Monadnock OB-GYN Associates PA
Patient Registration

Patient's Name:______________________ Maiden Name:__________ Date of birth:______________

Home Phone:______________ Cell Phone:______________ Email Address: ______________________

Marital Status: S M D W Social Security Number______________________

Mailing Address:

______________________ ______________________, __________ __________

May we contact you at the above listed contact information? ________YES ________NO

Ethnicity- Hispanic or Latino______Not Hispanic or Latino______Race________Declined to disclose race__________

Primary Language________________

Name of **Patient's Employer**:________________ Name of **Spouse Employer**________________

Address________________ Address________________

Telephone__________Patient Occupation__________ Telephone________________

Name of Spouse:________________ Spouse DOB________Spouse SS#__________

Name of Person Responsible for bill (after insurance)______________________

Address________________ Relation__________Phone #__________

Referred by________________ **PCP name** (if different)______________MD

Address of PCP________________ Phone________________

Emergency Contact________________ Relationship________________

Address________________ Phone________________

Primary Medical Insurance Information

Insurance Name________________

Subscriber__________DOB__________

Group #__________Effective Date________

ID #________________

Secondary Medical Insurance Information

Insurance Name________________

Subscriber__________DOB__________

Group #__________Effective Date________

ID #________________

I hereby authorize payment directly to Monadnock OB-GYN, of the insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to obtain the necessary referrals and/or authorizations from my primary care physician and/or referring physician when required. I also authorize release of any information relating to my medical claim. My signature also allows Monadnock OB-GYN physicians and/or staff to speak with the person(s) I designate re: □medical condition, □filling, □appointments, □test results, or □to return a call to the office.

□Permission to leave messages on unattended devices (i.e. answering devices/voice mail)
□Permission to release correspondence, medical samples, prescriptions to family/friends with proper identification.

Name________________Relation________________Phone________________

Name________________Relation________________Phone________________

______________________ ______________________
Signature of patient or authorized representative Date

MONADNOCK OB GYN ASSOCIATES, PA

Chart # ______________
Chart page# ______________

PLEASE ANSWER THE FOLLOWING TO THE BEST OF YOUR ABILITY

NAME: ______________ Age: ______ DOB: ______ Today's Date ______

Primary Care Physician ______________ Referred by: ______________ Preferred Pharmacy: ______________

REASON FOR VISIT: ______________

Use back of form if additional space needed

	NONE	EXPLAIN IF ANY:
1.MEDICAL PROBLEMS PAST AND PRESENT:	☐	1. ______________
2. ALL SURGERIES (INCLUDE ANESTHESIA PROBLEMS)	NONE ☐	2. ______________
3. MEDICATIONS INCLUDE NON-PRESCRIPTION VITS. HERBS	NONE ☐	3. ______________
4. ALLERGIES TO MEDICINE OR LATEX	NONE ☐	4. ______________

MENSTRUAL HISTORY: Age of first menses ______ Interval (from day 1 of bleed to day 1 of next cycle) ______
\# of days of flow ______ Severity of cramps (1-10, 10 being worst) ______ Age at menopause ______

Do you have:	YES	NO	IF YES, EXPLAIN
Problems with periods	☐	☐	______
Bleeding since Menopause	☐	☐	______
Vaginal Itch/Discharge	☐	☐	______
Pain/Bleeding with Intercourse	☐	☐	______
Breast Lump/Nipple Discharge	☐	☐	______
Problems with Urination	☐	☐	______
Do you or your partner use Contraception	☐	☐	______
History of Herpes, HPV, Hepatitis, Syphilis Chlamydia, Gonorrhea, PID, other	☐	☐	______
Have you ever received a blood transfusion	☐	☐	______

Pap: ☐All Normal ☐Any Abnormal -if yes, explain: ______ Year of last ______
Mammogram: ☐All Normal ☐Any Abnormal -if yes, explain: ______ Year of last ______

OBSTETRICAL: *(Please provide the number of...)*

Total Pregnancies ______ Miscarriages/Terminations ______ Live Births ______ Preterm (<38 weeks) ______
Still Births (after 7 months) ______ Cesarean Sections ______ Living Children ______ Ectopic ______ (Tubal pregnancy)

FAMILY HISTORY: *(Has anyone in your family had...)*

	Yes	No	Relative
Breast Cancer	☐	☐	______
Ovarian Cancer	☐	☐	______
Uterine Cancer	☐	☐	______
Cervical Cancer	☐	☐	______
Colon Cancer	☐	☐	______
Other Cancer	☐	☐	______
Hereditary Diseases	☐	☐	______

	Yes	No	Relative
High Blood Pressure	☐	☐	______
Diabetes	☐	☐	______
Stroke	☐	☐	______
High Cholesterol	☐	☐	______
Osteoporosis	☐	☐	______
Thyroid Disease	☐	☐	______
Infertility	☐	☐	______

SOCIAL:

	Yes	No	
Smoking	☐	☐	______ Packs/Day
Alcohol	☐	☐	______ Drinks/Day
Caffeine	☐	☐	______ Cups/Day
Cocaine, Marajuana, Heroin	☐	☐	______ Other ______
Seat Belt Use	☐	☐	______
Violence in Home	☐	☐	______ If yes, Explain ______

Occupation: ______________
Marital Status: ☐ Single ☐ Married ☐ Living with partner
Have you had sex with: ☐ Men ☐ Women ☐ Both
Number of lifetime sexual partners ______

OFFICE USE ONLY

Medical History Summary Completed/Updated

Initials: ______ Date: ______
Initials: ______ Date: ______
Initials: ______ Date: ______

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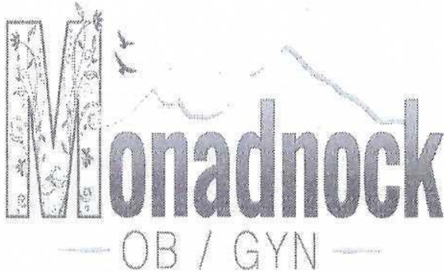
Initials: ______ Date: ______
Initials: ______ Date: ______

(MOB004) 4-24-08



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PATIENT FINANCIAL POLICY

At Monadnock OB-GYN Associates, we are dedicated to providing the best possible care for our patients. We believe that an important part of providing quality healthcare is establishing clear patient financial policies. Please review these policies carefully. If you have any questions, our Billing Office staff can be reached at 603-924-3088. **Please note: Our office is separate from Monadnock Hospital's billing services and payments. All billing inquiries should be made to our office directly.**

PAYMENT – Payment in full is expected at the time of your visit. We will accept cash, check, or credit cards. Payments include any copayments, unmet deductibles, coinsurance or services not covered by your insurance. If you do not have insurance coverage, payment in full is expected at the time of your visit. **By signing below, you authorize us to contact you regarding payment using the home phone and cell phone provided, including leaving messages on unattended devices, such as an answering machine or voicemail, as well as contacting you via text or SMS messaging, and by the email you provided.**

INSURANCE – Monadnock OB-GYN participates with numerous health plans. We file claims to all health plans on your behalf but since your insurance is a contract between you and your health plan, **you are ultimately responsible for payment.**
As a courtesy, Monadnock OB-GYN verifies coverage for certain benefits with participating health plans. ***Verification of benefits by Monadnock OB-GYN is not a guarantee of coverage or payment. It is advisable for you to personally verify coverage for your services with your health plan.*** If your health plan determines that a service is "not covered", you will be responsible for the
complete charge. If your insurance requires a written referral to be seen by our practice, you need to come prepared with the appropriate referral. Understand that we must stay within the guidelines of the referral when providing your care. We will ask you to reschedule your appointment if a referral is not provided.

OUTSIDE LABORATORY
We send the majority of blood work and pathology samples to Quest Diagnostic and Monadnock Community Hospital. This will generate a separate bill.

CANCELLATION OR MISSED APPOINTMENTS – **In order to serve all of our patients Monadnock OB-GYN requires at least 24 hours advance notice** for cancelled appointments. If you do not cancel your appointment at least 24 hours prior to missing an appointment, you may be subject to a $50 missed appointment fee.

RETURNED CHECKS – A $25.00 service charge will be applied for returned checks. You will be asked to bring cash, certified funds or a money order to cover the amount of the check, plus the $25.00 service charge prior to receiving any further services from our Practice.

COLLECTION – In the event your account is placed in a collection status, any additional fees incurred due to this process will be added to your outstanding balance. This includes but is not limited to collections agency fees, attorney fees, court costs, interest and fines. **The authorizations you have given us to contact you regarding payment are extended to any collection agency, attorney, or third party we may use to collect payment from you on our behalf.**

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Name____ Relation____________________

Home Phone: ____________________________ Celll Phone: ____________________________

I have read and understand Monadnock OB-GYN's Patient Financial Policy, as above, and agree to be bound by these terms; I also understand and agree that these terms may be amended by the Practice from time to time.

___________________________________ ___________________________________
Signature of Patient (or Guarantor, if Applicable) Date

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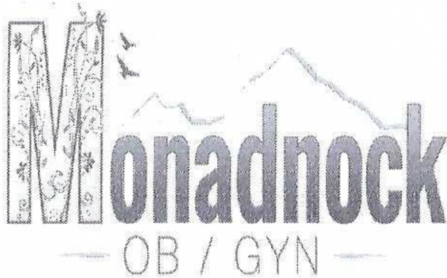

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No Show Policy

Our office requires a 24 hour notice to cancel or reschedule an appointment. At Monadnock OB-GYN Associates, we make every effort to schedule your appointment in a timely fashion, while ensuring the appointment length allows time for you to discuss your medical concerns with your provider. A last minute cancellation or missed appointment not only delays your care, but also prevents us from rescheduling another patient who could have been seen at that time.

We do understand that sometimes unforeseen emergency situations arise; however, we ask that you provide us with the courtesy of canceling or rescheduling your appointment at least 24 hours prior to your scheduled appointment.

Please be aware that you may be charged $50 for each appointment that is missed or rescheduled with less than 24 hour notice. If you have more than two last minute rescheduled or missed appointments you may be discharged from our practice.

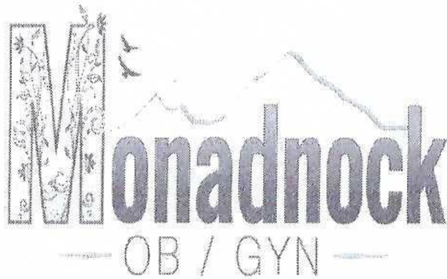
Thank you for your attention to this matter.

Arrival Policy

We ask patients to arrive 15 minutes prior to the scheduled appointment time. This allows us to check you into the system and verify your information prior to your appointment with the provider.

Late Policy

If you arrive 10 minutes late for your appointment there is a possibility your appointment may be rescheduled. This will be done in order to keep the appointments following running on time.



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HIPAA Notice of Privacy Practices

Effective Date: *August/2013*

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact a member of our office staff 603-924-9444.

OUR OBLIGATIONS:

We are required by law to:

Maintain the privacy of protected health information

Give you this notice of our legal duties and privacy practices regarding health information about you

Follow the terms of our notice that is currently in effect

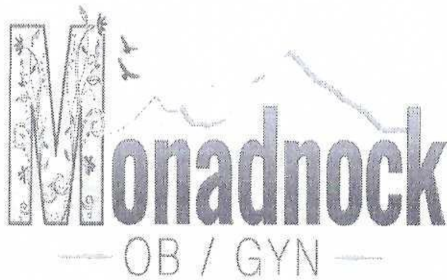
HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share



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information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

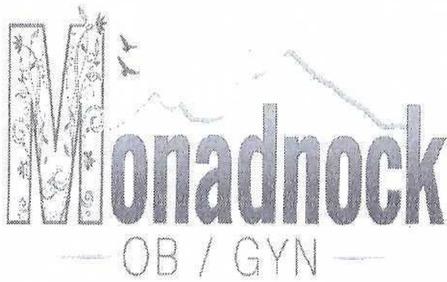
As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.



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Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

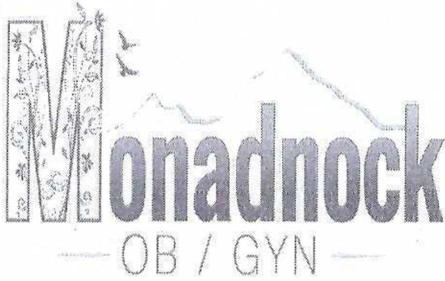
Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law



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enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

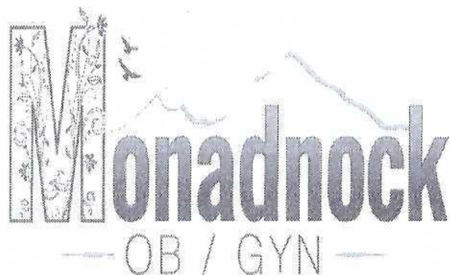
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Monadnock OB GYN Associates PA. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.



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Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

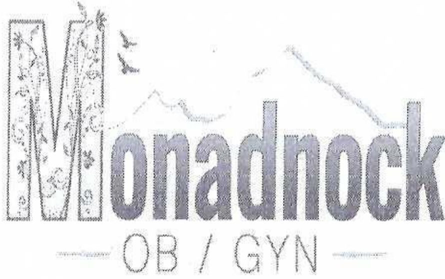
Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Monadnock OB GYN Associates, PA.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Monadnock OB GYN Associates, PA.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Monadnock OB GYN Associates, PA. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request,



454 Old Street Road
Suite 302
Peterborough, NH 03458
603-924-9444

David R. Levene, M.D., F.A.C.O.G.
Pamela A. Stetzer, D.O., F.A.C.O.O.G.
Morgan Jenkins, MD
Melody Eckardt, M.D., F.A.C.O.G.
Heather L. Arel, MSN, APRN

in writing, to Monadnock OB GYN Associates, PA. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

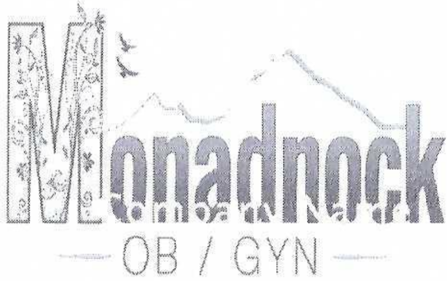
Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.monadnockobgyn.com. To obtain a paper copy of this notice, Monadnock OB GYN Associates, PA.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the current privacy officer or office manager. All complaints must be made in writing. **You will not be penalized for filing a complaint.**



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Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, ______________________________________
Patient Name

___________ I have received a copy of Monadnock OB-GYN, Associates Notice of Privacy Practices

___________ I have declined a copy of Monadnock OB-GYN, Associates Notice of Privacy Practices

______________________________________ Date ______________________________________
Signature of Patient

______________________________________ Date ______________________________________
Signature of Witness

*THIS PAGE MUST BE SIGNED AND RETURNED AT THE TIME OF YOUR APPOINTMENT.

*This form may be view at www.monadnockobgyn.com