# Associates in Central Ohio OB/GYN, INC

**575 Westar Crossing, Suite 102 • Westerville, OH 43082 • (614) 839-5555**
**6482 East Main Street, Suite B • Reynoldsburg, OH 43068 • (614) 856-0327**
acoog-obgyn.com

Dear _____,

We are happy that you have chosen us for your Gynecological care. To ensure that your visit is prompt as possible, we have enclosed your registration paperwork. Please complete and present it to the receptionist upon arrival to your appointment. In addition, we also require that you present your insurance card and co-pay, deductible, or coinsurance due at the time of service. If you have had a recent insurance change and have not yet received a card from your insurance carrier, you must contact our office prior to your appointment so that we may advise you of the information required prior to being seen. We ask that you arrive for your appointment 30 minutes early to complete the registration process. In order for our physicians to maintain a timely schedule and to keep our patients' wait time minimum, we ask that you please read the list of office policies below. If you fail to comply with any of these items, you will be asked to reschedule.

- ALL PAPERWORK MUST BE FILLED OUT COMPLETELY.
- YOU MUST HAVE YOUR INSURANCE CARD AND ANY REQUIRED CO-PAY, DEDUCTIBLE, OR COINSURANCE AT THE TIME OF YOUR APPOINTMENT.
- YOU MUST BE ON TIME FOR YOUR APPOINTMENT. IF AT ANY TIME YOU HAVE A CHANGE OF ADDRESS, EMPLOYMENT, OR INSURANCE WE ASK THAT YOU ARRIVE AT LEAST 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME IN ORDER TO UPDATE THIS INFORMATION
- IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL, YOU MUST OBTAIN THIS PRIOR TO YOUR APPOINTMENT. IF YOU DO NOT HAVE THE PROPER REFERRAL, YOU WILL BE ASKED TO RESCHEDULE.
- PLEASE GIVE 24 HOURS NOTICE TO CANCEL OR RESCHEDULE AN APPOINTMENT. FAILURE TO DO SO MAY RESULT IN A NO-SHOW CHARGE BEING APPLIED TO YOUR ACCOUNT.

We look forward to meeting you!

Sincerely,

*The Providers of Associates in Central Ohio OB/GYN*

# Associates in Central Ohio OB/GYN, Inc. (ACOOG)

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☐ New patient ☐ Established patient

## Patient Information

Last Name First Name Middle Initial

Address

City State Zip Code

Home Phone Work Phone Cell Phone

E-mail Address Marital Status

**Preferred method for appointment reminders (Check one): Call☐ E-mail☐ Text☐** Primary Care Physician:_____

Social Security Number: ____ - ____ - ____ Date of Birth: ____ / ____ / ____

## Emergency Contact

May we release protected health information to this individual? ☐ YES ☐ NO

Last Name First Name MI

Address

City State Zip Code

Home Phone Work Phone Cell Phone

E-mail Address Relationship

## Insurance

What is the name of your insurance provider: ☐ Medicare ☐ Medicaid ☐ Other

Other (Please Specify): _____ Effective Date: ____ / ____ / ____

/

Name of policy holder: Last Name First Name Middle Initial Relationship to Patient

Address of policy holder if not the same as Patient's

City State Zip Code

Phone: (_____) _____ - _____

Social Security Number of Policy Holder: _____ - _____ - _____ Policy Holder Date of Birth: _____/_____/_____

Insurance Identification Number: _____ Group Identification Number: _____

## Employment

Status: ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Unemployed Other: _____

Name of Employer (Company Name) Occupation

Phone Number: (____) ____ - ____

Address

City State Zip Code

Preferred Name: Pronouns:

DOB: Age:

Primary Care Doctor:

Pharmacy: Pharmacy #:

Pharmacy Address:

Reason for Visit:

| Allergy (medication, food, latex, etc.) | Reaction |
|---|---|
| | |
| | |
| | |
| | |

____ No Known Allergies

| Medication | Dose | Frequency | Prescriber |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are you currently experiencing, or do you have a history of domestic violence? Yes No

Are you currently experiencing, or do you have a history of sexual assault? Yes No

Personal History of Any of the Following:

| | | |
|---|---|---|
| Anemia | Glaucoma | Lupus |
| Arthritis | Heart Disease | Seizures |
| Asthma or COPD | High Blood Pressure | Sickle Cell |
| Blood Clots | High Cholesterol | Stomach Ulcers |
| Diabetes: Type 1 or Type 2 | Kidney Infection or Stones | Stroke |
| Eating Disorder | Liver or Gallbladder Disease | |
| | | |
| Anxiety | Hematologic (bleeding) Disease | Varicosities |
| Celiac Disease | Hypothyroidism | Cervical Cancer |
| Depression | Infertility | Colon Cancer |
| Endometriosis | Osteoporosis/Osteopenia | Uterine Cancer |
| Fibroids/Leiomyoma | Pre-eclampsia | Vulvar Cancer |
| Gestational Diabetes | Thrombophilias/Clotting Disorder | Other Cancer: _____ |
| Headaches/Migraines | Urologic Disorder | |

Have you ever been hospitalized? If yes, briefly list when, where, and what for:

| | |
|---|---|
| First Day of Your Last Menstrual Period: | |
| How often do you get a period? | |
| How many days do your periods last for? | |
| Monthly Flow: | Light Moderate Heavy |
| Are your periods painful? | Yes No |
| Do you have bleeding between periods? | Yes No |
| Date of last pap test: | |
| Result: | Normal Abnormal |

Have you ever needed any of the following for an abnormal pap test? If yes, when?

| | |
|---|---|
| Colposcopy | Laser |
| Cold Knife Cone | LEEP |

| | |
|---|---|
| Age at First Period: | |
| Age at Last Period: | |
| If menopause, any postmenopausal bleeding? | Yes No |

Have you ever received the HPV vaccine, known as Gardasil: Yes No Unsure

| | |
|---|---|
| Have you ever been sexually active? | Yes No If no, please skip this section. |
| Are your partners: | Male Female Both |
| Number of partners in the past year: | |
| Do you have any sexual problems? | Yes No |
| If yes, please list: | |

Do you have a history of any of the following?

| | | | |
|---|---|---|---|
| Chlamydia | Hepatitis | HIV | Syphilis |
| Gonorrhea | Herpes | HPV | Trichomonas |

| | |
|---|---|
| Are you planning pregnancy in the next year? | Yes No |
| Are you consistently preventing pregnancy? | Yes No |
| What birth control are you currently using? | |
| What is your desired birth control method? | |
| Are you interested in emergency contraception? | Yes No |

| | Date | Location | Result |
|---|---|---|---|
| Last Mammogram | | | |
| Last Bone Scan | | | |
| Last Colonoscopy | | | |

Total Number of Pregnancies: Total Living Children:

Total Number of Miscarriages or Abortions: Total Ectopic Pregnancies:

| Date | Weeks | Weight | Sex | Vaginal, Cesarean | Complications |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Family History**

| | |
|---|---|
| Mother: | |
| Father: | |
| Siblings: | |
| Grandparents: | |
| Other Pertinent History: | |

____ Family History Unknown

| | |
|---|---|
| Tobacco Use | Never Former Current |
| Alcohol Use | None Occasional Moderate Heavy |
| Recreational Drug Use, including THC | Never Former Current |
| Caffeine Use | None Occasional Moderate Heavy |
| Exercise Level | None Occasional Moderate Heavy |
| Have you ever received a blood transfusion? | Yes No |

Gender Identity:

Assigned Sex at Birth:

Sexual Orientation:

| Date | Surgery | Location Performed |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Do you experience any of the following:

Abdominal Pain
Blood in Urine
Chest Pain
Constipation
Diarrhea
Fatigue
Hot Flashes
Night Sweats
Pain with Sex
Pain with Urination
Pelvic Pain
Shortness of Breath
Skin Changes
Sleep Problems
Urinary Incontinence/Leaking
Urinary Urgency
Vaginal Discharge
Vaginal Itching
Vaginal Odor
Weight Gain
Weight Loss (unintentional)

**Risk assessment for hereditary cancer syndromes**

Patient name: _____ Patient date of birth:_____

Have you had BRCA or other cancer genetic testing in the past (check one)?

_____ Yes (date_____) If so, you don't have to continue filling out this form.

_____No. Please continue.

For the following questions, please consider the following individuals: Yourself, mother, father, sister, brother, cousin, aunt, uncle, grandparents, niece, nephew, great grandparents.

| **Family history of Cancer** | | | **Mother's side (who and what age)** | **Father's side (who and what age)** |
|---|---|---|---|---|
| Yes | No | Example | Self age 30, Aunt age 40, cousin age 20 | |
| Yes | No | Ovarian Cancer | | |
| Yes | No | Breast cancer **before age 50** | | |
| Yes | No | Two or more breast cancers on the same side of the family | | |
| Yes | No | Male breast cancer | | |
| Yes | No | Ashkenazi Jewish ancestry **AND** breast, ovarian or pancreatic cancer | | |
| Yes | No | Colorectal or uterine (endometrial cancer) **before age 50** | | |
| Yes | No | Three or more colorectal or uterine(endometrial) cancers on the same side of the family | | |

**Office use only:**
Meets criteria for genetic testing? Yes No
If yes, please check one:
_____Affected family member tested negative, testing not indicated.
_____Genetic test today.
_____Patient to consider (Brochure given: Yes No).
_____Referral sent for genetic counselling.
_____Other: _____

Provider signature: _____

PRIVIA HEALTH

## Authorization and Consent to Treatment

***Assignment of Benefits and Authorization to Release Medical Information.*** I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

***Guarantee of Payment & Pre-Certification.*** In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

***Consent to Treatment.*** I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being; however I may refuse any particular treatment or procedure.

If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

***Consent to Call, Email & Text.*** I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

***HIPAA.*** I understand that my provider's Privacy Notice is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and that I may request a paper copy at my provider's reception desk.

***I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.***

**Printed Name of Patient:** **Email:** _____

**Signature:** _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

**Name and Relationship of Person Signing, if not Patient:** _____

***Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.**

PRIVIA HEALTH

**Preferred Communication:**
The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

**Patient Name:** **Date of Birth:**

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

☐ **Send all communication through my Patient Portal.**

☐ **Home Telephone:**_____ ☐ **Cell Phone:**_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Work Telephone:**_____ ☐ **Written Communication:**_____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Please send all of my mail to my home address on file
- ☐ Please send all mail to THIS address:

_____

_____

☐ **Other:**_____

**My Preferred Contacts:**

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results. **You** have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information below**Please update this information in writing promptly if your preferences change.**

**Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.**

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experience team at 1-888-774-8428 - Monday – Friday 8 am – 6 pm ET.

**•Name:**_____**Telephone:**_____**Relationship:**_____
**Email::**_____

**•Name:**_____**Telephone:**_____**Relationship:**_____
**Email::**_____

**•Name:**_____**Telephone:**_____**Relationship:**_____
**Email::**_____

**ACKNOWLEDGMENT:** I understand that HIPAA may permit my provider to share my information with other persons**not** named on this form as needed for my care or treatment or to obtain payment for services provided.

**Patient Signature:** _____ **Date:** _____
**(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)**

# Associates in Central Ohio OB/GYN, Inc.

The doctor and patient are desirous of entering into and/or maintaining a positive physician/patient relationship that focuses on quality patient care and open lines of communication. The parties to this agreement shall agree to pursue a good faith effort to resolve any problems that may arise between them. As a part of entering into the physician/patient relationship, the patient agrees to submit in writing to Associates in Central Ohio OB/GYN, Inc., any dispute, controversy or disagreement arising out of or relating to the physician/patient relationship and the agreement to provide medical services.

1. After the matter has been presented in writing to Associates in Central Ohio OB/GYN, Inc., the parties shall use negotiation in an attempt to reach a voluntary resolution of their differences.

2. If the dispute, controversy or disagreement is not resolved in a reasonable time, then the matter shall be submitted to mediation in accordance with the Associates in Central Ohio OB/GYN, Inc. Rules of procedure.

   Mediation is a process in which a neutral third party helps the doctor and the patient discuss the issues that have arisen between them with the ultimate goal of resolving any problems. Either party is entitled to seek legal representation at any time, but Associates in Central Ohio OB/GYN, Inc. wishes to provide the patient with this opportunity to settle any problems that may have arisen without the need to incur additional cost and fees.

   These Mediation Rules of Procedure provide in part that:

   - The patient is not required to reach a resolution in mediation.
   - The mediator (or co-mediators) will be a neutral third party who is trained in mediation.
   - All mediation sessions are considered confidential as defined in Ohio Revised Code 2317.123.
   - The costs of mediation will be paid by Associates in Central Ohio OB/GYN, Inc.
   - The date, time and place of any mediation session shall be scheduled by the mediator in consultation with the parties.
   - The use of mediation does not preclude either party from pursuing any other remedies that may be available to them.
   - Any agreements reached by the parties shall be in writing and signed by both parties.
   - Parties considering mediation should remember by signing this agreement they agree to make a good faith effort at mediation prior to pursuing litigation. Any decisions may affect their legal rights. Mediation is not a substitute for legal advice. Parties should consult with their legal counsel for any questions regarding legal rights.

It is the goal of Associates in Central Ohio OB/GYN, Inc. that all physicians and patients engage in a cooperative approach to ensure quality healthcare and that any conflicts that may arise between them will be resolved in the same cooperative style through mediation.

Patient _____ Date _____

Doctor _____ Date _____

PRIVIA HEALTH

## FINANCIAL POLICY

We are pleased that you have chosen us as your healthcare provider. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care. We require all patients to sign our *Authorization and Consent To Treatment Form* before receiving medical services. That form confirms that you understand that the healthcare services provided are necessary and appropriate and explains your financial responsibility with respect to services received as set forth in this policy.

## PATIENT RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. When the insurance plan provides immediate information regarding patient responsibility, we may request payment for your share when you schedule and/or when you present for your appointment. As a convenience to you, we can save a credit card on file to settle your account when you check in or out. You may receive an estimate for your patient responsibility prior to or at the time of your service. If there is a difference in the estimated patient responsibility, we will send you a statement for any balance due. If a credit balance results after insurance pays, we will apply the credit to any open balance on your account. If there are no open balances, we will issue a refund.

If you have an Annual Wellness Visit or Physical/Preventative Exam, but need or request additional services, we may bill you for those additional services. All services for patients who are minors will be billed to the custodial parent or legal guardian. If you are uninsured and demonstrate financial need and complete the required paperwork, financial assistance may be available. If you have a large balance, a payment plan may be available.

## INSURANCE

We ask all patients to provide their insurance card (if applicable) and proof of identification (such as a photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e., self-pay). We accept assignment of benefits for many third party carriers, so in most cases, we will submit charges for services rendered to your insurance carrier. You are expected to pay the entire amount determined by your insurance to be the patient responsibility. Keep in mind that our fees are for physician services only; you may receive additional bills from laboratory, radiology or other diagnostic related providers.

**You are responsible for understanding the limitations of your insurance policy, including:**

- If a referral or authorization is necessary for office visits. (If it is required and you do not have the appropriate referral or authorization, you may be billed as an uninsured patient).
- What prescribed testing (lab, radiology, etc.) is covered under your insurance policy. (If you choose to have non-covered testing, we will require full payment at the time of your visit.)
- Any co-payment, coinsurance or deductible that may apply

## NO SURPRISES ACT / GOOD FAITH ESTIMATE OF CHARGES

If you do not have insurance or are not using insurance to pay for your care, you have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the NO SURPRISES ACT, health care providers must give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least one (1) business day before your medical service or item.
- You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-888-774-8428.

## CARD-ON-FILE PROCESS

You may be requested to provide a credit card when you check-in for your visit. The information will be held securely until your insurance has paid their share and notified us of any additional amount owed by you. At that time, we will notify you that your outstanding balance will be charged to your credit card five (5) days from the date of the notice. You may call our office if you have a question about your balance. We will send you a receipt for the charge.

This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork

and ultimately helps lower the cost of healthcare. Your statements will be available via your patient portal and our Customer Support line is available to answer any questions about the balance due. If you have any questions about the card-on-file payment method, please let us know.

**YOUR RESPONSIBILITIES**

***Outstanding Balances.*** After your visit, we will send you a statement for any outstanding balances. We send out statements when the balance becomes the patient's responsibility.

All outstanding balances are due on receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. Your outstanding balances can be paid conveniently via our patient portal.

We may add a finance charge of 1.33% of your outstanding account balance every month if you do not pay your account in full.

**If you have an outstanding balance for more than ninety (90) days, you may be referred to an outside collection agency and charged a collection fee of 23% of the balance owed, or whatever amount is permitted by applicable state law, in addition to the balance owed.** In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional services unless special arrangements have been made.

***No-shows.*** If you miss your appointment, you may be charged a $50.00 fee for a missed appointment, a $75.00 fee for a missed pediatric appointment, a $100.00 fee for a missed physical, or a $200 fee for a missed procedure or surgery. This fee will need to be paid before you are allowed to schedule another appointment. This fee cannot be billed to insurance.

***Interpreter and Translation Services.*** If you have requested interpreter or translation services for your visit and you miss your appointment without cancelling at least forty-eight (48) hours prior to your scheduled appointment, you may be charged the amount that the translation or interpreter service charges your care center for such missed appointment.

*Additional information about our financial policies is available on our website at priviahealth.com.*

***Thank you for choosing us as your healthcare provider!***