hospital for Delivery:_____

Information for Father of baby

Father of baby: DOB:	What Insurance will your baby be covered under?
Phone/ Cell # S.S #	If baby is a Boy, do you want him **circumcised**?
Father of baby **Insurance**:	
Policy # Group #	
Insurance address: Ins Phone #	

GENETICS SCREENING and INFECTION HISTORY

	Yes	No		Yes	No
Will you be 35 years or older at time of delivery			Recurrent Pregnancy Loss (>3), or a Stillbirth		
Thalassemia (Italian, Greek, Mediterranean, or Asian)			Medications (including Supplements, Vitamins, Herbs, OTC drugs)		
Neural Tube Defect (meningomyelocele, Spina Bifida or Anencephaly)			Illicit/Recreational Drugs or Alcohol		
Congenital Heart Defect			If yes, agents & strength/dose		
Downs Syndrome/ Other inherited genetic/ chromosomal disorder			Lives with someone with TB or exposed to TB		
Tay-Sachs (Jewish, Cajun, French Canadian)			Patient or partner has history of Genital Herpes (HSV)		
Sickle Cell Disease or Trait			Rash or Viral illness since last menstrual period		
Hemophilia			Positive Group B Strep with previous pregnancy		
Muscular Dystrophy			History of STD, GC, Chlamydia, HPV , Syphilis		
Cystic Fibrosis			History of HIV		
Huntington's Chorea			History of Hepatitis		
Intellectual Disability/Autism			Other Infection History		
If yes was fragile X tested?			History of Chicken Pox or vaccine- W**hich one?**		
Other Inherited Genetic or Chromosomal Disorder			Hemoglobinopathy or Carrier		
Maternal Metabolic Disorder (e.g. Type 1 Diabetes, PKU)			Other Structural Birth Defect		
Patient or baby's father had a child with birth defect not listed			Recent travel history outside of country?		

PAST PREGNANCY HISTORY

Date	Weeks Delivered	Births Weight	Sex	Type of Delivery & Anesthesia	Preterm Labor or Other Complications

Although we are advocates of natural labor and will support you if this is your plan, we are not proponents of "The Bradley Method." We believe very strongly in doing what is in the best interest of both mother & baby, and therefore cannot adhere to the unusual expectations set forth by Bradley courses you may have attended.

The American College of Obstetrics and Gynecology (ACOG) and the State of Tennessee recommend Screening HIV (AIDS) testing be performed on all pregnant women as part of their prenatal lab work, as treatment is now available to newborns with the HIV virus. This testing is performed in the beginning of your pregnancy, and during the third trimester. It is our policy to follow these guidelines.

The physicians of each division of Memphis Obstetrics & Gynecological Association appreciate you entrusting them with your medical care and hope to make your pregnancy experience as comfortable and convenient as possible.

FINANCIAL & ADMINISTRATIVE POLICIES

Consent to Treat

- I hereby give my permission to Memphis Obstetrics & Gynecological Association, P.C.(MOGA) and the divisions' thereof for medical treatment including but not limited to examination, injections, blood tests, diagnostic testing, or medical procedures deemed necessary and appropriate for diagnosis and treatment.

DISCLOSURE OF INSURANCE COVERAGE: COMMERCIAL / TENNCARE / MEDICAID

- I certify that I have provided ALL INSURANCE INFORMATION to the practice & it is my responsibility to notify the practice of any changes.

PATIENT PAYMENT POLICY AND COVERED SERVICES

- I understand that I am responsible for all charges associated with my care. It is the policy of MOGA to collect all patient balances, co-pays, and deposits due from patients at the time of service.
- Health insurance plans **may not** provide coverage for all medical services, tests, and/or procedures that our providers may offer or recommend for treatment. It is my responsibility to know and understand the services covered by my insurance, and if insurance does not cover these services, I will be responsible for payment.
- I authorize MOGA to release any information concerning my treatment and irrevocably assigned to them all insurance benefits for my care.
- Our office may contact your insurance carrier to verify your insurance coverage and benefits. An **estimate** of your financial responsibility will be determined according to the contractual agreement between MOGA and your insurance company. Our Benefits Coordinators may review your benefits with you to explain your financial obligations, and you may be required to pay a deposit prior to services being rendered.
- If an insurance claim is denied due to incorrect personal information or incorrect insurance information that you have provided, you will be billed for any unpaid claims for services, and payment in full will be due immediately.
- If your account or any account for which you are responsible is sent to a collection agency due to non-payment of any patient balance, you may be dismissed from the practice and denied future care and services by all providers within MOGA. Additionally, a collection fee of up to 40% will be added to your account balance. I understand I am responsible for the collection fees and/or attorney fees incurred in the collection of this account.
- You are responsible for knowing which hospital your insurance carrier allows you to utilize for procedures, tests, and admissions.
- If you do not have medical coverage with an insurance for which MOGA participates or if you are a new patient and cannot supply a valid insurance card or for which coverage cannot be determined, you must pay in full at the time of service.
- Certain labs collected in this office may be sent to an outside lab for testing. As such, you may be billed by the reference lab.
- If you are required to have a referral or other prior authorization for medical services, it is your responsibility to obtain this.
- We will require that accounts with self-pay balances to pay their balances to zero ($0) prior to receiving further services by our practice.

RETURNED CHECK CHARGE

- MOGA will charge the patient account $25.00 for any returned checks to cover MOGA's cost for any related bank charges.

CANCELLATION POLICY

- MOGA requires a 24 hour cancellation notice for any scheduled medical appointment or surgery/procedure.
- No shows and cancellations without a 24-hour notice may receive a $20.00 charge for missed office visits and $150.00 for missed surgeries or procedures. This charge will be the patient's responsibility and will not be billed to or reimbursed by your insurance.
- If a patient repeatedly misses or cancels appointments, the patient may be dismissed from the practice.

WELLNESS/ANNUAL VISITS WITH OTHER PROBLEMS

- If during your annual/well-woman preventive care exam, you have or need treatment for a problem, if the problem is addressed during the visit in lieu of scheduling a separate appointment, in addition to the preventive exam it may be necessary that a problem/E&M visit be billed along with other labs, testing, and/or procedures, which may be subject to copays and/or deductible.

PERSONAL INFORMATION VERIFICATION

- It is our policy to verify your demographic and insurance information **at every visit** to help insure that claims are processed timely and accurately. Although it may seem unnecessary at the time, this is extremely important to our billing process. Please bring your insurance card with you **EVERY VISIT**. Additionally, a photo ID will be requested from all patients.

FORMS AND PAPERWORK

- There is a minimum fee of $20.00 for the release of medical records which is the responsibility of the patient to pay prior to receiving the records. For records that exceed twenty (20) pages, there may be an additional charge of $0.50 per page for all pages exceeding the first twenty (20) pages.
- A $25.00 fee will be charged to complete FMLA and standard disability forms. An additional fee of $25.00 will be charged for submitting subsequent forms.

Practice Guidelines

- Routine medication refills are handled during office hours only. We do not refill any prescriptions (including narcotics) after hours or on weekends. When calling for prescriptions, please have your pharmacy phone number available.
- If you have a question for the nurse or your provider, we will return your call as soon as possible, giving priority to emergencies and scheduled patients in the office. At the time of your call, please let us know if you will be unavailable at a certain time.
- Physician excuses for days missed from work or school are written only for the days you are seen in our office and additional days needed for recovery. We are unable to write excuses for illnesses not evaluated in our office. We also do not backdates excuses.

A photocopy of this statement is considered to be as valid as the original.

Patient Signature _____ Date: _____

HIPAA Privacy and Release of Information Authorization

I, _____ hereby authorize Memphis Obstetrics & Gynecological Association, P.C. and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to the practice. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority and the right to exchange immunization data with my state immunization registry.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____ _____

Patient Printed Name Date

_____

Patient Signature

Memphis Obstetrics & Gynecological Association, P.C.

Privacy Management - Protected Health Information & Communications

Protected Health Information:

I hereby authorize release of my protected health information (PHI), including account status, test results, scheduled appointments, and information regarding my treatment, to persons I have listed below. Any person who is not listed will not be able to obtain protected health information. It is not necessary to list other treating physicians or insurance companies. This authorization will remain in effect until revoked by the patient.

Name of authorized person	Relationship	Phone number
1.		
2.		
3.		
4.		
5.		

Patient Communications /Automated Messages:

Our practice utilizes an electronic medical records system with an integrated Patient Portal which allows patients, providers & practice staff to communicate more securely and efficiently.

Please indicate your automated messaging preference(s), one you will be sure to see, for each of the following items:

Health Notifications: When Lab results and health reminders are available on the Patient Portal you will be notified via the method you choose. Which notification method do you prefer?

□ Email □ Phone □ Text message

Appointment Reminders: Reminders about scheduled appointments and/or appointments needing to be scheduled.

□ Email □ Phone □ Text message

Announcements: Notifies you of an appointment cancellation/reschedule, office closure or delayed opening and other important office announcements.

□ Email □ Phone □ Text message

Billing: Notification of new Billing Statements & outstanding balances. Statements and outstanding balances can be viewed and paid on the Patient Portal at any time.

□ Email □ Phone □ Text message

These notification preferences only apply to **automated messages** from our office. Our office may still contact you via phone if an urgent matter requires your attention.

Patient Signature: _____ Date: _____

Printed Name: _____

Memphis Obstetrics & Gynecological Association, P.C. (MOGA/MCW/WPG/WHS)

CONFIDENTIAL PATIENT MEDICAL HISTORY

Name:_____ Birthdate:_____

Allergies: _____

Do you have a **LATEX Sensitivity / Allergy**: Yes: □ No: □ **Other Allergies** (circle): Iodine, X-ray dye, Eggs, Peanuts

MEDICATIONS: Please list ALL medications that you take, the strength, and how often you take them

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PHARMACY (Name and Number): _____

OTHER HEALTH CARE PROVIDERS YOU CURRENTLY SEE (other than MOGA)

Provider Name	**Specialty (ie: PCP, Cardio)**	**Phone Number:**

IMMUNIZATIONS: Please check if you have received these adult immunizations and indicate when

□ Influenza (Flu) / Date:	□ Tetanus / Date:
□ Pneumonia / Date:	□ Tdap (Tetanus, Diptheria & Pertussis)/ Date:
□ HPV Vaccine/Gardasil (Series of 3 shots – Initial shot, 2 months later, then 6 months from 1st shot) Dates (Approx. date is ok): #1 _____ #2 _____ #3 _____	

FAMILY HISTORY: Check illnesses of your **IMMEDIATE BLOOD RELATIVES** and **LIST THE RELATION**

□ Adopted: Family history unknown	□ Hypertension/ High blood pressure / relation:	
□ Blood clotting disorder / relation:	Malignant neoplastic disease/Cancer: (please list relative)	
□ Cerebrovascular accident (CVA) / Stroke	□ Breast: _____	□ Uterine: _____
□ Cystic fibrosis / relation:	□ Colon: _____	□ Other: _____
□ Diabetes /relation:	□ Ovarian: _____	
□ Disorder of thyroid/ relation:	□ Myocardial Infarction (heart attack)	
□ Heart disease / relation:	□ Substance abuse:	
□ Hypercholesterolemia / relation:	□ Other Family History:	

SOCIAL HISTORY: Provide the following information about **YOURSELF**

Tobacco or Cigarette Use: □ Never Smoked □ Former Smoker - Date Quit _____ □ Current Smoker - # per day ____ # of years_____	Do you use recreational drugs? □ Yes □No If yes, which one(s) and how often? _____
Relationship Status: □ Single □ Married □ Widowed □ Divorced □ Separated	Sexual Orientation: □ Heterosexual □ Homosexual □ Bisexual
Lives □ alone or □ with others	Are you currently in a situation or relationship that makes you feel unsafe or threatened? □Yes □No
Education (highest grade completed): _____	If yes, explain _____
Occupation: _____	Do you refuse blood products or medical treatment of Any kind because of religious beliefs? □ Yes □ No
Work Status: □Part-time □Full-time □Retired □Unemployed □Disabled	Explain:_____
Do you drink alcoholic beverages? □ Yes □ No	Do you have an advanced directive: □ Yes □ No
If yes, how much? _____	Other: _____

Memphis Obstetrics & Gynecological Association, P.C. (MOGA/MCW/WPG/WHS)

CONFIDENTIAL PATIENT MEDICAL HISTORY

Name:_____ Birthdate:_____

SURGICAL HISTORY: Please list surgeries or procedures and **provide dates (**month and/or year is fine**)**

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

GYN History:

Birth control method: _____	□ Infertility
Are you sexually active? □ Yes □ No	□ Polycystic Ovarian Syndrome
If no, have you ever been sexually active? □ Yes □ No	Age of Menopause _____
Age of first sexual activity: _____	Postmenopausal Bleeding? □ Yes □ No
Number of sexual partners in lifetime: _____	Taking hormone replacement therapy? □ Yes □ No
Menses: (**only complete if still having periods**)	Have you ever had any of the following infections?
Age of first period _____	□ Chlamydia □ Gonorrhea □ Herpes □ HIV □ Syphilis
□ Regular (21-35 days apart) □ Irregular	Abnormal Pap Smear: □ Yes - date: _____ □ No
Duration of menses: _____ days	□ Colposcopy/Biopsy of cervix Date: _____
Menstrual Flow: □Mild □Moderate □Severe	□ Cryo/Date:_____
	□ LEEP/Date: _____ □ CKC/Date: _____

Last **Pap Smear**: Date:_____ Provider: _____
Last **Mammogram**: Date: _____ Facility: _____
Last **Complete Physical Exam with Primary MD**: Date: _____ Provider Name: _____
Last **DEXA Scan** (**Bone Density**): Date: _____ Facility: _____
Last **Colonoscopy**: Date: _____ Provider Name: _____

OB History: (Please list details of each pregnancy below)

Total Pregnancies: ____ Full term: ___ Preterm: ___ Elective abortions: ___ Miscarriages: ___ Ectopics: ____ Multiple births ____ Living ____

Date	Weeks Delivered	Birth wt	Sex	Type of Delivery & Anesthesia	Preterm Labor or Other Complications

PAST MEDICAL HISTORY: Please check illnesses or conditions **YOU** have had.

□ Autoimmune Disorder	**Heart Disease**:
Blood disorders: □ Anemia	□Atrial Fibrillation □Congestive Heart Failure □CAD
□ DVT (Blood Clot in leg) □ PE (clot in lung)	□High Cholesterol □High Blood Pressure (HTN)
□ Blood Transfusion: Date(s): _____	**Kidney Disease:** □ Kidney Stones □ Other_____
Sickle Cell : □ Trait □ Disease	**Lung Disease**: □Asthma □COPD □Pneumonia
□ Breast Problems (specify) _____	Do you use a CPAP machine for sleep apnea? □ Yes
Cancer: □Breast □Ovarian □Uterine □Colon	**Musculoskeletal**:
□ Other Cancer(specify) _____	Arthritis: □ Osteoarthritis □ Rheumatoid Arthritis
□ Diabetes □ Gestational diabetes (in pregnancy)	□ Osteopenia □ Osteoporosis □ Other _____
□ Eating Disorder	**Neurological**: □ Migraine Headaches
Gastrointestinal Disorders:	□ Seizure Disorder/Epilepsy □ Stroke
□ Acid Reflux/ GERD □ Celiac Disease □ Cirrhosis	**Psychological:** □Anxiety □Bipolar □Depression □ADD
□ Crohn's Disease □ Diverticulitis □ Hepatitis/Liver Disease	**Thyroid Disorder**: □Goiter □Underactive □Overactive
□ Irritable Bowel □ Ulcerative Colitis	**Varicella**/Chicken Pox: □ Had Virus **or** □ Had Vaccine
□ Other (specify): _____	

Patient Signature: _____ Date:_____

MEMPHIS OBSTETRICS & GYNECOLOGICAL ASSOCIATION, P.C.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO OBTAIN THIS INFORMATION. PLEASE REVIEW CAREFULLY. YOU HAVE THE RIGHT TO OBAIN A COPY OF THIS NOTICE UPON REQUEST.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We are permitted by law to use and disclose patient health information for treatment, payment, and healthcare operations.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other healthcare providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

Healthcare Operations. We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcome of your case and others similar to it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use and disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information about you for the following purposes:

Required by Law: We are required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent serious threat to the health and safety of you, another person, or the public.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Research: We may use or disclose information for approved medical research.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

In any other situation, we will require written authorization before using or disclosing any protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Revocation requests must be made in writing and submitted to the clinic's Privacy Officer.

You have the following rights with regard to your health information. Please contact our office to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by them.
Confidential Communications: You may ask us to communicate confidentially by, for example, sending notices to a special address or not calling with appointment reminders.
Inspect and Obtain Copies: In most cases, you have the right to look at or obtain a copy of your health information. There may be a charge for the copies.
Amend Information: If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the existing information or add the missing information. We are not required to agree to such amendment, but must let you know our reasons.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. Upon request, you may receive a copy of this notice.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You may also request a copy of our Notice at any time. For more information about our privacy practices, contact our Privacy Officer.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we have made about your records, please contact our Privacy Officer. You may also send a written complaint to the U.S. Department of Health and Human Services. The Privacy Officer will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person / Privacy Officer
If you have any questions, complaints, or requests, please contact:

Stephanie Wheeler	Ami Jennings
8110 N Brother Blvd, Ste.200	6215 Humphreys Blvd # 401
Bartlett, TN 38133	Memphis, TN 38120
(901) 202-6122 or swheeler@clearlymd.com	(901) 767-8442, ext 2020 or ajennings@mogamd.com

This Notice became effective April 14, 2003, and was revised on January 14, 2020.