Boston OBSTETRICS & GYNECOLOGY

REGISTRATION FORM

Primary Care Physician's Full Name: **PCP Phone:**

PATIENT INFORMATION

Patient's Last Name:	First:	MI:	Birth date: / /

Former/Maiden name:	Race: Ethnicity:	Marital status (circle one): Single / Married / Divorced / Legally Separated / Widow

Street address:	Apt/Unit:	Social Security no.:

City:	State:	Zip Code:	❑ Mailing Address ❑ Permanent Address

Home phone no.:❑Best #	Cell Phone no.: ❑Best #	Work phone no: ❑Best #	Ok to leave confidential phone message on your "best" phone number?
( )	( )	( )	❑Yes ❑No

Email Address:	Would you like us to sign you up for the patient portal? (Gives you the ability to view your medical record, lab results, request rx's, track appts., etc. securely online.) ❑Yes ❑No
Employer/Occupation:	

I chose clinic because or was referred to clinic by:

❑ Family ❑ Friend ❑ Close to home/work ❑ Internet Search ❑ Dr._____

Other family members seen here (please list all)**:**

INSURANCE INFORMATION

Primary Insurance (check one): ❑ Blue Cross Blue Shield ❑ Harvard Pilgrim ❑ United HealthCare ❑ Cigna ❑Aetna
❑ Tufts ❑Network ❑Neighborhood ❑BMC ❑Tricare ❑MassHealth ❑Medicare ❑Other:

Subscriber's name:	**Subscriber's DOB** / /	**Policy Number:**	**Group no. (if applicable):**

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Policy no.:	Group no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

PHARMACY INFORMATION

Local Pharmacies- ❑ CVS ❑ Walgreen's ❑ Rite Aid ❑ Osco ❑ Stop & Shop ❑ Target ❑ Wal-Mart ❑ Eaton ❑ J.E. Pierce ❑ Other:
Mail Order Pharmacies- ❑ Express Scripts ❑ Medco ❑ Bioscript ❑ Other:

Pharmacy Street:	**City:**	**Phone no:**

IN CASE OF EMERGENCY

Name of local emergency contact person:	**Relationship to patient:**	**Primary phone no.:** ( )	**Work phone no.:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Boston Ob/Gyn or insurance company to release any information required to process my claims.

Patient/Guardian Signature:_____ Date:_____

Boston Obstetrics & Gynecology LLC

Patient Addressograph

OBSTETRIC MEDICAL HISTORY

Name:

DOB:

Patient Name: _____

Date Form Completed: _____

* If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

PERSONAL HEALTH HISTORY

1. ☐ Yes ☐ No Are you allergic to any medications?

If yes, please list: _____

2. Please mark any condition that you have or have had in the past:

☐ Cancer	☐ HIV/AIDS	☐ Diabetes
☐ Epilepsy	☐ Thyroid disorder	☐ Eating disorder
☐ Heart disease	☐ Headaches	☐ Depression
☐ High blood pressure	☐ Arthritis or lupus	☐ Asthma
☐ Kidney disease	☐ Frequent infections	☐ Anemia
☐ Hepatitis	☐ Bowel disease	☐ Herpes
☐ von Willebrand's disease or other bleeding disorders		☐ Sexually transmitted diseases
☐ Blood clotting disorder (eg, phlebitis)		☐ Recurrent urinary tract infections

Describe, if needed: _____

3. Please indicate any surgery that you have had: _____

4. Please describe any health problems or symptoms that you are having at this time: _____

5. ☐ Yes ☐ No Do you or any family member have a history of problems with anesthesia?

If yes, please describe: _____

6. ☐ Yes ☐ No Do you have any religious objections to any form of medical treatment (eg, refusal of blood transfusion)?

If yes, please describe: _____

 AA198 12345/65432

Boston Obstetrics & Gynecology LLC

Name:

DOB:

EXPOSURES AFFECTING HEALTH	
1. ☐ Yes ☐ No	Do you smoke cigarettes? If yes, how many packs per day? _____
2. ☐ Yes ☐ No	Do you drink alcoholic beverages? If yes, how often? _____ What type of drinks? _____
3.	Please list any medications taken since your last period, including prescriptions, over-the-counter drugs, multivitamins, other supplements, and any herbal medicines: _____
4.	Please list any illicit or recreational drugs used since your last period (eg, cocaine, marijuana):
5. ☐ Yes ☐ No	Do you have any reason to believe you may have been exposed to AIDS (eg, a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bisexual male, exposure to an intravenous drug user)?
6. ☐ Yes ☐ No	Are you ever exposed to chemicals or radiation (eg, X-rays)? If yes, please describe: _____
7. ☐ Yes ☐ No	Are you on a restricted diet? If yes, please describe: _____

GYNECOLOGIC HEALTH HISTORY	
1.	When was your last Pap test? _____
☐ Yes ☐ No	Have you ever had an abnormal Pap test? If yes, when and how were you treated? _____ What was the diagnosis? _____
2. ☐ Yes ☐ No	Have you ever had gonorrhea ☐, chlamydia ☐, or pelvic inflammatory disease ☐? If yes, when, how, and where were you treated? _____
3. ☐ Yes ☐ No	Have you ever had herpes? If yes, how often do you have outbreaks? _____
☐ Yes ☐ No	Have you ever had syphilis? If yes, how, when, and where were you treated? _____
4. ☐ Yes ☐ No	Have you ever used an IUD (intrauterine device) for contraception? If yes, please indicate when: _____
☐ Yes ☐ No	Did you have any problem with the IUD? If yes, please describe: _____
5. ☐ Yes ☐ No	Have you been treated for infertility? If yes, please describe when and treatment received: _____
6. ☐ Yes ☐ No	Do you have any other concerns related to your past health history? If yes, please list: _____

Boston Obstetrics & Gynecology LLC

Name:

DOB:

FAMILY HISTORY & GENETIC SCREENING

1. ☐ Yes ☐ No Have you or has the baby's father had a child born with a birth defect?
   If yes, please describe: _____

2. ☐ Yes ☐ No Did either you or the baby's father have a birth defect?
   If yes, please describe: _____

3. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (eg, mental retardation, birth defects, deformities, or inherited diseases such as hemophilia, muscular dystrophy, or cystic fibrosis):
   _____
   _____
   _____
   How is this child/person related to you? _____

4. ☐ Yes ☐ No Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillborn)?
   If yes, have either of you had genetic counseling? ☐ Yes ☐ No
   If yes, have either of you had chromosomal testing? ☐ Yes ☐ No
   Where and what were the results? _____

5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds:

   ☐ Yes ☐ No Eastern Europe Jewish ancestry
   If yes, have you had Tay-Sachs screening tests? ☐ Yes ☐ No
   If yes, have you had a Canavan screening test? ☐ Yes ☐ No
   Date _____ Result _____

   ☐ Yes ☐ No African American
   If yes, have you had sickle cell screening? ☐ Yes ☐ No
   Date _____ Result _____

   ☐ Yes ☐ No European Ancestry
   If yes, have you had cystic fibrosis screening? ☐ Yes ☐ No

   ☐ Yes ☐ No Mediterranean Ancestry or Southeast Asian Ancestry
   If yes, have you had screening for inherited forms of anemia such as thalassemia? ☐ Yes ☐ No

6. Please list any other concerns you have about birth defects or inherited disorders:
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

7. ☐ Yes ☐ No Will you be 35 years or older at the time the baby is born?

8. ☐ Yes ☐ No Will the father be 50 years or older?

Boston Obstetrics & Gynecology LLC

Name:

DOB:

PSYCHOSOCIAL SCREENING*	
1. ☐ Yes ☐ No	Do you have any problems (job, transportation, etc.) that prevent you from keeping your health care appointments?
2. ☐ Yes ☐ No	Do you feel unsafe where you live?
3. ☐ Yes ☐ No	In the past 2 months, have you used any form of tobacco?
4. ☐ Yes ☐ No	In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks)?
5. ☐ Yes ☐ No	In the past year, have you been threatened, hit, slapped, or kicked by anyone you know?
6. ☐ Yes ☐ No	Has anyone forced you to perform any sexual act that you did not want to do?
7.	On a 1–5 scale, how do you rate your current stress level? Low · 1 2 3 4 5 High
8.	How many times have you moved in the past 12 months? _____
9.	If you could change the timing of this pregnancy, would you want it ☐ Earlier ☐ Later ☐ Not at all ☐ No change

*Modified and reprinted with permission from Florida's Healthy Start Prenatal Risk Screening Instrument. Florida Department of Health. DH 3134. September 1997.

_____

Patient Signature

_____

Print Name

_____

Date

Boston OBSTETRICS & GYNECOLOGY

Medication List

Patient Name:_____ Date of Birth: _____

Drug Allergies:	Describe Reaction:
1.	
2.	
3.	
4.	
5.	

	Start Date	Medication Name	Dose/Strength	Frequency	What is this medication for?
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

Disclaimer: This list represents the medicines you are taking based on the information you have provided us. If you have any questions or concerns about medicines we did not prescribe, please contact the prescribing physician.

Patient Signature:_____Date:_____ Reviewed by:_____

Notice of Privacy Practices

Brenda Baker, M.D. Anjélica Carbajal, M.D. Jacqueline Croopnick, M.D. Mimi Yum, M.D. Michelle Lafornara, M.D.

ONE BROOKLINE PLACE
SUITE 423
BROOKLINE, MA 02445
Phone: 617-566-1535 Fax: 617-566-0988

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.

This Notice of Privacy Practices describes how we 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. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support the operation of the physician's practice and any other use required by law.
2. **Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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.
3. **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
4. **Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients in the hospital. In addition, we may use a sign-in sheet at the front desk where you will be asked to sign your name, time of arrival and update your demographic information. We may, also, call you by name in the waiting room when the physician, the nurse practitioner or the nurse is ready to see you. We may use or disclose your protected health information, as necessary; to contact you to remind you that it is time to set up your annual appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation, Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

1. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

2. You have the right to request a restriction or your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also, request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

3. You have the right to request to receive confidential communications from us by the alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request.

4. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

5. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number 617-566-1535.

THIS COPY IS FOR YOUR RECORDS-PLEASE SIGN THE CONSENT ON THE SIGNATURE PAGE THAT WAS GIVEN TO YOU AT CHECK-IN.

HIPAA & CONFIDENTIALITY NOTICE FORM

Patient First & Last Name:	Date of Birth:

HIPAA Notice of Patient Privacy Practices

I acknowledge receipt of Boston Obstetrics & Gynecology, LLC practice privacy notice. I may request an additional copy of the privacy notice at any time.

X_____ **Date:**_____
Patient Signature

Consent to communicate with PCP, Community Care Providers and/or Mental Health Providers

In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician and other community care providers, including mental health providers, and to your insurance company. These communications may include information about your medical treatment and mental health of substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care.

Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician, Health Insurance Company and/or mental health providers.

X_____ **Date:**_____
Patient Signature

Consent for Rx Hub Inquiry

I hereby provide my consent for the Practice of Boston Obstetrics & Gynecology, LLC to obtain my Rx History using the SureScripts-RxHub network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-RxHub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to-system communications.

X_____ **Date:**_____
Patient Signature

Doctors affiliated with Beth Israel Deaconess Medical Center (BIDMC) and other doctors who participate in the Beth Israel Deaconess Care Organization (BIDCO) participate in a **Health Information Exchange (HIE).** The HIE is a secure computer network that, with my permission, will allow my BIDMC and BIDCO providers to view all of my health information (medical records). The HIE protects the confidentiality, privacy and security of the information. By making my health information available electronically, my BIDMC and BIDCO providers will be able to better coordinate my care. By signing this form, I give my permission to my BIDMC and BIDCO providers to view my health information electronically via the HIE.

I understand that my health information may contain (now or in the future) certain types of sensitive information:

- ☐ HIV/AIDS status
- ☐ genetic testing
- ☐ treatment for substance abuse (alcohol or drug)
- ☐ venereal disease(s)
- ☐ mammography records
- ☐ family planning services
- ☐ confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human services professional
- ☐ if I am an emancipated minor, information about my treatment and diagnosis (but not shared with my parents)

By signing this form, I agree to the release of *all* my health information, including sensitive information, to my BIDMC and BIDCO providers through the HIE.

> If you do not wish for sensitive information to be released in connection with the HIE, please do not sign this consent.

I understand that BIDMC, BIDCO, and my health care provider have taken reasonable steps to protect my confidentiality.

This Authorization will stay in effect from the date of my signature below until my provider is no longer participating in the HIE. I have the right to take back my consent (revocation), in writing, at any time. My revocation will be effective when my provider receives it. I may also contact my provider's Privacy Officer by mail at [insert address], by telephone at [insert number] or by email at [insert email address].

I have read this Authorization form and I understand what it says. All of my questions have been answered in a language that I understand. I agree with the information on this form. By signing this form I authorize my health care provider to use or disclose my health information in order to participate in the HIE.

_____ _____

Signature of Patient Date

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____

Signature of Authorized Personal Representative | Relationship to Patient | Date

Patient Name:_____

Date of Birth:_____

Patient Financial Responsibility Consent Form

Welcome to Boston Obstetrics & Gynecology, LLC. Please read carefully this important information about your financial responsibility for payment of you care and services.

The providers of Boston Ob/Gyn are participating providers with most insurance companies. However, our list of accepted insurances is subject to change at any time and not all plans under all companies are accepted. In order to avoid unexpected charges, **please confirm that your particular health benefit plan is accepted by Boston Ob/Gyn.** You should reach out to your carrier when you initiate care here to familiarize yourself with the limits of your policy and what it will and will not provide coverage for. We do our best to guide patients through this process, but ultimately it is impossible for us to keep abreast of the requirements in the thousands of insurance products on the market**. It is an individual patient responsibility to understand the provisions, limits and requirements of their individual benefit plan(s) and advise us accordingly.**

Please be aware that patients are ultimately responsible for insuring payment for all medical services provided. If a carrier denies payment for services because a plan requirement was not met, services were considered "non-covered", the plan benefits were exceeded, care is considered medically unnecessary or treatment is considered experimental, among other reasons, patients will be held accountable for those charges.

Please bring your insurance card with you to each visit and notify our staff of any changes in your coverage. All patient accounts are to be paid at the time of service. We will ask you for payment on any outstanding balances prior to being seen by your physician. Boston Ob/Gyn accepts cash, checks and major credit cards. Checks that are returned to Boston Ob/Gyn unpaid from your account will be assessed an additional $25.00 Non-Sufficient Funds fee.

LABWORK: Throughout the course of your care, your physician may send blood and tissue samples to a variety of clinical laboratories. **If your insurance plan contains restrictions or limitations on lab work, please make it known to our staff before your blood is drawn or sent for processing**. Provided you let us know in advance of a test being performed, we can in many instances, route routine samples to labs that will accept your insurance.

Please be aware that Boston Ob/Gyn has no role in or control over billing issues related to clinical laboratory or imaging fees. If you have questions about bills received for laboratory charges or insurance coverage available to you, please contact the clinical laboratory in question and / or your insurance provider.

Boston OBSTETRICS & GYNECOLOGY

OTHER FEES NOT COVERED BY INSURANCE:

APPOINTMENT CANCELLATIONS: When you make an appointment, we reserve time specifically for you. Unfortunately, when a patient does not show for their scheduled appointment, another patient loses an opportunity to be seen. Therefore, if you need to cancel or re-schedule, you are asked to notify us as soon as possible, but by no later than 24 hours in advance. Appointment cancelled without 24 hours notice may be assessed a cancellation fee of $25. Habitually cancelling or not showing to your appointments may cause us to ask you to find another physician for your healthcare needs.

SEL-PAY (patients w/o insurance): We have a self-pay discount for those patients who choose to have an appointment without insurance coverage. Payment in full is required at the time of the visit. Patients who would like to find out about the cost of a self-pay visit, should call or meet with our billing department. The cost that is quoted is subject to change based on the actual visit/consult with the physician. Additionally, the cost that is quoted is for *physician services only*. It does not include necessary labs, cultures, bloodwork, radiology, etc. as those are all billed by and paid to outside facilities.

The providers and staff of Boston Obstetrics & Gynecology, LLC are committed to excellence in customer service and quality of care of our patients. Feel free to contact our office for questions or concerns regarding your financial health insurance issues.

_____ _____

Patient Signature Date Signed

_____ _____

Witness Signature Date Signed