Health ONE® Premier Integrated OBGYN
Physician Care℠

Email Address: _____ Age at **TODAY'S** Visit_____ Years

Patient Name (First): _____ (Last): _____ (Middle): _____
Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____
SSN#: _____-_____-_____ Date of Birth: _____/_____/_____
Gender Identity: ___Female ___Male ___Transgender Female to Male ___Transgender Male to Female
___Genderqueer ___Choose not to disclose ___Additional Gender category not listed _____
Ethnicity:
___White ___African American ___American Indian/Alaska Native ___Asian ___Hispanic Mixed Race ___Other Refused to Report
Marital Status (Circle): Married Single Divorced Widowed Partner Other: _____
Employment Status: Employed Self-Employed Not Employed Retired Student (Full time/Part time)
Employer Name: _____ Occupation: _____
Employer Address: _____ City: _____ State:_____ Zip Code:_____
Primary Care Physician: _____ Phone Number: (_____) _____

Spouse/Partner Information

Name (First): _____ (Last): _____(Middle): _____
Cell Phone: (_____) _____ Work Phone: (_____) _____
Date of Birth: _____/_____/_____ Sex (circle): Female Male Occupation: _____

Emergency Contact

Name (First): _____ (Last): _____ Relationship: _____
Home: (_____) _____ Cell: (_____) _____ Work: (_____) _____

Primary Insurance Information and Responsible Party Information Same as above □

Responsible Party Name (First): _____ (Last): _____ (Middle): _____
Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (_____) _____ Cell Phone: (_____) _____
E-mail address: _____
SSN#: _____-_____-_____ Date of Birth: _____/_____/_____ Sex (circle): Female Male
Employer Name: _____Work Phone: (_____) _____
Employer Address: _____ City: _____ State: _____ Zip Code: _____
Insurance Name: _____ Customer Service Phone: (_____) _____
Subscriber ID: _____ Group ID:_____ Copay $:_____
Effective Date:_____ Termination Date: _____
Billing Address: _____ City: _____ State:_____ Zip Code:_____

Patient Signature: _____ Date: _____

HPV & Pap Smears

In recent years, our knowledge of abnormal cells in the cervix caused by HPV (human papillomavirus) has grown exponentially. We now know that significant cervical abnormalities and cancers of the cervix are caused by infection with certain high-risk strains of HPV. 50-75% of healthy women will suppress an acquired HPV infection within 18 months. In addition, it takes several years an initial HPV infection to progress to significant cervical abnormalities. In light of this information, the American Congress of Obstetricians and Gynecologists recommends the following:

1. **Adolescents (women age 20 and younger):** Pelvic examination only when indicated by medical history. No Pap smear testing.

2. **Women ages 21-24:** Pap smear testing every 3 years.

3. **Women ages 25-29:** Pap smear testing every 3 years. An HPV test should be done only if the Pap smear reveals atypical cells.

4. **Women age 30 and older:** Pap smear and HPV testing every 5 years. When these are done together, the sensitivity of the test increases so that only 1 in 1,000 significant cervical abnormalities are missed. If a woman tests persistently positive for high-risk strains of HPV (even if the cervical cells appear normal), she will require additional evaluation.

5. **Woman age 65 and older:** No Pap smear testing, unless significant abnormalities of the cervix have been found in the preceding 20 years.

Regardless of your Pap smear and HPV test results, you must be seen annually for a breast exam, pelvic exam, and counseling regarding women's health issues.

While the HPV test is covered by most insurances plans, you may receive a bill due to the following: 1. You have not yet met your annual deductible, 2. Your insurance plan has a co-share (i.e. Plan pays 80%, Patient pays 20%), 3. You have a lab deductible, 4. Your employer has decided to "carve out" or not pay for specific screening tests.

Please call the following number to determine your specific payment responsibility: 1-866-895-1HPV (1-866-895-1478)

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature: _____ Date: _____

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PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. _____ (Patient or Guardian Initials)
Financial Agreement.

- I acknowledge, that as a courtesy, Premier Integrated OBGYN may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____ **(Patient or Guardian Initials)**
Third Party Collection. I acknowledge that Premier Integrated OBGYN may utilize the services of a third party business affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____ **(Patient or Guardian Initials)**
Assignment of Benefits. I hereby assign to Premier Integrated OBGYN any insurance or other third-party benefits available for health care services provided to me. I understand Premier Integrated OBGYN has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Premier Integrated OBGYN, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

4. _____ **(Patient or Guardian Initials)**
Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Premier Integrated OBGYN by the Medicare or Medicaid program.

5. _____ **(Patient or Guardian Initials**)
Consent to Telephone Calls for Financial Communications. I agree that, in order for Premier Integrated OBGYN , or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Premier Integrated OBGYN or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Premier Integrated OBGYN or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____ **(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature: _____ **Date:** _____

If you are not the Patient, please identify your Relationship to the Patient (Circle or mark relationship(s) from list below):

Spouse Guarantor Parent Legal Guardian Healthcare Power of Attorney Other: _____

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TO BE COMPLETED FOR ALL ANNUAL WELL-WOMAN VISITS

Patient Name: _____ Date of Birth: _____/_____/_____

We would like to clarify for you what an **"Annual Well-Woman Visit"** represents. This visit is a time for you and your physician to review your medical history, to perform a comprehensive physical examination. **The focus of the visit is on the promotion of health and prevention of disease.**

Topics to be included are breast and pelvic exam, appropriate cancer screening, family history looking for inherited diseases, high-risk behaviors such as smoking, alcohol use and drug use, and obesity. The goal of the visit is to identify risk factors for current or future health problems and to identify undetected problems so they can be addressed. It is also a chance for you to share with us your health concerns.

The following are examples of things that are included in an annual well-woman visit: cervical cancer screening, clinical breast exam, recommendation for mammogram or colonoscopy, routine immunizations, surveillance of existing birth control or hormone replacement therapy, and discussion of safe sex practices.

Evaluation or treatment of additional medical concerns you may have, or newly diagnosed or chronic medical problems (such as high cholesterol, high blood pressure, skim problems) particularly when testing and/or management of medications is involved, is not part of the annual well-woman visit. We have generally included management of these problems in the same visit as the well-woman exam for the sake of patient convenience. Otherwise, a separate visit would need to be scheduled.

However, for some patients, a visit for both a well-woman exam and management of other medical problems/concerns at the same visit may trigger a copay/co-insurance for the visit. Please understand that a copay/co-insurance may be charged because you are having two services on the same day. If this situation is unsatisfactory to you, we can schedule the services on separate days.

We hope this clarifies for you how we try to coordinate your preventive care needs with treatment of your new or chronic medical problems.

Patient Signature:

_____

Date:

_____

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Patient Consent Form

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician of their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until I revoked in writing.

I understand **Premier Integrated OBGYN** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge the **Premier Integrated OBGYN** will use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

Medicare Patients: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services at **Premier Integrated OBGYN.**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	Date
Printed Name of Patient or Personal Representative	Relationship to Patient
Printed Name of Witness	Employee Job Title
Signature of Witness	Date

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Premier Integrated OBGYN "No-Show" Policy

Our goal is to provide quality care in a timely manner. In order to do so we have had to implement a "No Show" appointment cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Definition of "No-Show" Appointment
Premier Integrated OBGYN defines a "no-show" appointment as any scheduled appointment, in which the patient either:

- Does not show
- Cancels with less than 24 hours' notice
- Arrives more than 15 minutes late and is consequently unable to be seen

Premier Integrated OBGYN Expectations
When a patient schedules an office visit with us, we expect them to arrive at our practice 15 minutes prior to their scheduled visit. This allows time for the patient and our check-in staff to address any insurance or billing questions and/or to complete any necessary paperwork before the scheduled visit.

In order to be respectful of the medical needs of the Premier Integrated OBGYN community please be courteous and contact us promptly if you are unable to attend an appointment. This time will be reallocated to someone who may be in need of urgent treatment.

If it is necessary to cancel your appointment, we ask that you call at least two (2) working days in advance. Appointments are in high demand, and your early cancellation will give another patient the possibility to have access to timely medical care.

While we ask that our patients avoid cancelling or rebooking a scheduled visit with less than 24 hours notice, we do realize that things come up. In this situation, we still ask that the patient contact our office as soon as they realize they need to cancel or rebook. It is always better to call rather than to "no-show/no call". The staff member handling the call will pass the information on to the Practice Coordinator so that appropriate action is determined.

By signing below, I acknowledge that I have read and understand the "No Show" policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____

Patients Printed Name

_____

Patient (or Responsible Party) Signature

_____

Date

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Telephone Messaging Consent

Frequently, someone at Premier Integrated OBGYN will need to contact you by telephone regarding your health and/or your protected health information. In order to best protect your privacy, as well as provide excellent patient care, we ask that you complete the following consent. This provides us with specific direction as to where we may contact you regarding test results or specific information that you may want us to communicate to you.

I permit Premier Integrated OBGYN leave detailed phone messages at the following telephone numbers and/or with the following individuals. I agree that this consent will remain valid until revoked in writing by me or by an authorized designee (i.e., durable power of attorney)

Contact Numbers	**May we leave a detailed message?**	**Preference (1, 2, or 3)**
Home: _____	Y / N	_____
Work: _____	Y / N	_____
Cell: _____	Y / N	_____

Patient Name: _____Date of Birth: _____

Patient (or Responsible Party) Signature: _____Date: _____

Your Patient Rights

Welcome to our Practice. We respect our patients' dignity and pride. This document will explain your patient rights and responsibilities. It is part of your patient registration and is an important part of your health care plan. If you have any questions, please contact the Practice/Clinic leadership.

Our commitment to you, our patient, includes the following rights. We affirm that we will **deliver high-quality health care to every patient without regard to**: *age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, health condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law*

Considerate and Respectful Care

- Fair, high-quality, safe and professional care
- Care regardless of color, race, religion, creed, etc.
- Consideration, respect, and recognition of you and your individuality
- Treatment privacy
- Safe environment
- Ask for (except in emergencies) a person of the same sex to be available for any part of an exam, treatment or procedures performed by a person of the opposite sex
- Not be undressed any longer than needed for the exam, test, procedure, or other reason
- Private and discreet consultation, exam, and care. See Notice of Privacy Practices (NOPP) for the full list of privacy and security of health information/medical record rights
- To wear appropriate personal clothing and religious or other symbolic items, as long as they do not interfere with your treatment or diagnostic procedures

Health Status and Care

- Be informed of your health status in terms and / or language that you, your family, and caregivers can be expected to understand
- Take part and be active in your care and treatment plan
- Participate in decisions in your care, unless your doctors or others believe it is harmful to you
- Know, be told, and understand:
    - the names, roles, and qualifications of your health care experts that provide your care
    - your follow-up care
    - risks, benefits and side effects of all medicines and treatment procedures for your diagnoses
    - innovative or experimental medicines and treatment procedures of diagnosis offered
    - alternative treatment options offered
    - your procedure and to "give informed consent" before it begins
    - possible outcomes of your care and treatment
    - the assessment and management of your pain
    - When and if the Practice recommends other health care institutions:
        - to participate in your care
        - to know who these other health care places are and what they will do
        - to refuse their care
- Get help from the doctor and others for follow-up care, if available
- To change providers or get a second opinion, including specialists at your request and expense

Decision Making and Notification

- Choose a person to be your health care representative or decision-maker
- Exclude those you do not want help from or to join in your care or decisions

- Ask for, but not have the right to demand, services the Practice does not think are needed or appropriate
- Refuse treatment
- Be included in experimental research only with your written consent
- Refuse experimental research including new drug and medical device investigations
- Receive the information necessary to approve a treatment or procedure
- Give consent to a procedure or treatment

Access to Services

- Receive translator, interpreter or other necessary services or devices to help you communicate with the Practice in a timely manner
- Bring a service animal except where prohibited pursuant to Practice policy
- Have access to our facility buildings and grounds in compliance with The Americans with Disabilities Act, a law that stops discrimination against people with disabilities. The ADA policy is available upon request
- Prompt and reasonable response to questions and requests for service

Ethical Decision

- Talk to and join in with your doctor about:
  - conflict resolutions
  - withholding resuscitative services
  - foregoing or withdrawing life sustaining care
  - investigational study or clinical trials
- Know that if your health care expert decides your refusal to accept treatment prevents you from getting the right care (as stated by its ethical and professional standards), it can end the relationship

Protective Service

- Receive available protective and advocacy services
- Be given the Practice's policies and procedures for:
  - Initiation, review, resolution of patient complaints, including the address and phone number to file complaints
- Discuss complaints, issues, or problems with your doctor and the Practice management team
- File a complaint with the Department of Health or others with your concerns about patient abuse, neglect, misuse of your property at the Practice, other unresolved complaints, patient safety, and quality concerns
- Have a fair review of alleged patient right violations
- Receive, as offered by state law:
  - care and treatment for mental illness or development disability
  - all legal and civil rights as a citizen
- Understand and expect emergency procedures without unneeded delay within Practice scope
- Get needed information to approve a treatment or procedure

Payment and Administrative

- Review your health care bill regardless of your ability to pay it or the payment source
- Receive information about available financial resources
- If uninsured, to receive, before the provision of a planned nonemergency medical service, a reasonable estimate of charges for such service and information regarding any discount or charity policies for which the uninsured person may be eligible.
- Know if the Practice, doctors and other team members accept Medicare, the government's health insurance for those aged 65+ or disabled
- Know and understand the Medicare charges for your services and treatment provided

- Receive if you ask, with explanation, a reasonable estimate of your health care charges before treatment
- To be free from any requirement to purchase drugs, or rent or purchase medical supplies or equipment from any particular source (specifically in accordance with the provisions of the CA Section 1320 of the Health and Safety Code) and also to receive patient choice in these type of decisions

Your Patient Responsibilities

You are an important and active member of your care plan. You have certain responsibilities to yourself and to your care team.

In the spirit of shared trust and respect, we ask you to:

- Give true and complete information about your:
  - Health status
  - Medical history
  - Hospitalizations
  - Medicines
  - Other matters about your health
  - Contact information, family members and caregivers and other needed information
- Let us know:
  - any risks about your care
  - Changes in your care, illness, or injury
  - Safety concerns
  - Violation of your patient rights
  - If you understand your care plan and what we expect from you
  - If you don't understand your care plan or its information
  - If you have or need to ask questions
- Please:
  - Follow your care plan and instructions created by your doctor, nurses or other health care team members
  - Keep appointments and, if you cannot make your appointments, let us know at a minimum 24 hours before your appointment
  - Be responsible for your actions if you refuse care or don't follow doctor's orders
  - Pay your health care bills in a timely manner
  - Follow practice procedures, rules and regulations
  - Be thoughtful of the rights of other patients and our staff
  - Be respectful of yourself and our staff
  - Help staff to assess your pain, to assist you to discuss and get prompt relief, communicate your concerns about pain medicines and develop a pain management plan
  - Treat the doctor and our health care staff with respect and consideration
  - Accept that bad language or behavior is not tolerated and may be grounds for dismissal
  - Accept we may end our relationship if you do not follow your doctor's orders or care plan

Patient Name: _____Date of Birth: _____

Patient (or Responsible Party) Signature: _____Date: _____