Metropolitan OB/GYN
Patient Information Form

Today's Date:_____ Age at **TODAY'S** Visit_____Years
Patient's Name (First):_____ (Last):_____(Middle):_____
Address:_____ Apt. #:_____
City:_____ State:_____ Zip Code:_____
Home Phone:(_____)_____Cell Phone:(_____)_____
SSN #:_____-_____-_____ Date of Birth:_____/_____/_____ Sex (circle): F M
Ethnicity: □ White □African American □American Indian/Alaska Native □Asian
□Hispanic □Mixed Race □Other □Refuse to Report
Marital Status (circle): Married Single Divorced Widowed Other
Employment Status (circle): Employed Self-Employed Unemployed Retired
Full Time Student Part time Student
Employer Name:_____ Work Phone:(_____)_____
Employer Address:_____ City:_____
State:_____Zip Code:_____ Occupation:_____
Primary Care Physician:_____ Phone Number(_____)_____

Spouse/Partner Information
Name (First):_____ (Last)_____ (Middle)_____
Work Phone:(_____)_____ Cell Phone:(_____)_____
Date of Birth:____/____/____Sex (circle): F M Occupation:_____
Emergency Contact (not at same address):_____Relationship:_____
Home Phone:(_____)_____ Work:(_____)_____ Cell:(_____)_____

Responsible Party and Primary Insurance Information
Responsible Party Name (First):_____ (Last)_____ (MI)_____
Address:_____ Apt.#:_____
City:_____ State:_____ Zip Code:_____
Home Phone:(_____)_____ Cell Phone:(_____)_____
SSN #:_____-_____-_____ Date of Birth:_____/_____/_____ Sex (circle): F M
Employer Name:_____ Work Phone:(_____)_____
Employer Address:_____ City:_____
State:_____Zip Code:_____ Insurance Name:_____
Customer Service Phone:(_____)_____
Subscriber ID:_____ Group ID:_____ Copay $_____
Effective Date_____ Termination Date:_____
Billing Address:_____
City:_____State:_____Zip Code:_____

Secondary Insurance Information
Insurance Name:_____ Customer Service Phone:(_____)_____
Subscriber ID:_____ Group ID:_____ Copay $_____
Effective Date_____ Termination Date:_____
Billing Address:_____
City:_____State:_____Zip Code:_____

Please share your EMAIL address _____
Who referred you to our Practice?_____

Signature_____ Date_____

Metropolitan OB/GYN
HealthOne Clinic Services

Please provide us with your pharmacy information:

Pharmacy Name:_____

Phone Number: (___)_____

Address:_____City:_____
State:_____Zip Code:_____

I the undersigned authorize Metropolitan OB/GYN to leave (circle one):

Detailed Or General

Voice mail messages regarding future appointments, test results and personal information on the number I specify:

Phone Number :(_____)_____

Metropolitan OB/GYN
PATIENT FINANCIAL AGREEMENT

1. **_____(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, **Metropolitan Ob/Gyn** may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. **_____(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **Metropolitan Ob/Gyn** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. **_____(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **Metropolitan Ob/Gyn** any insurance or other third-party benefits available for health care services provided to me. I understand **Metropolitan Ob/Gyn** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Metropolitan Ob/Gyn,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. **_____(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **Metropolitan Ob/Gyn** by the Medicare or Medicaid program.

5. **_____(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for **Metropolitan Ob/Gyn**, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Metropolitan Ob/Gyn** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Metropolitan Ob/Gyn** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. **_____(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify)_____

Metropolitan OB/GYN
HealthOne Clinic Services

TO BE COMPLETED FOR ALL ANNUAL WELL-WOMAN VISITS

Patient Name: _____

Date of Birth:_____/_____/_____

We would like to clarify for you what an **'Annual Well-Woman Visit'** represents. This visit is a time for you and your physician to review your medical history, to perform a comprehensive physical examination. **The focus of the visit is on the promotion of health and prevention of disease.**

Topics to be included are breast and pelvic exam, appropriate cancer screening, family history looking for inherited diseases, high risk behaviors such as smoking, alcohol use and drug use, and obesity. The goal of the visit is to identify risk factors for current or future health problems and to identify undetected problems so they can be addressed. It is also a chance for you to share with us your health concerns.

The following are examples of things that are included in an annual well-woman visit: cervical cancer screening, clinical breast exam, recommendation for mammogram or colonoscopy, routine immunizations, surveillance of existing birth control or hormone replacement therapy, and discussion of safe sex practices.

Evaluation or treatment of additional medical concerns you may have, or newly diagnosed or chronic medical problems (such as high cholesterol, high blood pressure, skin problems) particularly when testing and/or management of medications is involved, is not part of the annual well-woman visit. We have generally included management of these problems in the same visit as the well-woman exam for the sake of patient convenience. Otherwise, a separate visit would need to be scheduled.

However, for some patients, **a visit for both a well-woman exam and management of other medical problems/concerns at the same visit may trigger a copay/co-insurance for the visit**. Please understand that a copay/co-insurance may be charged because you are having two services on the same day. If this situation is unsatisfactory to you, we can schedule the services on separate days.

We hope this clarifies for you how we try to coordinate your preventive care needs with treatment of your new or chronic medical problems.

Patient signature **Date**

_____ _____/_____/_____

Metropolitan Ob/Gyn "No-Show" Policy

Our goal is to provide quality care in a timely manner. In order to do so we have had to implement a "No Show" appointment cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Definition of "No-Show" Appointment
Metropolitan Ob/Gyn defines a "no-show" appointment as any scheduled appointment, in which the patient either:

- Does not show.
- Cancels with less than 24 hours notice.
- Arrives more than 15 minutes late and is consequently unable to be seen.

Metropolitan Ob/Gyn Expectations
When a patient schedules an office visit with us, we expect them to arrive at our practice 15 minutes prior to their scheduled visit. This allows time for the patient and our check-in staff to address any insurance or billing questions and/or to complete any necessary paperwork before the scheduled visit.

In order to be respectful of the medical needs of the Metropolitan Ob/Gyn community please be courteous and contact us promptly if you are unable to attend an appointment. This time will be reallocated to someone who may be in need of urgent treatment.

If it is necessary to cancel your appointment we ask that you call at least two (2) working days in advance. Appointments are in high demand, and your early cancellation will give another patient the possibility to have access to timely medical care.

While we ask that our patients avoid cancelling or rebooking a scheduled visit with less than 24 hours notice, we do realize that things come up. In this situation, we still ask that the patient contact our office as soon as they realize they need to cancel or rebook. ***It is always better to call rather than to "no-show/no-call".*** The staff member handling the call will pass the information on to the Practice Coordinator so that appropriate action is determined.

By signing below, I acknowledge that I have read and understand the "No Show" policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Patient (or Responsible Party) Signature **Date**

_____

Patients Printed Name

Metropolitan OB/GYN
HealthOne Clinic Services
Patient Consent Form

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand **Metropolitan OB/GYN** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **Metropolitan OB/GYN** will use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

Medicare Patients: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services at **Metropolitan OB/GYN.**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents

_____ _____

Patient (or Responsible Party) Signature **Date**

_____

Patients Printed Name

Insurance Billing For Pregnancy

We at **M**etropolitan OB/GYN try our best to inform you of our billing policies. Each insurance policy is different regarding what is a paid benefit. **It is your responsibility as the policy holder to know your insurance benefits**. Please call your insurance company any time you have questions regarding your benefits.

Frequently asked questions:

How is my insurance billed?
Your first visit to our office is a diagnostic visit. Your insurance will be billed immediately for these services. The diagnosis is "Amenorrhea" which means no menses. It will not be billed as pregnancy, we will establish pregnancy at this visit.

Your next visit is the beginning of your **"prenatal care"** all routine prenatal visits, delivery and routine postpartum visits are a **Global** fee billing. These services will be billed to you insurance company after you deliver.

Do I have a co-payment with each visit?
This differs by each insurance company: most policies require one co-payment for the diagnostic visit and one for prenatal care. Some insurance companies require a co-payment for the diagnostic visit and for each prenatal visit. It is **YOUR** responsibility to call your insurance carrier and find out how **YOUR** policy is written. Insurance companies can change policy rules on January 1st every year, so be sure to check each year. What was done during another pregnancy may no longer apply.

What is NOT in the Global fee?
Pap Smears, the laboratory that processes your pap will bill your insurance company for these services. You will also be required to pay a co-payment for these services in our office.

Blood Work, the laboratory that processes your blood work will bill your insurance company for these services.

Ultrasounds, we will bill your insurance company on the date of service. If you have had ultrasounds at another facility, for genetic screening or care, your 18-20 week anatomy, or at the hospital, they will also bill your insurance company on the date of service.**WARNING:** Some insurance companies only allow one ultrasound per pregnancy, regardless of where it was performed.

Non-stress test, if done in our office, we will bill your insurance company on the date of service. If you go to the hospital they will bill your insurance company on the date of service.

Non-routine prenatal visits, if you come in for a problem during pregnancy we will bill your insurance on the date of service. You will also be required to pay a co-payment for these services.

High risk pregnancy, if you are considered high risk you may require additional visits. Most insurances will cover your high risk pregnancy at the Global fee, although some charges may be considered non-routine, requiring a co-payment.

How much do I owe?
This depends on the type of coverage you have with your insurance company. Some individuals have insurance that have a large deductible or co-payment for the patient to make, Some people have a traditional 80%/ 20%. This means the insurance pays
80% of the bills and you are responsible for 20% of the bills. It is **YOUR** responsibility to check on your policy so you know what to expect.

What if I change insurance companies during my pregnancy?
Depending on how many visits you have had or haven't had yet, you could be "breaking the global", which means we will need to bill your old insurance for visits you already had and start billing your new insurance for your current/upcoming visits. It is very important that you tell our office immediately about your change of insurance. ***Any delays can cost you: If not notified in a timely matter, the insurance company can deny payment, making you responsible.***

We have **ONLY** discussed the charges for the doctor. You may have responsibility for the hospital bills as well. **PLEASE** contact your insurance company to get the details on your benefits.

If you would like to contact Rose Medical Center to verify there billing process and to get estimated charges, please call:
Rose Financial Services: 303-320-2626

I acknowledge that I have read and understand the insurance billing process for my pregnancy. Metropolitan Ob/Gyn will bill my insurance on behalf of me, and I will be responsible for the amount they do not pay.

Signature_____ Date _____

Print Name_____