6301 UNIVERSITY COMMONS
SUITE 310
SOUTH BEND, IN 46635

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www.obgynni.com

Welcome to OBGYN Associates.

We are happy you have chosen our practice for your specific medical needs. Please fill out the enclosed forms and bring them with you to your appointment. *We do ask that you please arrive at our office at least twenty minutes before your scheduled appointment time, this enables us to complete our registration process.*

The charge for your initial appointment will be approximately $237 to $316, any additional services will be charged accordingly. Fees are to be paid at the time of service. We accept cash, personal check, Visa, MasterCard and Discover for payment. If you have one of the following insurance carriers we will file this charge with your insurance company on your behalf. If you do not have your current insurance card with you at your appointment you will need to pay at the time of service and file for reimbursement.

Advantage HMO
Sagamore
Medicare
Blue Cross/Blue Shield/Anthem
Select Health Network
Community Health Alliance
Cigna PPO
United HealthCare
Aetna PPO
Private HealthCare Systems (PHCS)
Indiana Medicaid MHS, Anthem or MDWise SHN
WE DO NOT ACCEPT MICHIGAN MEDICAID

Many insurance companies are now requiring their members to use a preferred laboratory. <u>Please inform us if you need to use a lab other than the South Bend Medical Foundation.</u>

<u>If you need a referral from your primary care physician, it is your responsibility to obtain the referral prior to your appointment.</u> If you are unsure if you need a referral or if you have any questions regarding your benefits, please contact your insurance company.

Thank you.

Just a reminder that your appointment is scheduled for _____/_____/_____ @ ____:____ am/pm

Please bring a list of your current medications including strengths and dosages.

OBGYN ASSOCIATES OF NORTHERN INDIANA, P.C.

LAST NAME ______________________________FIRST NAME________________INIT_______
ADDRESS____
CITY___________________________________STATE_______________ZIP______________
HOME PHONE (___)______________________ CELL PHONE (___)_____________________
WORK PHONE (___)______________________ EXT ____________________________
BIRTH DATE_______________AGE_____SOCIAL SECURITY_________________________
MARITAL STATUS: SINGLE________MARRIED________
ALTERNATE CONTACT NUMER (   ) ________________NAME_________________________

EMPLOYER____
ADDRESS____

PARENT/SPOUSE NAME_________________________________BIRTH DATE_______________
ADDRESS____PHONE (___)_______________
EMPLOYER____
EMPLOYER ADDRESS ____
SOCIAL SECURITY______________________________WORK PHONE (___)_______________

NEAREST RELATIVE____
ADDRESS____PHONE (___)________________

PRIMARY INSURANCE________________________ID#_________________ACC#__________
CARDHOLDER NAME ___________________________________DATE OF BIRTH ___________
EMPLOYER ____
ADDRESS ____SOCIAL SECURITY ___________

SECONDARY INSURANCE______________________ID#_________________ACC#__________
CARDHOLDER NAME ___________________________________DATE OF BIRTH ___________
EMPLOYER ____
ADDRESS ____SOCIAL SECURITY ___________

REFERRED BY____
ADDRESS____PHONE_________________

I authorize OBGYN Associates of Northern Indiana to release information concerning illness or treatments to my insurance carrier and also direct payment to the physician(s) who rendered medical services.

I will accept responsibility for payment of fees submitted by OBGYN Associates of Northern Indiana for any balance not covered by my insurance.

PATIENT SIGNATURE____DATE________________

As parent/guardian, I give my permission to consult with and/or treat ____________________________
____________________ . I also authorize OBGYN Associates of Northern Indiana to submit fees for services rendered to my insurance carrier for payment. If, for any reason, the fees are not covered I agree to accept responsibility for the outstanding balance.

PARENT/GUARDIAN SIGNATURE_________________________________DATE_____________

OBGYN ASSOCIATES OF NORTHERN INDIANA, PC

MEDICAL INFORMATION RELEASE

I hereby authorize OBGYN ASSOCIATES OF NORTHERN INDIANA, P.C., to release any medical or appointment information to the following persons:

(i.e. – spouse, parents, children or significant other)

NAME	RELATIONSHIP
1.	
2.	
3.	

SIGNATURE: ______________________________ **DATE:** ______________

TO BE KEPT IN PATIENT'S CHART AT ALL TIMES

6301 University Commons, Ste 310
South Bend, IN 46635

Please complete both sides of form.

OB-GYN ASSOCIATES OF NORTHERN INDIANA, P.C.

NAME: ______________________________________ AGE: _______ DATE: ________________

INITIAL PATIENT SELF-HISTORY FORM

Provide all information requested to the best of your ability.
ALLERGIES (Include medications, Latex, Iodine)

____

GYNECOLOGIC HISTORY

Age at first menses (period) ________ Age at menopause (if applicable) ________

(The following questions refer to your "natural" periods when not on birth control pills or hormones)

Usual # of days of period ________ Period interval (1st day to 1st day) ________ days

How many days are: Heavy ________ Medium ________ Light ________

Have you ever had an abnormal pap smear? ________

If yes, how was it treated? ____________________________________When? ______________

Date of last pap smear ________ Have you had a mammogram? ________ When? ________ Result ____________________

Types of birth control used, including vasectomy ____

Have you had any gynecologic surgery? (Including Tubal Ligations, D&C's, Cryo, Leep, Ovarian surgery)

If yes, what kind? ____ When? _______________

____ _______________

____ _______________

Do you have any knowledge of your mother using hormones (DES, Diethylstilbestrol) during her pregnancy with you? ________

PREGNANCY HISTORY

# of full-term deliveries _______ # of premature deliveries ______ # of miscarriages ______ Was surgery needed? _______

# of abortions ______ Any complications? ____________________ Any "tubal" pregnancies? ____ When? _____________

# of vaginal deliveries ________ # of Cesarean sections ________ Years of deliveries ______________________________

Any serious complications during your pregnancies or deliveries? ____

____

RISK FACTORS

Your answers to these questions help us to determine if you have risk factors for cancer, infections or AIDS:

Have you ever received a blood transfusion? ________ Do you smoke? _____ How much? ________ How many years? _____

Do you consume alcohol? ________ How often? _______________________

Have you ever used marijuana, cocaine, heroin, barbituates, or speed? _____ If yes, last used? ________ Any needles? ______

Age at first intercourse ________ Total # of sexual partners ________ Total # of sexual partners in last year ________

Have you had any sexually transmitted infections? _______ If yes, what? _________________________ When? ___________

Do you believe yourself to be at risk of exposure to the AIDS virus? ________

Please complete both sides of form.

SURGERY (Other than gynecologic)

TYPE	WHEN	DOCTOR	COMPLICATIONS

HOSPITALIZATIONS (Non-surgical, other than pregnancy)

CONDITION	WHEN	DOCTOR	TREATMENT

PAST AND PRESENT MEDICAL PROBLEMS

☐ **Abnormal PAP, h/o**	☐ Depression	☐ Hypercoagulable disorder	☐ Preterm delivery, prior
☐ Anemia	☐ DES Exposure	☐ Hyperlipidemia	☐ Psychiatric disease
☐ Asthma	☐ Diabetes mellitus	☐ Hypertension	☐ Pulmonary embolism
☐ Autoimmune disease	☐ Drug/alcohol use	☐ Incompetent cervix	☐ Recurrent miscarriages
☐ Bartholin's gland cyst	☐ Endometriosis	☐ Infertility	☐ Seizure disorder
☐ Blood transfusion, h/o	☐ Family hx of genetic disorder	☐ Neonatal death, prior	☐ Thyroid disease
☐ Breast cancer	☐ Fetal death, prior	☐ Phlebitis	☐ Tuberculosis
☐ Breast mass	☐ Fibroid uterus	☐ Obesity	☐ Uterine cancer
☐ Bruising / bleeding disorder	☐ Gallbladder disease	☐ Ovarian cancer	☐ UTI, h/o recurrent
☐ Cerebrovascular accident	☐ Genital herpes, exposure	☐ Ovarian cyst	☐ Vaginal infections, recurrent
☐ Cervical cancer	☐ Genital herpes, h/o	☐ PID	☐ STD
☐ Clotting disorder	☐ Heart murmur	☐ Polycystic ovary syndrome	
☐ Coronary heart disease	☐ Hemoglobinopathy	☐ Prolapsed uterus	
☐ Cystocele	☐ Hepatitis/Liver disease	☐ Premature rupture of membranes	

Other Medical/Surgery History not listed____

____

FAMILY HISTORY *Include Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM), Grandfather (GF), and Children (C) only.*

Diagnosis ◀ Family member Indicated by M-Mother, F-Father, B-Brother, C-Child, etc.

Diagnosis		Family member	Diagnosis		Family member
Alive and Well ☐			Diabetes	○ Yes ○ No	
Alcoholism	○ Yes ○ No		Downs syndrome	○ Yes ○ No	
Asthma	○ Yes ○ No		Hemophilia-A	○ Yes ○ No	
Autoimmune disorder	○ Yes ○ No		Hyperlipidemia	○ Yes ○ No	
Breast cancer	○ Yes ○ No		Hypertension	○ Yes ○ No	
Cervical cancer	○ Yes ○ No		Mental illness	○ Yes ○ No	
Coagulopathy	○ Yes ○ No		Mental retardation	○ Yes ○ No	
Colon cancer	○ Yes ○ No		Muscular dystrophy	○ Yes ○ No	
Coronary artery disease	○ Yes ○ No		Ovarian cancer	○ Yes ○ No	
Cerebrovascular accident	○ Yes ○ No		Seizure disorder	○ Yes ○ No	
Cystic fibrosis	○ Yes ○ No		Sickle cell disease	○ Yes ○ No	
Depression	○ Yes ○ No		Spina bifida	○ Yes ○ No	
Developmental delay	○ Yes ○ No		Thyroid disease	○ Yes ○ No	
			Other ________	○ Yes ○ No	

Other Family History not listed____

____

Check if adopted/family history not known ☐

ObGyn Associates of No. Indiana, PC

Financial Policy

We are committed to providing you with the best possible medical care. We are available to work with you if you have special financial needs. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Our office participates in a variety of insurance plans. **It is your responsibility** to:

- Bring your insurance card to every visit;
- Obtain the necessary physician referral or pay all office fees at time of service or completion of services. NOTE: if the referral has not been obtained, you will be asked to sign an Insurance Referral Waiver.
- Remit payment for medical care not covered under your insurance (deductibles, co-pays, non-covered services, etc.) at time of service;
- Be prepared to pay your co-pay at each visit. Payment may be made by cash, check or credit card.
- All private pay fees will be collected at time of service.

If we do not participate in your insurance program, our office is happy to file the claim; however, payment in full is expected from you within 30 days.

For patients 17 years and younger, a parent or guardian must accompany them and sign below (exception: patients 17 years and younger declared emancipated minors). It is the parent or guardian's responsibility to bring the necessary referrals and insurance cards and also to make any payment due at time of service.

Our charges are determined by what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company's member services department (the number is on your insurance card).

Our practice firmly believes that a good physician/patient relationship is based upon understanding and communication. Questions about financial arrangements should be directed to the Central Billing Office. The office may be reached by dialing 574-251-2100.

Please sign below to indicate that you have read and agree to this Financial Policy.

I understand and agree to this Financial Policy:

______________________________________ ____________________

Signature of Patient or Responsible Party Date