Bergen County Gynecology, P.C.

PATIENT INFORMATION

LAST NAME _____FIRST NAME_____ MIDDLE _____

MAIDEN NAME (IF ANY)_____DATE OF BIRTH_____

SS# _____PLACE OF BIRTH _____

MARITAL STATUS _____RACE _____ ETHNICITY _____

PREFERRED LANGUAGE _____OTHER LANGUAGES SPOKEN_____

ADDRESS _____CITY_____ST_____ZIP_____

HOME PHONE # _____ CELL # _____

EMAIL _____OCCUPATION_____

EMPLOYER _____ WORK PHONE # _____

SIGNIFICANT OTHER'S NAME __ _____ CELL # _____

EMERGENCY CONTACT _____

EMERGENCY PHONE # _____ RELATIONSHIP TO PATIENT _____

PRIMARY CARE DOCTOR _____ PHONE # _____

REFERRING DOCTOR (IF ANY)_____PHONE #_____

***Who May We Thank For Referring You to Our Office*_____**

PHARMACY ADDRESS: _____

PHARMACY PHONE:_____

May we leave a message?
Home: YES☐ NO☐ **Cell:** YES☐ NO☐ **Work:** YES☐ NO☐ **Email:** YES☐ NO☐

PRIMARY INSURANCE INFORMATION:

POLICY HOLDER LAST NAME _____FIRST NAME _____MI ____

DATE OF BIRTH _____/_____/_____ SS# _____ PHONE # _____

RELATIONSHIP TO PATIENT_____

INSURANCE CARRIER_____POLICY ID#_____GROUP#_____

SECONDARY INSURANCE INFORMATION:

POLICY HOLDER LAST NAME _____FIRST NAME _____MI ____

DATE OF BIRTH _____/_____/_____ SS# _____ PHONE # _____

RELATIONSHIP TO PATIENT _____

INSURANCE CARRIER_____POLICY ID#_____GROUP#_____

I certify that the information I have supplied is accurate and true to the best of my knowledge. I authorize that the physician and/or employees of Bergen County Gynecology can contact me via telephone, e-mail, text, or fax, or leave me a message if they are unable to contact me directly.

Patient's Signature:_____Date:_____

Guardian's Signature:_____Date:_____

If patient under the age of 18, I give permission for my child to receive treatment from Dr. Jennifer Cho.

Name of Minor:_____

Patient/Guardian/Guarantor's Signature:_____Date:_____

Bergen County Gynecology, P.C.

PATIENT MEDICAL HISTORY FORM

Patient Name:_____

What is the reason for your visit today? _____

_____

OB HISTORY: Have you ever been pregnant? YES / NO

If YES, how many: Children _____ Miscarriages _____ Abortions_____

Premature deliveries_____ Stillbirths_____ Living Children_____ Ectopics_____

GYN HISTORY:

Last Menstrual Period (Start Date):_____

Last PAP Smear Date:_____ Last Mammogram Date:_____

GYN ISSUES	YES	NO	DON'T KNOW
Do you have normal periods **now**?			
How often do you get a period?			
How long does your period last?			
How heavy is your flow? ( ) Heavy ( ) Normal ( ) Light			
Have you had irregular periods in the past for more than 6 months?			
Do you have severe pain with your period?			
If so, how severe? ( ) Mild ( ) Moderate ( ) Severe			
Are you sexually active?			
If so, men, women, or both? ( ) Men ( ) Women ( ) Both			
Do you have pain with intercourse?			
Have you ever had a sexual transmitted infection?			
If so, which ones? ( ) Herpes ( ) Genital Warts ( ) Gonorrhea ( ) Chlamydia ( ) Trichomonas ( ) Syphilis ( ) Other:			

MEDICATIONS:

NAME OF DRUG	DOSAGE [how much]	FREQUENCY [how often]

ALLERGIES:

Medications/Food/Environment	Type Of Reaction

PAST MEDICAL HISTORY:

_____

_____

PAST SURGERIES/HOSPITALIZATIONS:

_____

_____

FAMILY HISTORY: If you do, please list relationship and age

_____

_____

SOCIAL HISTORY:

HISTORY	YES	NO
Do you smoke?		
Do you drink alcohol?		
Do you do any drugs?		
Do you exercise?		
Have you ever been abused physically or sexually?		

REVIEW OF SYSTEMS: Any other unrelated, related symptoms?

_____

_____

I have filled out this medical history form to the best of my knowledge.

Patient's Signature_____ **Date**_____

Bergen County Gynecology, P.C.

OFFICE POLICY FORMS

Patient Name: _____

APPOINTMENT POLICY NOTICE

Bergen County Gynecology is aware that life happens and that you may need to cancel your appointment. If you must cancel or reschedule your appointment, we ask that you try to notify us at least 24 hours in advance. We understand that sometimes this is not possible. If we notice that you regularly cancel or miss appointments without advanced warning, you will be charged a $25 fee.

We will try to stay on schedule as much as possible, as we respect your time. Please call ahead if you have scheduling issues, and we will try to accommodate your needs. If you are late for your appointment, every effort will be made to see you in a timely fashion. There will be times, however, when you will need to wait longer than usual, or will be offered to reschedule your appointment.

I have read the above and agree this cancellation policy.

_____ _____

Signature of Patient **Date**

CONSENT FOR GENERAL PATIENT CARE AND ASSIGNMENT OF BENEFITS

I have read the above policies and understand my responsibilities as a patient. I authorize Bergen County Gynecology, including physicians and employees, to provide medical care to me and I agree to pay all fees and charges for such services. I authorize Bergen County Gynecology to release any and all information, including protected health information, necessary to process forms for the payment of medical benefits for the services rendered. I also authorize the release of protected health information to other health care providers concerning my illness and treatments. I assign all payments for medical services rendered, to be made directly to Bergen County Gynecology. If my insurance covers an annual visit, but there is a deductible for an office visit or any issues outside of an annual visit, I agree I will be charged $150 upfront and will pay this upfront.

_____ _____

Signature of Patient **Date**

Bergen County Gynecology, P.C.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

Bergen County Gynecology, P.C. is committed to providing high quality medical care. In order to serve you best, it is important that you understand the reimbursement process. Please read this financial responsibility form and sign at the bottom to acknowledge your accountability.

INSURANCE COVERAGE

Your health plan is an arrangement between you or your employer and your insurance company. While we may participate in the plan and make every effort to verify your benefits, your plan will ultimately determine your coverage and requirements for pre-certifications, pre-authorizations, or referrals. It is your responsibility to know and understand your particular coverage and benefits. We cannot know the benefits and exclusions of every patient's policy. If your coverage is not in effect at the time of your visit, financial responsibility of payment is yours.

At each visit, please verify your current demographic and insurance information. It is imperative that we have accurate information to ensure that the appropriate claims are sent to the correct insurance carrier with the appropriate information. This does not guarantee payment. You must disclose all appropriate insurance information to include primary and secondary insurance coverage to ensure in-network participation with your plan and that claims are timely filed with the appropriate insurance carrier. A list of participating insurances can be found on our website and are available upon request. A non-covered service may be denied by your insurance due to benefit limitations, policy exclusions, or waiting periods. Any non-covered service is your responsibility and payment is due at the time of service.

PREVENTATIVE VERSUS PROBLEM VISIT EXAMINATIONS AND FINANCIAL INFORMATION ON THIRD PARTY ENTITIES INVOLVED IN YOUR CARE

A well woman exam is a preventive visit when a healthy patient comes in to undergo *screening* for various illnesses and diseases. Once a concern, symptom or complaint is voiced, this may lead to additional services exclusive of the well woman exam that must be rendered to address these issues. These additional services may be subject to deductibles, co-insurances and copays. Your insurance company will send you an Explanation of Benefits that will detail how your bill was paid by them and any amount for which you may be responsible. By law, you are responsible for these amounts as well as any non-covered services outlined in your health plan. Payment of the patient portion is due at the time of service. If it is not paid at the time of service, you will receive an invoice for your portion.

If your visit requires a specimen such as a Pap smear, bloodwork, a culture or biopsy, these specimens are sent to an outside laboratory. You may receive a separate bill from that laboratory which is separate from your office visit. If you have services performed at a hospital, you may receive additional separate bills from the hospital, anesthesia department or other healthcare providers. If you have a procedure performed in our office that requires anesthesia, these services are provided by a third party Anesthesia group. Some providers in the Anesthesia group may be out of network in some insurance plans. These services are billed separately from your in-office procedure performed by Bergen County Gynecology. Inquiries regarding billing and rates for any of these services can be directed to their particular billing departments. Some insurance companies require precertification for certain

services. We will make every effort to verify your benefits and obtain any necessary precertification prior to your appointment, but this is not a guarantee of payment.

NON-PARTICIPATING INSURANCE ACCOUNTS

The financial obligations of patients who are insured by carriers with which the practice does not participate in are considered self-pay accounts. It is your responsibility to verify with your insurance company, if the physician you are scheduled to see, is an in-network (participating provider) with your specific insurance plan. It is also your responsibility to inform us of any changes with your insurance carriers or plan. By signing this agreement, you are individually obligated to pay the full charge of all services rendered at Bergen County Gynecology, P.C. if you belong to a plan in which Bergen County Gynecology, P.C. does not participate and you consent to treatment by an out of network provider

PAYMENTS:

We accept cash, checks, or credit cards. All returned checks will be charged a **$35.00** fee. If you have a balance due for previous services, your payment will be applied to the oldest balance first. In the event that your account has a credit, we reserve the right to transfer credits to any outstanding balances prior to issuing a refund. Patient account with balance over 120 days past due, will be referred to a collection agency. Collection agency fees may be applied to your balance. If my insurance covers an annual visit, but there is a deductible that is applied for any issues outside of a routine annual visit, I agree to pay a $150 fee upfront, as the additional issues are not covered by insurance necessarily. If the insurance does pay the claim, I am aware that I am entitled to be refunded the difference from my deductible upfront fee of $150.

I INTEND TO PAY MY MEDICAL EXPENSES AS FOLLOWS: (Check one or more)

( ) Cash ( ) Check ( ) Credit Card ( ) PPO/HMO Insurance

I authorize treatment of the person named above and agree to pay all fees charged for such treatment. I agree to pay all charges for myself and members of my family shown by statements, promptly upon presentation thereof, unless prior arrangements have been made in writing prior to billing date. I agree that for the services provided to me by Bergen County Gynecology P.C., I will pay my account at the time services are rendered. If copays, deductibles and co- insurance are designated by my insurance company or health plan, I agree to pay them to Bergen County Gynecology P.C. All copays and past due balances are due and payable at the time of service.

ASSIGNMENT OF BENEFITS

I hereby authorize Bergen County Gynecology, P.C. to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such surgical or medical care. I also authorize and request my insurance company to pay directly to the above named Doctors the amount due me in my claim for basic medical, major medical and/or surgical treatment or services, by reason of such treatment or services rendered to:

Bergen County Gynecology, P.C.
106 Grand Avenue, Suite #300
Englewood, New Jersey 07631

_____ _____

Patient's name (Print) Patient's Signature

Bergen County Gynecology, P.C.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Today's Date: _____

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

The practice will use and disclose protected health information without notice for the purpose of treatment, obtaining payment, or supporting the day-to-day operations of the practice.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person (s), or business associates of this office not related to obtaining payment (insurance or other payer) or treatment (referring physician or referred physician) as described above:

Name	**Phone**	**Relationship**
_____	( ) -	_____
_____	( ) -	_____
_____	( ) -	_____
_____	( ) -	_____

Effective Date **for this authorization is the signed date and will stay in effect until office has written notice of expiration except in the case of a minor. If patient is under the age of 18 years of age at time of this authorization release the expiration is effective immediately on patient's 18th year birthday._____/_____/_____**

I understand I have the right to:

1. **Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.**
2. **Inspect a copy of Patient Health Information being used or disclosed under federal law.**
3. **Refuse to sign this authorization.**
4. **Receive a copy of this authorization.**
5. **Restrict what is disclosed with this authorization.**

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

I have received a copy of Bergen County Gynecology, P.C. Notice of Privacy Practices and understand my rights.

_____ _____

Signature of Patient or Guardian **Date**

_____

Printed Name of Patient or Guardian

Bergen County Gynecology, P.C.

NOTICE OF PRIVACY PRACTICES

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

You may contact our Privacy Officers, **Michelle Leiva, Claire Jung** at 201-608-0670 or mleiva@bcgynecology.com and cjung@bcgynecology.com for further information about the complaint process.

Bergen County Gynecology, P.C.

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

Date: _____

By signing below, the patient acknowledges that she was provided with a copy of the Bergen County Gynecology Notice of Privacy Practices for Protected Health Information and understands its terms.

_____ _____

Name of Patient (Print) Signature of Patient

If completed by a patient's personal representative, please print and sign your name in the space below.

_____ _____

Name of Personal Representative (Print) Signature of Personal Representative

_____ Relationship to Patient

For Bergen County Gynecology use only.
Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Bergen County Gynecology Notice of Privacy Practices but was unable to for the following reason:

Patient refused to sign
Patient unable to sign
Other_____

_____ _____

Employee Name Date

This form should be placed in the patient's medical record.