Suncoast Obstetrics and Gynecology

Gynecology
New Patient Pre-Registration

PO Box 1117
Crystal River, FL 34423
Ph. (352) 564-8245 Fax (352) 564-8201

Name _____ Home Phone _____

Mailing Address _____ Cell Phone _____

City _____ State ____ Zip _____ Date of Birth _____

Physical Address _____ Single ___ Married ___ Divorced ___ Widowed ___

City _____ State ____ Zip _____ Social Security # _____

Employer _____ Work Phone _____

E-mail Address _____

Spouse/Parent Name _____ Home Phone _____

Home Address _____ City _____ State ____ Zip _____

Employer _____ Work Phone _____

Primary Insurance _____ Secondary Insurance _____

Policy # _____ Policy # _____

Insured Date of Birth _____ Insured Date of Birth _____

Insured Social Security # _____ Insured Social Security # _____

EMERGENCY CONTACT _____ Relationship _____

Home Phone _____ Office Phone _____

Primary Physician _____

By signing below I give consent for treatment to be rendered by Scott Redrick, M.D. and/or his designees. I am also aware that the use of an outside laboratory may result in additional charges that will also be my responsibility. I also assign all medical payments by my insurance company be made to Suncoast OB/GYN. I understand that I am financially responsible for charges and/or co-payments not paid by said insurance. If necessary I authorize Suncoast OB/GYN to release any medical records to said insurance to secure payment.

x _____ x _____

Patient/Legal Guardian Date

Medical History

Reason for Visit:

Current Medication:	Dose:

Allergies:	
Medication	**Reaction**

Medical History:	
Condition	**Status**

Past Surgeries:	
Date	**Procedure**

Hospitalization	
Date	**Reason**

Family History:	
Relative	**Condition**
Mother	
Father	
Sister	
Brother	
Daughter	
Son	
Maternal Grandmother	
Paternal Grandmother	
Maternal Aunt	

Social History:
Occupation
Alcohol
Tobacco
Illicit Drugs

Patient Name _____ Date _____

Signature _____ DOB _____

Please indicate yes or no to any condition in your current history.

Yes	No	Condition	Yes	No	Condition
		Heavy periods			Shortness of breath
		Pain during sex			Nausea
		Sexually active			Vomiting
		Post Menopausal symptoms			Diarrhea
		Pain during period			Abdominal pain
		Infertility			Constipation
		Bleeding between periods			Urinary Urgency
		Bleeding after sex			Frequent Urination
		Pelvic pain			Excessive Urniation
		Irregular periods			Urinary incontinence
		Fatigue			Herpes
		Abnormal vaginal discharge			HIV
		Weight gain			Cold intolerance
		Weight loss			Heat intolerance
		Rash			Headache
		Lumps			High stress level
		Breast changes			Depression
		Chest pain			Sleep disturbances
		Palpitations			Mental or physical abuse
		Dizziness			Sexual abuse

Partner's Name	

OB/GYN History

Gynecologic History	
Last menstrual period	
Menarche (age of first menses)	
Menstrual regularity	
Menopause (age of last menses)	
Birth Control	
Abnormal Pap	
Abnormal Mammogram	
Last Pap	
Last Mammogram	
Sexually Transmitted Disease	
Pelvic Inflammatory Disease	
Urinary Incontinence	

Obstetrical History	
Total Pregnancies	
Living Children	
Miscarriage	
Abortion	
Ectopic Pregnancy	
Vaginal Delivery	
Cesarean Section	

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 amde by alternative means, such as sending correspondence to the individual's home.

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

☐ Home/Cell Phone _____

___ O.K. to leave message with detailed information

___ Leave message with call-back number only

☐ Work Telephone _____

___ O.K. to leave message with detailed information

___ Leave message with call-back number only

☐ Written Communication

___ O.K. to mail to my home address

___ O.K. to mail to my work/office address

___ O.K. to fax to this number _____

DO YOU HAVE AN ADVANCED DIRECTIVE/LIVING WILL YES NO (Circle One)

NOTE: Full disclosure of medical information may be released to the person(s) listed below. Examples: Family Members, Caregivers, Friends

_____ _____

_____ _____

Privacy Information

The Department of Health and Human Services has established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it si appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of our personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

_____

Patient/Parent/Legal Guardian Signature Date

Suncoast Obstetrics and Gynecology

I hereby request that the following medical information be transferred

From: _____
_____
_____
_____
_____

To: Dr. Scott Redrick, MD
PO Box 1117
Crystal River, FL 34423
Phone 352-564-8245
Fax 352-564-8201

Patient Name: _____ DOB: _____

I authorize the above doctor to release requested information contained in my patient records including information regarding communicable diseases and infections which include sexually transmitted disease "STD", HIV Results, AIDS and Hepatitis.

- ☐ Paps
- ☐ Blood Work
- ☐ Mammogram Reports
- ☐ OP Reports/Pathology
- ☐ Diagnostic Tests

It is further understood that the information released is for the office of Suncoast OB/GYN only and will not be released to other entities.

_____ _____

Patient/Legal Guardian Signature Date

Suncoast Obstetrics and Gynecology

To All Patients,

We are in the process of going paperless! Following is the information we will need in order to comply with the government standards for *Electronic Medical Records*:

Name: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ White
☐ Black or African Amer ☐ Hispanic ☐ Other Pacific Islander ☐ Other Race
☐ Prefer Not To Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer Not To Answer

Language: ☐ English ☐ Indian [Includes Hindi & Tamil] ☐ Spanish ☐ Russian ☐ Other

This information, like all other information you have given us, is kept in the strictest of confidence, compliant with the HIPPA laws. Thank you so much for your cooperation.directions in the e-mail. To sign up for this FREE service, please print your e-mail address below:

Also, we now have *Patient Portal*. You can now view and print your medical records online. You can enter all of your information before you come into the office to see the Doctor. Once you sign up for this FREE service, you will be sent an e-mail telling you how to get into your account. Follow the step by step directions in the e-mail. To sign up for this FREE service, please print your e-mail address below:

☐ I accept participation

☐ I decline participation

E-mail address: _____

Patient Signature:_____ Date: _____

Suncoast Obstetrics and Gynecology

LAB REQUEST FORM

There are times when tests performed in our office will be sent to outside laboratories for evaluation and interpretation. Please inform us which laboratory you want us to send your tests performed in our office. (e.g., Pap smear, cultures and pathology specimens)

Lab Corp _____ **Quest** _____ **Gynecor** _____ **Other** _____

It is your responsibility to make sure that we are informed which laboratory you want us to send your test. Our office fee ***does not*** include lab charges. Please sign below that you have communicated to our office which facility you prefer. We will keep this on file in your chart. If there are any changes in the future, please let our office know. We will need you to sign another form, so we can keep your file updated.

SELF PAY PATIENTS:

When we send specimens to an outside laboratory, ***you will incur additional costs and be billed by the laboratory which performs the testing.*** We typically will choose a laboratory and try to minimize the costs that you incur. Many times we are unable to predict or even give a reasonable estimate of the costs that may be incurred or charged by an outside laboratory.

If you desire to take the specimen yourself and submit it to a laboratory of your choice and hand deliver it to that laboratory, you will need to tell us this in advance. If you do not wish to have any specimens sent to an outside laboratory, you are also required to tell us this in advance. If you do choose this option, we will not be able to perform cultures, pap smears or pathology specimens during your evaluation.

Patient Name: _____ Date: _____

Patient Signature: _____

Suncoast Obstetrics and Gynecology

Financial Policy / Insurance Information

Suncoast OB/GYN's Financial Policy is designed to help avoid misunderstandings about billing and payment for our services. Our goal is to provide the best possible medical care while also controlling administrative costs. This policy outlines patient and practice responsibilities regarding billing and payment for services.

- Our practice participates with many health insurance companies. Our billing staff will submit claims for services rendered to a patient who is a member of one of these plans. Our patients must provide all necessary insurance information and complete all required forms before leaving the office.
- If a patient is a member of an insurance plan with which we do not participate, the patient is expected to make payment in full at the time of service; however, we will file the claim on the patient's behalf.
- If a patient has no insurance and will be a self pay, the fee we charge is for our office only. Any lab bills or any other orders will be between the patient and the facility where the testing is to be done. It is the patient's responsibility to contact the facility providing the services.
- It is the patient's responsibility to make payment at the time of service for any co-payment or co-insurance due. Any services not covered by patient's insurance plan are the patient's responsibility and payment in full is expected at the time of service. Failure to make a co-payment on the day of service or pay in full within 90 days will result in your account being placed with the Collection Agency and a 50% Collection Fee will be added to your balance. Once your account has reached our collection agency, you will be required to pay in full before scheduling another appointment with our office.
- Payment for services can be made by cash, check, credit card or debit card. We accept all major credit cards. Suncoast OB/GYN reserves the right to charge a minimum fee of $35.00 for all returned checks.
- It is the patient's responsibility to ensure that any required authorization or referral for treatment is provided prior to the visit. In the absence of a required referral or authorization, the patient may be personally responsible for payment for the services rendered. You will also have the option to reschedule your appointment.
- It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at **EACH VISIT.** Also, to provide us with any changes with address or phone numbers.
- Our billing team is happy to help with insurance questions relating to claims that have been filed, provide additional information the insurance carrier needs to process the claim and provide financial counseling regarding non-covered benefits. However, patients should direct questions about coverage for specific procedures to an insurance company representative. We recommend that you speak with the member services department and obtain and document the name of the representative you speak with. The phone number for member services is usually on your insurance card.
- If you are scheduled for surgery, you are responsible for any un-met deductible or co-insurance payment to our office at least one week prior to date of surgery. **Please no checks!** In addition to the surgeon's fee, Hospital and Anesthesiologist will be billed separately. Their fees are separate from ours. You are responsible to find out if they are participating with your insurance. We are not responsible for their billing.

Patient Signature Date

Printed Name