JASPER
OBSTETRICS & GYNECOLOGY
613 Dorbett Street • Jasper, IN 47546

Patient Information Form

PATIENT INFORMATION

PATIENT NAME			S.S.#
DATE OF BIRTH	AGE	MARITAL STATUS:	◯ Single ◯ Divorced ◯ Married ◯ Widowed
ADDRESS			
CITY	STATE		ZIP
PRIMARY PHONE (Circle type)	CELL HOME WORK	_____ Leave message with callback number ONLY _____ Leave detailed message	
ALT PHONE (Circle type)	CELL HOME WORK	_____ Leave message with callback number ONLY _____ Leave detailed message	
EMAIL	I authorize Jasper OB/GYN to communicate via (please circle) Text Voice Email		
EMPLOYER		OCCUPATION	
PRIMARY CARE PROVIDER		PHONE	
PREFERRED PHARMACY			

INSURANCE & FINANCIAL RESPONSIBILITY

PARENT/GUARDIAN (IF PATIENT IS MINOR):	PARENT S.S.#	D.O.B.

PRIMARY INSURANCE	PRIMARY POLICY HOLDER
POLICY HOLDER ID/SSN#	POLICY HOLDER DOB
SECONDARY INSURANCE	SECONDARY POLICY HOLDER
POLICY HOLDER ID/SSN#	POLICY HOLDER DOB

INSURANCE AUTHORIZATION & ASSIGNMENT

The above-named patient or responsible party requests payment of authorized Medicare, Medigap or Other Insurance Company benefits be made on my behalf to the billing Physician/Group for any services furnished to me by that party who accepts assignment. Regulation pertaining to Medicare Assignment of Benefits apply. I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature of Patient or Representative Date

AUTHORIZATION TO RELEASE INFORMATION

I understand my medical information may be released for purposes of treatment, payment, and healthcare operations, including but not limited to, my insurance company. I also hereby authorize Jasper Obstetrics and Gynecology to release my medical information to the following person(s), and I understand this authorization is in effect until I would revoke it in writing:

NAME	Relationship to Patient	Phone
NAME	Relationship to Patient	Phone
NAME	Relationship to Patient	Phone

_____ _____

Signature of Patient or Representative Date

HIPAA NOTICE OF PRIVACY PRACTICES

I, _____ **(Initial Here),** have received a copy of the Notice of Privacy Practices of Jasper Obstetrics and Gynecology, Inc.

CONTINUE ON REVERSE

FINANCIAL & OFFICE POLICIES

All professional services rendered will be charged to the patient. Co-Pays and charges in general are due at the time of service unless other arrangements have been made in advance. Patients without medical insurance should be prepared to pay a minimum of $150 at the initial visit.

Insurance Networks, Non-Covered Services

Not all services provided may be covered by insurance and it is the responsibility of the patient to be familiar with her insurance plan coverage. Jasper OBGYN will not be responsible for out-of-pocket expenses incurred for non-covered tests or procedures. Obtaining a referral for out-of-network care is the responsibility of the patient and Jasper OBGYN bears no responsibility for costs incurred for out-of-network services.

Pre-Authorization / Pre-Certification

Jasper OBGYN will contact the patient's insurance company to obtain pre-authorization prior to surgery and selected procedures. Pre-authorization is not a guarantee of benefits or insurance payment. Prior to surgery, Jasper OBGYN may collect applicable co-pays and deductible amounts due.

Prepayments for Procedures or OB Care

It is the policy of Jasper OBGYN to utilize prepayment collection for obstetric (OB) patients. Details of the prepayment plan and an overview of global OB billing is discussed with the patient at the initial visit, based on the patient's insurance, deductible, etc. Similarly, a surgery or procedure may require prepayment as specified by Jasper OBGYN with the balance being billed to the patient afterwards. Monthly payments may be agreed upon, but payment must be received at least every 30 days to avoid finance charges. In general, remaining balances must be paid in full within 180 days from the date of service. Patients in the process of applying for Medicaid should provide proof of a pending Medicaid application or will be responsible to pay $100 at the first OB visit.

Administrative Services

Jasper OBGYN charges $10.00 for completion of forms for FMLA, disability, or leaves of absence. There is no fee to release records to another medical provider. Medical records can only be released upon the patient's completion of an "Authorization to Release Medical Records" form and a family member may not sign for the patient. Requests for completed forms or medical records will be completed timely and are generally handled within 7-14 days.

Statements, Past Due Accounts

Statements are mailed to the patient or financially responsible party, itemizing services, as well as any payment, deductible, or co-insurance amount applied by the insurance plan. In the event an account becomes past due, it will be considered delinquent and subject to further collection action, including placement with a collection agency or attorney (subjecting the patient to potential dismissal from the practice). For questions regarding statements, payments, or due dates, please contact our billing office at (812) 481-2709. Patients are encouraged to communicate with the office during times of financial difficulty for assistance in management of the account.

Other Office Policies

Patient Information

New and established patients are responsible for supplying a current copy of their insurance card and updating demographic information annually or when changes occur. Patients must understand appointment reminders and/or test results will be mailed to the address on file with the office.

Test Result Notification

Patients are notified of results of tests ordered by Jasper OBGYN and instructed to contact the office if they have not been informed of results within 2-3 weeks. Exceptions to this policy might include normal results for pap smears or other labs, and normal results of screening/routine mammograms where facilities will notify patients according to their facility policy.

Timeliness, Missed Appointments ("No Shows")

Patients are asked to arrive to the office typically 15 minutes prior to their scheduled appointment time, leaving time for parking and paperwork completion. If a patient arrives late, it is possible the appointment may have to be rescheduled. Patients should contact the office at least 24 hours in advance of an appointment they wish to cancel or reschedule. "No shows" are a significant burden to the office and impact availability of appointments for other patients. Patients with repeated tardiness, "no shows" or late cancellations may be considered for dismissal from the practice.

Acknowledgement

I have reviewed and understand the above policies of the office and agree to abide by terms listed. If any balance is not paid, when due, I understand I will be responsible for the balance, plus interest, at a rate of 1 ½ % per month, 18% annum, on the balance due. Additionally, in the event that I fail to pay the account balance when due, including accrued interest, I agree to pay all collection costs including collection agency fees, reasonable attorney fees and court costs related to the recovery of money due for services (current and future) by Jasper Obstetrics and Gynecology, Inc.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Patient Health History

PATIENT INFORMATION

NAME	DOB	AGE
PREVIOUS OBGYN PROVIDER/OFFICE*		***PLEASE REQUEST MEDICAL RECORDS BE SENT TO OUR OFFICE.***
PRIMARY CARE PROVIDER		

REASON FOR SEEKING CARE WITH OUR OFFICE: (CHECK ALL THAT APPLY)

◯ **PREVENTIVE ANNUAL GYN CARE**
◯ **PREGNANCY**
◯ **FIBROID MANAGEMENT**
◯ **VULVAR PAIN/ITCHING**
◯ **ABNORMAL PAP SMEAR**
◯ **MENOPAUSE SYMPTOMS**
◯ **SECOND OPINION**
◯ **ABNORMAL BLEEDING**
◯ **PELVIC PAIN**
◯ **SURGERY CONSULT**
◯ **BIRTH CONTROL OPTIONS**
◯ **VAGINAL DISCHARGE/ODOR**
◯ **OTHER:**

MENSTRUAL HISTORY

WHAT AGE DID YOU HAVE YOUR FIRST PERIOD?

DO YOU STILL HAVE PERIODS? ◯ YES ◯ NO (SEE BELOW)

IF 'YES':		**IF NO:**
FIRST DAY OF LAST PERIOD:		AGE WHEN PERIODS STOPPED
ARE YOUR PERIODS REGULAR?	◯ YES ◯ NO	REASON THEY STOPPED: (IF KNOWN)
# DAYS YOU TYPICALLY BLEED		◯ MENOPAUSE ◯ HYSTERECTOMY ◯ ABLATION ◯ UNKNOWN ◯ OTHER:
DO YOU BLEED/SPOT BETWEEN PERIODS?	◯ YES ◯ NO	ANY BLEEDING/SPOTTING AFTER MENOPAUSE OR HYSTERECTOMY? ◯ YES ◯ NO
DO YOU HAVE PAINFUL PERIODS?	◯ YES ◯ NO	
DESCRIBE YOUR TYPICAL PERIOD FLOW:	◯ LIGHT ◯ MODERATE ◯ HEAVY	

HEALTH MAINTENANCE HISTORY

Check all you have previously had and supply details.

◯ PAP SMEAR	DATE OF LAST:	WAS IT NORMAL?	◯ YES ◯ NO
	HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR?		◯ YES ◯ NO
◯ MAMMOGRAM	DATE OF LAST:	WAS IT NORMAL?	◯ YES ◯ NO
◯ COLONOSCOPY	DATE OF LAST:	WAS IT NORMAL?	◯ YES ◯ NO
◯ DEXA (BONE DENSITY SCAN)	DATE OF LAST:	WAS IT NORMAL?	◯ YES ◯ NO

HAVE YOU COMPLETED VACCINATION FOR HPV? ◯ YES ◯ NO

CONTINUE NEXT PAGE

SEXUAL HEALTH HISTORY

ARE YOU SEXUALLY ACTIVE? ◯ YES ◯ NOT CURRENTLY ◯ NEVER

ANY RECENT CHANGE IN PARTNER? ◯ YES ◯ NO

SEXUAL PREFERENCE: ◯ MEN ◯ WOMEN ◯ BOTH

DO YOU USE A FORM OF BIRTH CONTROL? ◯ YES (Specify below) ◯ NO If NO, are you attempting pregnancy? Y N

◯ BIRTH CONTROL PILLS (OCP's) ◯ PATCH / RING ◯ CONDOMS ◯ DEPOPROVERA
◯ NATURAL FAMILY PLANNING ◯ TUBAL LIGATION ◯ ESSURE ◯ VASECTOMY
◯ NEXPLANON / IMPLANON ◯ WITHDRAWAL ◯ IUD (Specify type):

PLEASE INDICATE IF YOU HAVE EVER HAD ANY OF THE FOLLOWING INFECTIONS:

◯ CHLAMYDIA ◯ GENITAL HERPES ◯ GENITAL WARTS ◯ GONORRHEA ◯ HEPATITIS B ◯ HEPATITIS C
◯ HIV / AIDS ◯ HPV ◯ PID ◯ SYPHILIS ◯ TRICHOMONAS

PLEASE INDICATE IF YOU HAVE ANY QUESTIONS OR CONCERNS WITH ANY OF THE FOLLOWING (or Specify):

◯ PAIN WITH INTERCOURSE ◯ DECREASED SEXUAL DESIRE ◯ OTHER INTIMACY CONCERN:

SOCIAL HISTORY

Are you: ◯ SINGLE ◯ MARRIED ◯ DIVORCED ◯ WIDOWED ◯ IN A RELATIONSHIP ◯ OTHER

Any religious/cultural preferences that may impact your care? ◯ YES* ◯ NO **Specify:*

Do you use ALCOHOL?	◯ YES ◯ NO ◯ NEVER	If YES, # drinks per week:
Do you use TOBACCO or SMOKE?	◯ YES ◯ NO ◯ NEVER	If YES, how much/often:
Do you VAPE?	◯ YES ◯ NO ◯ NEVER	If YES, how much/often:
Any DRUG USE?	◯ YES ◯ NO ◯ NEVER	If YES, specify type/how often:

(Examples: Marijuana, Narcotics, Amphetamines, etc.)

Have you ever been physically hurt by someone? ◯ YES ◯ NO

Are you in a relationship with someone who threatens or physically hurts you? ◯ YES ◯ NO

Have you ever been forced into having sexual activities? ◯ YES ◯ NO

ALLERGIES

Please indicate if you have allergies to any of the following and provide details:

Drug Allergies

◯ Cephalosporins (i.e. Keflex) ◯ Penicillin
◯ Codeine ◯ Quinolones (i.e. Cipro)
◯ Erythromycin (i.e. Z-Pack) ◯ Sulfonamides (ie. Bactrim, Septra)
◯ Hydrocodone (i.e. Lortab, Vicodin) ◯ Tetracyclines
◯ NSAIDS (i.e. Ibuprofen, Aleve) ◯ Other:

Foods & Other Substances

◯ Adhesive Tape ◯ Other
◯ Eggs
◯ Iodine
◯ Latex Gloves

CONTINUE NEXT PAGE

MEDICAL HISTORY *(Check all which YOU have or have had previously)*

GYNECOLOGICAL
- ◯ ABNORMAL PAP SMEAR(S)
- ◯ BREAST ISSUES
- ◯ ENDOMETRIOSIS
- ◯ INFERTILITY
- ◯ PCOS
- ◯ UTERINE FIBROIDS
- ◯ OTHER:

LUNG DISEASES
- ◯ ASTHMA
- ◯ COPD
- ◯ OTHER:

KIDNEY/URINARY SYSTEM
- ◯ FREQUENT UTI's
- ◯ KIDNEY INFECTION
- ◯ KIDNEY STONES
- ◯ URINARY INCONTINENCE
- ◯ OTHER:

CANCER *(Specify Year)*
- ◯ BREAST
- ◯ COLON
- ◯ MELANOMA
- ◯ OVARIAN
- ◯ UTERINE
- ◯ OTHER

CARDIOVASCULAR
- ◯ ANEMIA
- ◯ BLOOD CLOTS
- ◯ BLOOD TRANSFUSION
- ◯ HEART ATTACK
- ◯ HEART DISEASE
- ◯ HEART VALVE ISSUES
- ◯ HIGH BLOOD PRESSURE
- ◯ HIGH CHOLESTEROL
- ◯ IRREGULAR HEARTBEAT
- ◯ SICKLE CELL DISEASE
- ◯ OTHER:

GASTROINTESTINAL
- ◯ ACID REFLUX (GERD)
- ◯ CROHN'S DISEASE
- ◯ IRRITABLE BOWEL SYNDROME
- ◯ LIVER DISEASE
- ◯ ULCERATIVE COLITIS
- ◯ OTHER:

ANY OTHER MEDICAL PROBLEM OR DISEASE?

BRAIN / NERVOUS SYS
- ◯ ANXIETY DISORDER
- ◯ BIPOLAR DISORDER
- ◯ DEPRESSION
- ◯ MIGRAINES
- ◯ SEIZURES
- ◯ STROKE / TIA
- ◯ OTHER:

METABOLIC SYSTEM
- ◯ DIABETES
- ◯ HIP FRACTURE
- ◯ OBESITY
- ◯ OSTEOPOROSIS
- ◯ THYROID DISEASE
- ◯ OTHER:

SURGERIES

Please list all surgical procedures you have had (including C-sections), including date, reason for surgery and type of surgery.

Date	Type of Surgery	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS

Please list all medicines you are currently taking:

Medication	Prescribed By	Dosage (Mg)	Frequency

CONTINUE NEXT PAGE

FAMILY MEDICAL HISTORY

HAVE YOU EVER OR ANY FAMILY MEMBER EVER HAD CANCER-RELATED GENETIC SCREENING? ◯ YES* ◯ NO

*If Yes, please indicate relationship and results:

Please note **family history** of any of the following in **children**, **siblings**, **parents**, **grandparents**, **aunts/uncles**:

GYNECOLOGICAL *Relationship & Age*
◯ ENDOMETRIOSIS _____
◯ INFERTILITY _____
◯ PREMATURE MENOPAUSE _____
◯ PRETERM DELIVERY _____
◯ OTHER: _____

CANCER *Relationship & Age*
◯ BREAST _____
◯ COLON _____
◯ OVARIAN _____
◯ UTERINE (Not cervical) _____
◯ PANCREATIC _____
◯ OTHER: _____

PSYCHIATRIC *Relationship & Age*
◯ DEPRESSION _____
◯ OTHER _____

CARDIOVASCULAR DISEASE *Relationship & Age*
◯ BLEEDING DISORDERS _____
◯ BLOOD CLOTS _____
◯ HEART ATTACK _____
◯ HEART DISEASE _____
◯ HEART VALVE ISSUES _____
◯ STROKE _____
◯ OTHER: _____

METABOLIC DISEASE *Relationship& Age*
◯ DIABETES _____
◯ HIGH BLOOD PRESSURE _____
◯ HIGH CHOLESTEROL _____
◯ HIP FRACTURE _____
◯ OSTEOPOROSIS _____
◯ THYROID DISEASE _____
◯ OTHER: _____

OTHER Please specify any other known hereditary or familial disease and list relationship:

OBSTETRIC HISTORY

HAVE YOU EVER BEEN PREGNANT? ◯ YES ◯ NO If YES, please input total numbers of each below.

# TOTAL PREGNANCIES	# FULL-TERM	# PRE-TERM <37 weeks	# LIVING CHILDREN	# MISCARRIAGES	# ECTOPICS	# MULTIPLES PREGNANCIES	# ABORTIONS (ELECTIVE)

PREGNANCY DETAILS (Complete ONLY if you are still of reproductive age)

DATE OF BIRTH (MM/DD/YYYY)	# WEEKS AT DELIVERY	TYPE OF DELIVERY	BABY'S SEX	BIRTH WEIGHT	ANESTHESIA?	ANY COMPLICATIONS?
			◯ M ◯ F			
			◯ M ◯ F			
			◯ M ◯ F			
			◯ M ◯ F			
			◯ M ◯ F			
			◯ M ◯ F			

GENETIC PROFILE Complete ONLY if you still of reproductive age

Please indicate if any of the following apply to you, your partner, or family members of either of you. Please specify relationship.

◯ CLEFT LIP OR PALATE *Relationship* _____
◯ CYSTIC FIBROSIS _____
◯ DOWN'S SYNDROME _____
◯ FRAGILE X SYNDROME _____
◯ HEART DEFECT _____
◯ HEMOPHILIA _____
◯ HUNTINGTON'S CHOREA _____
◯ MUSCULAR DYSTROPHY _____
◯ NEURAL TUBE DEFECT (Spina Bifida) *Relationship* _____
◯ PHENYLKETONURIA (PKU) _____
◯ SPINAL MUSCULAR ATROPHY (SMA) _____
◯ TAY-SACH'S DISEASE _____
◯ OTHER (Birth defects, genetic or chromosomal abnormalities, mental or special needs):

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Jasperobgyn.com

Medical Appointment Cancellation/No-Show Policy

Thank you for trusting your medical care to Jasper Obstetrics and Gynecology. When you schedule an appointment with us, we set aside time to provide you with the highest quality care. As a courtesy, we send multiple reminders via text, email, and/or voice message to help you remember your scheduled appointment. Please circle the method(s) you prefer to be notified. **TEXT** **EMAIL** **VOICE MESSAGE** **ALL THREE**

If your schedule changes and you cannot keep your appointment, please contact us as soon as possible so we may reschedule you and try to accommodate those patients who are waiting for an appointment. You can reach us through our patient portal at myhealthrecord.com, reply to your reminder, or call us at 812-481-2229.

Please review our Cancellation and No-Show Policy below:

A "cancellation" is when someone cancels/reschedules her appointment within the 24 or 48-hour time frame indicated below OR arrives more than 15 minutes after the scheduled time and is unable to be seen.

A "no-show" is when someone fails to show for an appointment without notice.

- There will be a $25 fee for an established OB/GYN visit that is considered a no-show or cancelled less than 24 hours prior to your scheduled appointment.

- There will be a $50 fee for a new OB visit OR a consult/specialty visit that is considered a no-show or cancelled less than 48 hours prior to your scheduled appointment. A specialty visit may involve an ultrasound, intrauterine device (IUD) insertion, saline infusion sonogram (SIS), Nexplanon insertion, endometrial biopsy, or colposcopy.

- There will be a $100 fee for an in-office hysteroscopy OR surgery scheduled at the St. Thomas Medical Center or Memorial Hospital that is considered a no-show or cancelled later than 48-hours prior to your scheduled surgery.

- We understand that unforeseen emergencies occur. The fees begin on the second offense in a two-year period. Upon the third offense, you may be considered for dismissal from the practice. If you incurred a fee because of an emergency, please contact our Practice Manager to further discuss your situation.

No-show and cancellation fees may be charged directly to the patient and not to the insurance company. Payment will be due before you may schedule your next visit.

I have read the Medical Appointment Cancellation/No-Show Policy and agree to its terms.

_____ _____

Signature (Patient/Parent/Guardian) Relationship to the Patient (if applicable)

_____ _____

Printed Name Date