PATIENT INFORMATION

PATIENT NUMBER			SSN		
PATIENT NAME: LAST		FIRST			SUFFIX
ADDRESS 1			CITY	STATE	ZIP CODE
ADDRESS 2			CITY	STATE	ZIP CODE
HOME PH #	WORK PH # & EXT		CELL PH #	SEX	DATE OF BIRTH
EMPLOYER			E-MAIL		
PRIMARY CARE PHYSICIAN				MARITAL STATUS	
EMPLOYMENT STATUS	STUDENT STATUS	RELATIONSHIP TO RESPONSIBLE PARTY			

ACCOUNT/RESPONSIBLE PARTY INFORMATION

LAST NAME		FIRST NAME, MI		SUFFIX
ADDRESS 1		CITY	STATE	ZIP CODE
ADDRESS 2		CITY	STATE	ZIP CODE
HOME PH #	WORK PH # & EXT	CELL PH #	SEX	DOB
SSN	EMPLOYER	EMAIL		

INSURANCE INFORMATION

INSURANCE CARRIER NAME	CARRIER ADDRESS		
ID NUMBER	GROUP NAME	CARRIER PHONE NO.	
SUBSCRIBER NAME	SUBSCRIBER DOB		RELATIONSHIP TO

EMERGENCY CONTACT INFORMATION

LAST NAME	FIRST NAME	DATE OF BIRTH
HOME PH#	WORK PH#	CELL PH #	RELATIONSHIP TO PATIENT

FINANCIAL AGREEMENT

I, the undersigned, authorize direct payments to Central Oregon OB/GYN. I acknowledge that I will be financially responsible for all charges, whether or not paid by my insurance. If it becomes necessary for third party collections, the undersigned agrees to pay for all costs and expenses including reasonable attorney fees. In addition, I authorize Central Oregon OB/GYN to release information, as necessary, in order to facilitate treatment, payment or other healthcare operations to insurance companies or medical providers involved in my medical care.

Signature: _____ Date: _____

Patient or Legal Guardian

HEALTH HISTORY FORM

Name: _____ Age: _____ Birthdate: _____
Home/Cell Phone: _____ Work Phone: _____
Primary Physician: _____ Physician that referred you: _____
Reason for **visit** today: _____

Medication

Medication Name & Dose	Allergies & Reaction

Gynecological & Obstetrics History

When was the first day of your last menstrual period? _____
Age at your first period? _____ Frequency? _____ Flow
Do you have menstrual cramps/pain? __ How severe? Mild ___ Moderate Severe
Do you ever bleed between periods? _____ After intercourse? ____ Since Menopause? _____
What do you use for contraception? _____

Have you ever had:

____ Fibroids	_____ Genital Herpes	_____ Bacterial Vaginosis
____ Endometriosis	_____ Gonorrhea	_____ Yeast Infection
____ Ovarian Cysts	_____ Chlamydia	_____ Hot Flashes
____ Endometrial Polyps	_____ Genital Warts	_____ Vaginal Dryness/Itching
____ Pelvic Inflammatory Disease	_____ Syphilis	_____ Mood Swings

Have you gone through menopause? _____ No ____ Yes What age? _____
Date of last pap smear: _____ Normal? ____ Yes ___ No
Have you ever had an abnormal pap smear? ___ Yes __ No Did you have: cryo colpo leep cone
Date of last mammogram: _____ Normal? ____ Yes ___ No Self breast exam? ___ Yes ___ No

Total number of pregnancies _____ Number of living children ____ Number of miscarriages _____
Ectopic pregnancies _____ Terminations _____ Difficulty getting pregnant? _____ Yes ___ No

Previous Deliveries:	Vaginal or C-Section?
Date: _____	_____
Date: _____	_____
Date: _____	_____
Date: _____	_____

Sexual History

Are you sexually active? ___ Yes ___ No Do you ever have pain with intercourse? __ Yes __ No
Any history of sexual abuse? Yes No _____

Surgical History

Have you **ever** had any surgeries? __ Yes ___ No If yes, please indicate what kind and the date of surgery.

_____ _____
_____ _____

****PLEASE TURN PAGE OVER TO COMPLETE QUESTIONNARE****

FINANCIAL POLICY FOR CENTRAL OREGON OB/GYN

CENTRAL OREGON OB/GYN is dedicated to providing quality care to our patients and is committed to helping patients understand our financial expectations for services provided in our physician clinic settings.

PAYMENT

We accept cash, checks, Visa, MasterCard and Discover. Payment is expected at the time of service for scheduled, routine services. If the patient does not pay the required amount or make approved financial arrangements, routine services (i.e. non-emergent/urgent, not medically necessary) may be rescheduled or cancelled.

- Patients with Insurance Coverage
  - Co-pay/Co-insurance - 100% payable at time of service
  - Deductible - minimum of 50% of any remaining deductible amount or 50% of estimated charges
- Patients with No Insurance / Self Pay
  - Payment in full at time of service is encouraged and will result in a 15% discount against all charges.

Obstetric Patients

- Obstetric patients are asked to pay their estimated balance in full by their delivery date. They are required to contact the clinic Billing Office staff to discuss the monthly pre-payment plan.

BILLING INSURANCE

We submit claims to primary, secondary and supplemental insurance as a courtesy to patients. Health insurance is a contract between the patient and their insurance carrier and patients are encouraged to contact their insurance to resolve any delays in payment

- Motor Vehicle Accidents (MVA) / Third Party Liability / Workers Compensation claims
  - Patients must advise staff if services are related to a work injury or other accident. We also require regular health insurance information in the event that the claims are denied or benefits exhausted.

FINANCING OPTIONS

Any balance remaining after insurance pays or denies as non-covered is due upon receipt of a statement from our office. It is the patient's responsibility to contact the billing office if they require financing.

- Patients meeting an agreed upon monthly payment plan are not assigned to a collection agency and will not be charged interest on the remaining balance, provided they meet the commitments of the payment plan.
- Patients are responsible for communicating in advance to the Billing office anytime an agreed upon payment plan may be broken. Lack of communication from the patient may result in further collection action. Patient accounts sent to collection agencies will have any discounted amounts reversed and patient will be responsible for the entire cost of the services. There will be no appeal options if the account is sent to collection.
- There will be three (3) statements sent out prior to assigning the account to the collection agency for recovery.

FORMS FEES

A fee of $25 will be charged for completion of medical leave forms, attending physician statements and disability forms. There may be an additional fee of $10 for any additional paperwork submitted.
This fee covers our administrative expenses related to physician/staff time, photocopying and mailing.

I acknowledge that I have received a copy of this financial policy. I agree to read this document and comply with the terms set forth in this policy for services rendered by CENTRAL OREGON OB/GYN.

_____ _____ Date: _____

Patient / Guarantor printed name Patient / Guarantor Signature

CENTRAL OREGON OB/GYN
John A. Murphy, MD, PC
Erin LeGrand DO FACOOG
2450 NE Mary Rose Place, Ste 220
Bend, OR 97701

HIPAA Privacy and Release of Information Authorization

I, _____, hereby authorize CENTRAL OREGON OB/GYN and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services. I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____ _____
Patient Printed Name Date

_____
Patient Signature

HIPPA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: Relationship:

_____ _____

_____ _____

Contact Information: _____

_____

_____ _____
Name of Individual Giving this Authorization Date of Birth

_____ _____
Signature of Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. 164.524