COLUMBUS OB/GYN SPECIALTY CENTER, PLLC
PATIENT INFORMATION SHEET

Chart#
(office use only)

TODAY'S DATE: _____

Patient's Legal Name: _____
(First) (MI) (Maiden) (Last)

Social Security #: ___-___-___ Birthdate: ___/___/___ Age:_____

Marital Status: Single Married Separated Divorced Widowed

PLEASE BE SURE TO PROVIDE ACCURATE ADDRESS & WORKING PHONE NUMBERS SO THAT WE CAN CONTACT YOU

Complete Mailing Address: _____

City: _____ State: _____ ZIP: _____-_____

Private Email: _____

Home Phone:(_____) _____-_____ Cell Phone:(_____) _____-_____

Employed By: _____ Occupation: _____

May we call you at work? Yes No If Yes, Work Phone: (_____) _____-_____

SPOUSE'S NAME: _____ Birthdate: ___/___/___
(First) (MI) (Last)

Social Security #: ___-___-___ Phone:(_____) _____-_____

Employed By: _____ Occupation: _____

IF NO SPOUSE, EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____ Contact Phone:(_____) _____-_____

May we share Medical Information with your Emergency Contact? Yes No

RESPONSIBLE PARTY/GUARANTOR (If patient is under the age of 18)

Legal Name: _____ Social Security #: ___-___-___

Birthdate: ___/___/___ Relationship to patient: _____

Complete Mailing Address: _____

City: _____ State: _____ ZIP: _____-_____

INSURANCE INFORMATION: We must have ALL of the information below AND a copy of the insurance card

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Name of Company:	Name of Company:
Name of Policyholder:	Name of Policyholder:
Policyholder's Date of Birth:	Policyholder's Date of Birth:
Relationship to Policyholder:	Relationship to Policyholder:
Policy/ID#:	Policy/ID#:
Group #:	Group #:

Due to constant changes and varieties of insurance plans, you will need to present your insurance card to the receptionist each time you visit our office. If you do not have your card, please expect to pay the full amount for that visit. It is the patient's responsibility to keep all information updated and accurate. Failure to notify us of any insurance changes will result in the patient being responsible for all charges.

Patient/Responsible Party Signature:_____ Date:___/___/___

How did you hear about our office? Doctor/Friend Referral_____

Website Telephone Directory Billboard Commercial Other _____

COLUMBUS OBGYN SPECIALTY CENTER, PLLC

Chart#
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Patient Name: _____ Patient's Date of Birth: _____
First Middle Initial Last

HIPPA Privacy Notice Acknowledgement

I have read the Notice of Privacy Practices for Columbus ObGyn Specialty Center. I understand that I may ask questions if I do not understand any part of the notice. I may also request a copy of the notice for my personal records.

_____ _____
Signature of Patient or Guardian Date

Authorization for Disclosure of Private Health Information to Family/Friend

I hereby authorize the providers of Columbus OB/Gyn Specialty Center, PLLC and their staff to discuss my private health information, to include the results of my medical tests such as pap smears, biopsies, exam findings, etc., and the need for further treatment based on the findings of such tests, with the following person(s):

Name	Relationship
_____	_____
_____	_____
_____	_____

I understand that because the person(s) receiving this information is/are not a health plan(s) or health care provider(s) covered by federal privacy regulations, the information may be disclosed by the recipient(s) and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying Columbus ObGyn Specialty Center in writing and that if I choose to do so, my request to revoke will not affect any actions by Columbus ObGyn Specialty Center before receiving my revocation.

_____ _____
Signature of Patient or Guardian Date

Authorization Denied to Disclose Private Health Information to Family/Friend

I am not a minor, and I do NOT want my private health information to be disclosed to any family member or friend. I understand that my refusal will not affect my treatment, payment, or eligibility for benefits.

_____ _____
Signature of Patient or Guardian Date

COLUMBUS OBGYN SPECIALTY CENTER, PLLC

Chart#
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Patient Name: _____
(First) (Maiden or Middle Initial) (Last)

ASSIGNMENT OF BENEFITS AUTHORIZATION

I hereby authorize Columbus ObGyn Specialty Center to furnish information to insurance carriers concerning my illness and treatments, including office/progress notes, surgical reports, laboratory and pathology results, and any other information necessary to process claims filed. I hereby assign to the provider(s) all payments for medical/surgical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance if assignment was taken.

_____ _____

Signature of Patient or Guardian/Parent (if a minor) Date

NONDISCRIMINATION POLICY

Columbus ObGyn Specialty Center does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services, and activities, or in employment.

COMMUNICATION WITH PERSONS OF LIMITED ENGLISH PROFICIENCY (LEP) AND FOR PERSONS WITH IMPAIRED HEARING, VISION, OR SPEECH

Columbus ObGyn Specialty Center will provide communication aids (at no cost to the person being served) to Limited English Proficient (LEP) persons and to persons with impaired hearing, vision, or speech, who wish to be patients here at our practice. If any of these resources are needed, please notify our office PRIOR to the day of your appointment so that arrangements can be made. Our contact number is 662-240-0095.

_____ _____

Signature of Patient or Guardian/Parent (if a minor) Date

COLUMBUS OBGYN SPECIALTY CENTER, PLLC

Payment Policy

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It is the policy of Columbus ObGyn Specialty Center Pllc that payment is due at the time services are provided. It is the patient's responsibility to check with the business office prior to being seen if you have any questions regarding fees, insurance information, etc. All outstanding balances must be paid in their entirety before any additional services will be provided by any provider employed at Columbus ObGyn Specialty Center.

Self-Pay

All self-pay patients are responsible for payment of their entire account at the time services are provided. For scheduled surgeries performed in the hospital, payment is due when the patient gets her preoperative orders. If a non-scheduled surgery is performed, payment is due immediately following discharge. If the entire balance cannot be paid at once, arrangements must be made with the business office immediately.

***Medicare**

The providers of this clinic are NON-Participating providers with Traditional Medicare and ALL Medicare Advantage plans. Therefore, Medicare beneficiaries may be responsible for payment of all services received in the office the day the service is provided. We will collect the limiting charge that is set by Medicare, and you will only be reimbursed 80% of that amount after your deductible has been met. Medicare will send this payment directly to you. Medicare will then cross your claim over to your supplemental carrier, and if a payment is due, it will be made directly to you also.

Medicaid

The providers of this clinic do participate with Mississippi Medicaid the Managed Care plans through Mississippi Medicaid. If a patient has Medicaid, they must present their card before services are provided. All applicable copays are due at the time services are rendered. If Medicaid is not in effect at the time of service, you are responsible for payment. If Medicaid becomes effective and you qualify for "retroactive eligibility", our office WILL NOT bill Medicaid for those services and REFUND the beneficiary.

Private Insurance

The providers of this clinic do not participate with all private insurances, and it is the patient's responsibility to check with the business office prior to being seen if you have any questions regarding your coverage here. For those insurances that we do not accept, the patient is responsible for payment in full at the time of the service, and we will give you a form that you can file with your insurance carrier to receive your benefits. For those insurances that we do accept, the patient is responsible for payment as outlined by their plan. Therefore, office copays, deductibles, and coinsurance amounts are due at the time of service. After the insurance has paid, the patient is responsible for any remaining balance. If payment arrangements need to be made, you must contact our business office immediately.

We are participating providers for the following networks:
BCBS of Mississippi, BCBS of Alabama, State Employees Network,
MPCN (Mississippi Physicians Care Network), Baptist Network,
UnitedHealthCare, Cigna, and Tricare (Standard and Prime).

If you have any questions about your insurance, ask someone in our business office prior to being seen by the provider. We will gladly assist you in finding out what your benefits are for the services provided in our clinic. It is the patient's responsibility, not the employees of Columbus ObGyn Specialty Center, to know your benefits, and ultimately it is the patient's responsibility for payment of their accounts.

I have read the above payment policy and understand my financial responsibility as a patient. I know that I can ask someone in the business office about my financial obligations prior to services being provided if I have any questions.

_____

Patient's Printed Name

_____ _____

Patient's Signature or Parent/Guardian (if a minor) Date

GYNECOLOGY

D.O.B. _____ PATIENT'S NAME _____

ADDRESS _____ INSURANCE _____ DATE _____

TEL. NO. _____ REFERRED BY _____ AGE _____ SEX _____ S.M.W.D. _____

PAST MEDICAL HISTORY:	SELF:	FAMILY:	ALLERGIES:
Diabetes			
Cancer			
Tuberculosis			
High Blood Pressure			MEDICATIONS:
Heart Disease			
Stroke			
Hepatitis			
Seizure			
Asthma			SOCIAL HISTORY:
Kidney Disease			Smoker: ☐ No ☐ Yes Amount:
Herpes/STD			Alcohol: ☐ No ☐ Yes Amount:
Blood Transfusion			Drugs or Marijuana: ☐ No ☐ Yes Amount:

PERSONAL HISTORY _____

PRESENT AILMENT _____

MENSTRUATION: FIRST AT AGE _____ DAYS INTERVENING _____ DAYS DURATION _____ AMOUNT _____ PAINS _____

LAST PERIOD _____ AMENORRHEA _____ MENORRHAGIA _____ DYSMENORRHEA _____ MENOPAUSE _____

VAGINAL DISCHARGE: COLOR _____ CHARACTER _____ AMOUNT _____

VESICLE SYMPTOMS: _____

GASTRO-INTESTINAL SYMPTOMS: _____

LAST MAMMOGRAM: OBSTETRICAL RECORD LAST PAP SMEAR:

	DATE	AT TERM	MONTH			PREGNACY COMPLI-CATED	DELIVERY OPERATIVE	MULTIPLE	MONTHS BREAST FED	WEIGHT AT BIRTH	REMARKS
			MIS-CARRIAGE	PRE MATURE	STILL BORN						
1											
2											
3											
4											

PHYSICAL EXAMINATION: TEMP._____ PULSE _____ RESP. _____ B.P. _____ WT. _____ HT. _____ **SURGERY:**

Normal (✓)	PHYSICAL EXAM
	HEEN:
	NECK:
	CHEST:
	CARDIOVASCULAR:
	BREAST EXAM:
	ABDOMINAL EXAM:
	PELVIC EXAM:
	External genitalia:
	Vagina:
	Cervix:
	Uterus:
	Adnexa:
	RECTAL
	EXTREMITIES: