West Long Branch OB/GYN

1019 Broadway, West Long Branch, NJ 07764 * Phone (732) 229-6797 * Fax (732) 229-6893
911 E. County Line Road, Lakewood, NJ 08701 * Phone (732) 367-9299 * Fax (732) 367-0433
1270 Route 35 South, Suite B, Middletown, NJ 07748 * Phone (732) 671-3597 * Fax (732) 229-6893

New Patient Information

Please be 15 minutes early for your first appointment. Bring this completed paperwork, your insurance card, and a government-issued ID (such as a driver's license or passport).

Patient Information:

Legal first name: _____ MI: _____ Legal last name: _____

Nickname: _____ Maiden name: _____ Date of birth: _____

Social security #: _____ Email address: _____

Address: _____ Apt #: _____ City/State/Zip: _____

Home phone: _____ Cell phone: _____

Work phone: _____Ext: _____ Preferred phone number: home / cell / work

Insurance Information:

Primary insurance name: _____ Address: _____

ID#: _____ Group #: _____

Subscriber Name: _____ Date of birth: _____

Relationship: self/parent/spouse/other: _____ Address: _____

Social security #: _____ Employer: _____

Secondary insurance name: _____ Address: _____

ID#: _____ Group #: _____

Subscriber Name: _____ Date of birth: _____

Relationship: self/parent/spouse/other: _____ Address: _____

Social security #: _____ Employer: _____

Emergency Contact Information:

Name: _____ Phone #: _____ Relationship: _____

Pharmacy Information:

Local pharmacy name: _____ Phone #: _____

Address: _____ City, State, Zip code: _____

Mail order pharmacy name: _____ Phone #: _____

Employer Information:

Employer name: _____ Occupation: _____

Demographic Information:

Preferred Language: ___ English
___ Other: _____

Ethnicity: ___ Decline to answer
___ Hispanic or Latino
___ Not Hispanic or Latino

Race: ___ Decline to answer
___ American Indian or Alaska Native
___ Asian
___ Black or African American
___ Middle Eastern
___ Native Hawaiian or Pacific Islander
___ White or Caucasian
___ Other: _____

Marital status: ___ Married
___ Single
___ Divorced
___ Separated
___ Widowed

Authorization for Payment:

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payment of medical benefits to Women's Comprehensive Healthcare of New Jersey, its successors and assigns, or any individual it may designate for services provided.

I further agree to pay all costs of collection, including attorney's fees associated with collection of any amount due to services rendered and performed. I will pay interest at the prevailing annual rate for all amounts 30 days past due. I understand that I am financially responsible to Women's Comprehensive Healthcare of New Jersey, its successors and assigns and any individual it may designate for any balance not covered by insurance.

_____ _____

Signature of patient or parent of minor Date

Authorization for Medicare:

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Women's Comprehensive Healthcare of New Jersey for any services furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature of patient Date

Receipt of Notice of Privacy Practices:

I have received a copy of Women's Comprehensive Healthcare of New Jersey's Notice of Privacy Practices.

_____ _____

Signature of patient Date

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Medical History Form

Name: _____ **Date of Birth:** _____ **Height:** _____

Please be 15 minutes early for your first appointment. Bring this completed paperwork, your insurance card, and a government-issued ID (such as a driver's license or passport).

Reason for your first visit:

_____

_____

_____

_____

Allergies (include medications, latex, and foods):

Allergen	Reaction	Allergen	Reaction
1		4	
2		5	
3		6	

Current Medications:

Medication	Dose	Medication	Dose
1		6	
2		7	
3		8	
4		9	
5		10	

Pregnancy History:

Total # of pregnancies	# of Full Term Deliveries	# of Preterm Deliveries	# of Abortions	# of Miscarriages	# of Ectopic Pregnancies	# of Living Children

	Delivery date	# of babies	Outcome (birth, abortion, miscarriage, ectopic)	Boy or girl	Baby's weight at birth	Vaginal or c-section	Weeks of gestation	Anesthesia (epidural, none)	Delivery location (hospital)	Notes/Complications
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										

Gynecologic History:

First day of your last period: _____ Age at first period: _____ Age at menopause: _____

Have you received the Gardasil vaccine for HPV? _____ What year was your last Pap smear? _____

Any abnormal Pap smears in the past? _____ What year? _____ What was the abnormality? _____

Any history of STDs? _____ Type(s): _____

How often do you get a period? _____ How many days does your period last? _____

Current birth control method: _____

Year of most recent: Mammogram _____ Colonoscopy _____ Bone density scan _____

Are you sexually active? _____ Do you have any sexual health problems? _____

Family History:

Relation	Problem(s)	Age at Death

Social History:

Do you smoke cigarettes? _____ How many packs per day? _____ How many years have you smoked? _____

What is your occupation? _____ How often do you exercise? _____

Special dietary guidelines: _____ Marital status: _____ Sexual orientation: _____

Do you drink alcohol? _____ Drinks per week: _____ Do you use illicit drugs? _____ Type: _____

How many caffeine drinks per day? _____ Do you perform a monthly breast exam? _____

Surgical History, including c-sections:

Year	Procedure	Complications

Medical History:

Problem	✓	Details	Problem	✓	Details
Anemia			Liver Problems		
Anesthesia Complications			High Cholesterol		
Anxiety			Hypertension		
Arthritis			Infertility		
Asthma			Kidney Problems		
Birth Defects			Lung Disease		
Breast Problems			Mental Health Problems		
Cancer			Musculoskeletal Problems		
Depression			Neurologic Problems		
Diabetes			Low Bone Density		
Endometriosis			PCOS		
Fibroids			Blood Clotting Disorders		
GI Problems			Thyroid Problems		
Migraines			Varicose Veins		
Heart Disease			Other		

Care Team:

Who is your primary care physician? _____ Office phone: _____

Any other information you would like us to know:

_____

_____

_____

_____

Please be <u>15 minutes early</u> for your first appointment. Bring this <u>completed</u> paperwork, your insurance card, and a government-issued ID (such as a driver's license or passport).

Signature: _____ Date: _____

West Long Branch OB/GYN

FINANCIAL POLICY

PAYMENT FOR SERVICES PERFORMED: All payments are expected at the time of your visit. Our office accepts cash, personal checks, Visa & Mastercard. Insurance co-payments are due at the time of service.

RETURNED CHECK FEE IS $30

MISSED APPOINTMENT FEE: Patients who do not show up on time for an appointment, or cancel with less than 24 hours notice will be charged a $25 fee. This fee will not be reimbursed by your insurance. Patients with three missed appointments may be asked to transfer their records to another doctor.

FORMS FEE: There is a charge for the completion of forms brought to the office. The fee for this service is $20 per pregnancy or gynecological issue, payable in advance. Forms will be completed within three (3) business days.

TRANSFERRING OF RECORDS: If you require a copy of your records, you must submit a written request and pay a copying fee. The fee will be $1/page with a $10 minimum and a $100 maximum. As always, if a collaborating physician (primary care or specialist) requests portions of your record to assist in your care, there is no charge.

COLLECTIONS CHARGE: Should your account require the action of a collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

ANNUAL WELL WOMAN EXAMS: If a separate problem is identified during the course of the Annual Exam, we are required to submit a separate claim from your preventative visit. Therefore, your insurance may apply a copay to these services.
Please understand that our practitioners cannot comply with any requests to improperly alter the medical records for the purpose of obtaining payment.

LAB CHARGES: You may get a separate bill from the lab facility that performs your lab work. These charges should be discussed directly with the lab facility.

OBSTETRICS: We have separate policies for Obstetrical services. You will be given these policies should your care warrant.

AGREEMENT: I have read and fully understand the Financial Policy set forth by WLB OB/GYN, and I agree to the terms of this policy. I also understand and agree that WLB OB/GYN may amend the terms of this Financial Policy at any time without prior notification to the patient.

EFFECTIVE DATE: Once you have signed this Agreement, you agree to all of the terms and conditions contained herein, and the Agreement will be in full force and effect.

_____ _____

Signature of Patient/Guarantor **Date**

Lifeline Medical Associates, LLC.
Financial Agreement

I, _____, Date of Birth_____
I authorize the release of medical information to process the claims for medical benefits and any payment of medical benefits to Lifeline Medical Associates, LLC.

I agree to pay all costs of collection and attorney's fees associated with collection due to services rendered and performed. I am financially responsible to Lifeline Medical Associates, LLC and its successors and assign any individual it may designate for any balance not covered by insurance.

_____ _____
Signature of Patient/Guardian Date

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Patient Disclosure Instructions

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

❑ **Home Telephone (List number below)**

_____

❑ Okay to leave message with detailed information
❑ Leave message with call back number only

❑ **Cell Phone (List number below)**

_____

❑ Okay to leave message with detailed information
❑ Leave message with call back number only

❑ **Written Communication**
❑ Okay to mail to my home address
❑ Okay to mail to my work/office address
❑ Okay to fax to number indicated_____
❑ Okay to send email to _____

I allow you to give my clinical information to or answer questions from (check all that apply):

❑ Spouse _____
❑ Parent _____
❑ Child _____
❑ Other (specify): _____
❑ Do not give my clinical information to anyone but myself.

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I,_____, have received a copy of Lifeline Medical Associates, LLC's Notice of Privacy Practices.
Patient Name

_____ _____
Signature of Patient Date

HIPAA Omnibus
Notice of Privacy Practices

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your Protected Health Information (PHI) to carry out Treatment, Payment or Health Care Operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. Please review it carefully.

We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. A copy of our current notice will always be posted in the waiting area. You may also obtain your own copy by accessing our website at lma-llc.com or calling the Privacy Officer at 973-316-6760

Some examples of **Protected Health Information** include information about your past, present or future physical or mental health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information such as your name, address, social security number or phone number.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

Treatment: We may use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your Protected Health Information may be used, as needed, to obtain payment for your health care services after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

Healthcare Operations: We may use or disclose, as-needed, your Protected Health Information in order to support the business activities of our practice, for example: quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities.

Appointment Reminders and Health-related Benefits and Services: We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your Protected Health Information for **fundraising activities**, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

Friends and Family Involved in Your Care: If you have not voiced an objection, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

Business Associate: We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, a billing company, an accounting firm, or a law firm that provides professional advice to us. Business associates are required by law to abide by the HIPAA regulations.

Proof of Immunization: We may disclose proof of immunization to a school about a student or prospective student of the school, as required by State or other law. Authorization (which may be oral) may be obtained from a parent, guardian, or other person acting in loco parentis, or by the adult or emancipated minor.

Incidental Disclosures: While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

Emergencies or Public Need:
We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you.

We may use or disclose your Protected Health Information in the following situations without your authorization: as required by law, public health issues, communicable diseases, abuse, neglect or domestic violence, health oversight, lawsuits and disputes, law enforcement, to avert a serious and imminent threat to health or safety, national security and intelligence activities or protective services, military and veterans, inmates and correctional institutions, workers' compensation, coroners, medical examiners and funeral directors, organ and tissue donation, and other required uses and disclosures. We may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a work related injury or disease that your employer must know about in order to comply with employment laws. Under the law, we must also disclose your Protected Health Information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

REQUIREMENT FOR WRITTEN AUTHORIZATION

There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

Most Uses of Psychotherapy Notes, when appropriate.

Marketing: We may not disclose any of your health information for marketing purposes if our practice will receive direct or indirect financial payment not reasonably related to our practice's cost of making the communication.

Sale of Protected Health Information: We will not sell your Protected Health Information to third parties.

You may revoke the written authorization, at any time, except when we have already relied upon it. To revoke a written authorization, please write to the Privacy Officer at our practice. You may also initiate the transfer of your records to another person by completing a written authorization form.

PATIENT RIGHTS

Right to Inspect and Copy Records. You have the right to inspect and obtain a copy of your health information, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the practice. We may charge a fee for the costs of copying, mailing or other supplies. If you would like an electronic copy of your health information, we will provide one to you as long as we can readily produce such information in the form requested. In some limited circumstances, we may deny the request. Under federal law, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information related to medical research where you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

Right to Amend Records. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment in writing. If we deny your request, we will provide a written notice that explains our reasons. You will have the right to have certain information related to your request included in your records.

Right to an Accounting of Disclosures. You have a right to request an "accounting of disclosures" every 12 months, except for disclosures made with the patient's or personal representatives written authorization; for purposes of treatment, payment, healthcare operations; required by law, or six (6) years prior to the date of the request. To obtain a request form for an accounting of disclosures, please write to the Privacy Officer.

Right to Receive Notification of a Breach. You have the right to be notified within sixty (60) days of the discovery of a breach of your unsecured protected health information if there is more than a low probability the information has been compromised.

Right to Request Restrictions. You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Your physician is not required to agree to your request except if you request that the physician not disclose Protected Health Information to your health plan when you have paid in full out of pocket.

Right to Request Confidential Communications. You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

Right to Have Someone Act on Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

Right to Obtain a Copy of Notices. If you are receiving this Notice electronically, you have the right to a paper copy of this Notice.

Right to File a Complaint. If you believe your privacy rights have been violated by us, you may file a complaint with us by calling the Privacy Officer at 973-316-6760, or with the Secretary of the Department of Health and Human Services. We will not withhold treatment or take action against you for filing a complaint.

Use and Disclosures Where Special Protections May Apply. Some kinds of information, such as alcohol and substance abuse treatment, HIV-related, mental health, psychotherapy, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.

Lifeline Medical Associates

Transforming Women's Healthcare

West Long Branch, OB/GYN

1019 Broadway
West Long Branch, NJ 07764
(732) 229-6797

www.lma-llc.com

Health Insurance Portability and Accountability Act of 1996

HIPAA OMNIBUS NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

Revised: March 25, 2013

By signing the Acknowledgement form you are only acknowledging that you received, or have been given the opportunity to receive, a copy of our Notice of Privacy Practices.