



Valley Perinatal™

Name _____ Date _____
Address _____ Phone _____
City _____ State _____ Zip Code _____
Occupation _____ Work Phone _____
Date of Birth _____ Soc. Sec. Num. _____
Cell Phone _____ Email _____
 Married Single Domestic Partner Other: _____
Spouse/Partner _____ Phone _____
Occupation _____ Work Phone _____
Emergency Contact _____ Relation _____
Phone _____

Doctor _____ Phone _____
Type of Doctor: ObGyn Family Physician Other (specify) _____

Insurance Information

Subscriber Name _____ Relationship To Patient _____
Subscriber Soc. Sec. Num. _____ Subscriber Date of Birth _____
Employer _____
Name of Insurance Company _____ Phone _____
Insurance Billing Address _____
ID/Subscriber Number _____ Group Or Plan # _____

Additional Insurance Information (if applicable)

Subscriber Name _____ Relationship To Patient _____
Subscriber Soc. Sec. Num. _____ Subscriber Date of Birth _____
Employer _____
Name of Insurance Company _____ Phone _____
Insurance Billing Address _____
ID/Subscriber Number _____ Group Or Plan # _____

I hereby authorize the release of necessary information to my attending physician. I hereby authorize the release of information necessary to secure the payment of benefits by my insurance company. I understand I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all insurance submissions.

Patient Signature: _____

Date: _____



PATIENT PELVIC QUESTIONNAIRE

Name _____ DOB _____

1. First day of your last period _____

2. Are you currently pregnant? Yes No Unsure

3. Total number of pregnancies _____ Deliveries _____ Miscarriages _____
Ectopics _____ Abortions _____

4. What medications are you currently taking?

a. Birth control Yes No

If yes: Pill Patch IUD Nuva Ring

For how long? _____

b. Hormone Replacement Therapy Yes No

If yes, name: _____ For how long? _____

c. List any other medications you are currently taking _____

5. Which of the following symptoms are you currently experiencing/what is the reason for your exam today?

a. Pelvic Pain Yes No

If yes, which side? Right Left Both

If both, which side is WORSE? Right Left Neither

If yes, how long have you been having the pain? _____

The pain is: Constant Comes and Goes Gone

b. Irregular cycles Yes No

If yes, how long have your cycles been irregular? _____

c. Abnormal bleeding Yes No

If yes, how many days does the bleeding typically last? _____

The flow is: Light Moderate Heavy With clots

How long have you had abnormal bleeding? _____

d. Painful intercourse Yes No

e. Check IUD placement Yes No

f. Cramping with cycles Yes No

If yes: Mild Moderate Severe

g. Other symptoms/reasons for exam: _____



PATIENT PELVIC QUESTIONNAIRE

Name _____ DOB _____

6. Do you have a history of or have you been previously diagnosed with any of the following?

- a. Endometriosis Yes No
 - b. Polycystic Ovarian Syndrome Yes No
 - c. Fibroids Yes No
 - d. Ovarian cysts Yes No
 - e. Endometrial polyps Yes No
 - f. Breast Cancer Yes No
- If yes, are you taking or have you taken Tamoxifen? Yes No
- g. Kidney Disease Yes No

Explain: _____

- h. Gastrointestinal Cancer Yes No
- i. Family History of Ovarian Cancer Yes No

Relation to you: _____

Other diagnoses: _____

7. Have you had any of the following procedures/surgeries?

- a. Hysterectomy Yes No Date: _____
 - b. Oophorectomy (ovarian removal) Yes No
- If yes, which ovary was REMOVED? Right Left Both

Date of removal: _____

Reason for removal: _____

- c. Cesarean section Yes No Number: _____
- d. Tubal-ligation/Essure Yes No Date: _____
- e. Laparoscopy Yes No Date: _____
- f. Endometrial biopsy Yes No Date: _____
- g. D&C Yes No Date: _____
- h. Myomectomy (fibroid removal) Yes No Date: _____
- i. Fibroid embolization Yes No Date: _____
- j. Endometrial ablation Yes No Date: _____
- k. IUD placement Yes No Date: _____

Type of IUD: _____

l. List other surgeries/procedures you have had and when: _____

8. Have you had any of the following?

- a. Prior pelvic Ultrasound Yes No Date: _____
- b. Abdominal/Pelvic CT Yes No Date: _____
- c. Pelvic MRI Yes No Date: _____
- d. Other: _____

9. Is there any additional information that you would like us to know?

Signature _____



TO OUR PATIENTS

The following is an explanation of our policies regarding patient accounts. Please take the time to read these policies, as they will describe your responsibilities for the handling of your account. If you feel that you need additional information or explanation regarding these policies, our manager will be glad to answer any questions.

Valley Perinatal Services (VPS) charges on a fee-for-service basis. We submit our services to your insurance company as a courtesy to you. However, you are responsible for the balance of the account and any portion not paid by your insurance. Please notify us of any changes in your insurance plan or coverage as soon as possible to help you in receiving benefits from your insurance.

If you are a self-paying patient, you will be required to pay for your office visits and procedures at the time of service. The front desk will be happy to provide you with an estimate of the charges.

You will receive a statement each month letting you know the activity and balance on your account. When your account becomes 60 days past due, you are responsible for the charges. At this time, we ask that you make payment in full. You will need to contact your insurance carrier to find out why they have not made payment.

A monthly billing charge of \$10.00 will be applied to your account after 60 days for each outstanding date of service. A service charge of \$25.00 will be added on all returned checks.

ACCEPTANCE OF TERMS

I certify that I have read and fully understand the policies of the FWC. I realize that I am responsible for my charges and that any collection of attorney's fees will be charged to me in the event that my account is not paid in full as described in the terms and conditions above.

Signature (patient or legally responsible party)

Date

ASSIGNMENT OF BENEFITS

I authorize FWC to bill my insurance company and to receive payments on my behalf from them. I authorize the physician to release information required for filing the necessary insurance claim forms.

Signature of legally responsible party

Date

WAIVER OF ASSIGNMENT OF BENEFITS

I understand by not signing the above assignment of benefits, I will be responsible for 100% of all charges incurred at the time of service.

Signature of legally responsible party

Date



NOTICE OF PRIVACY PRACTICES (NPP)

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.

The Valley Perinatal Services respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations:

For treatment:

- Information obtained by a technologist, physician or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing your care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
 - medical quality review by your health plan;
 - accounting, legal, risk management, and insurance services;
 - audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice").
- Request that you be allowed to see and get a copy of your protected health information
- You may make this request in writing.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released.
- It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.
- For help with these rights during normal business hours, please contact: Valley Perinatal Services, Privacy Officer, 480-551-9700.

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Our Responsibilities

We are required to:

- Keep your protected health information private
- Give you this notice
- Follow the terms of this notice

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help of Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact our Privacy Officer at 480-551-9700.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the Privacy Officer at our office. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to assist in disaster relief efforts.
- You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- **With Medical Researchers.** If the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply with Workers' Compensation Laws** if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
 - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public
 - to public health or legal authorities
 - to protect public health and safety
 - to prevent or control disease, injury, or disability
 - to report vital statistics such as births or deaths
- **To Report Suspected Abuse or Neglect** to public authorities
- **To Correctional Institutions** if you are in jail or prison, as necessary to your health and the health and safety of others.
- **For Law Enforcement** Purposes such as when we receive a subpoena, court order, or other legal process, or you are a victim of a crime
- **For Health and Safety Oversight Activities.** For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.
- **To The Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

We have a website that provides information about us at: www.valleyperinatal.com.

By signing, you acknowledge that we have provided you with this form of our privacy practices.

Patient's Name

Date



By signing below, I acknowledge that I have been provided with a copy of the Valley Perinatal Services Notice of Privacy Practices and have therefore been advised of how health information about myself may be used and disclosed by Valley Perinatal Services and how I may obtain access and control this information.

• _____
(Signature of Patient or Guardian)

• _____
(Print Patient name or Guardian)

• _____
(Date)

• _____
(Description of Guardian)

Please list who you want to have access to your pertinent medical information, (i.e.: family member, spouse)

1. _____

2. _____

3. _____

Preferred method of contact for test results:

Home# _____ May we leave a message? YES NO

Cell# _____ May we leave a message? YES NO

Work# _____ May we leave a message? YES NO

Email# _____ May we leave a message? YES NO



Insurance Verification

Patient Information

Patient Name: _____

Patient DOB: _____

Insurance Information

Insurance Company _____

Member ID # _____ Group # _____

Customer Service/Provider Phone # _____

When we bill your insurance company, any deductible and co-insurance charges will apply. Any payment that you make on your visit will be credited to your account. Once the insurance company makes payment, you will be responsible for any and all remaining balances.

*A healthcare deductible is the amount that you must first pay before your insurance will make any payment. For example, if you have a deductible of \$1500, and the cost of the medical services is \$800, you (**not your insurance company**) will be responsible for \$800. Your insurance company deducts this amount from your deductible, and you would have a balance of \$700 remaining. Once you have met the full amount of your \$1500 deductible, your insurance company will then make payment on future visits to any healthcare provider. The deductible must be paid every year, usually beginning Jan.1st.

**Once your deductible is met, many insurance companies still do not pay 100% of the healthcare cost. If that is the case you would have a co-insurance, which is a partial payment required by you in addition to what the insurance company will pay. It can be from 10-50% of the allowed amount until you have accumulated enough medical bills to meet your yearly out of pocket maximum.

***This is an **estimated** portion that is due. We contacted your insurance company and unfortunately we don't exactly know what your insurance will cover or what you will be billed until your claim is processed.

If you have any questions regarding your financial responsibilities please ask or call our billing department at (888) 279-8040

Patient Signature: _____

Date: _____