ROPER ST. FRANCIS
PHYSICIAN PARTNERS

PATIENT INFORMATION FORM

Referred by: ______________________________ **Primary Care Physician**: ____
Last Name: _______________________________ **First Name:** ____________________ **Prefix** ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.
Middle Name: _____________________________ **Preferred Name:** _____________________________________
Date of Birth: _____ /_____ /_____ **Age:** ______ **SSN:** _______ - _______ - ________
Address: __________________________________ **City:** ______________**County:** ________ **State:** _____ **Zip:** ____________
Email Address: ____________________________ **Home:** ( )_____-_____ **Cell:** ( )_____-_____**Work:** ( )_____-_______

May we leave a message about appointments or normal test results on the phone numbers you provided? ☐ Yes ☐ No
Would you like to receive appointment reminders via text message on your cell phone? ☐ Yes ☐ No
You consent to receive text messages from us that may contain health information or advice. You are not required to provide consent in order to receive such information or advice from your provider. Standard text messaging rates may apply.

Alternate Contact: **If you want us to contact you at an alternate address or telephone number, please provide below:**
Alt. Address: ___________________________ **City:** ______________ **State**: ____ **Zip**: ________ **Phone**: ( )_______-_________

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner ☐ Unknown
Ethnicity: ☐ Not Hispanic / Latino ☐ Hispanic / Latino ☐ Declined to Specify
Race: ☐ White ☐ Black / African American ☐ Asian ☐ American Indian / Alaska Native
☐ Native Hawaiian / Other Pacific Islander ☐ Declined to Specify ☐ Other Race
Birth Sex: ☐ Male ☐ Female **Gender Identity (optional):** _______________________________
Sexual Orientation (optional): ☐ Straight/heterosexual ☐ Lesbian ☐ Gay/homosexual ☐ Bi-sexual ☐ Choose not to disclose ☐ Other
Primary Language: ☐ English ☐ Spanish ☐ French ☐ Other: ______________________
Student Status: ☐ N/A ☐ Full-time ☐ Part-time **Employment Status**: ☐ N/A ☐ Full-time ☐ Part-time **Employer:** _______________
Name of Pharmacy: _______________________________ **Address**: ____________________ Phone: ( ) _____-_________
Emergency Contact Name: ________________________ **Relationship**: _________________ Phone: ( ) _____-_________

Guarantor/ Person Financially Responsible For the Payment of Healthcare Services If Other Than The Patient

Last Name: ______________________________ ☐ Mr. ☐ Mrs. ☐ Miss ☐ Other: ________ Sex: ☐ Male ☐ Female
First Name: ______________________________ Date of Birth: ____/____/____ Age: _____ SSN: ____ – ____ **-**_____
Middle: _________________________________ Relationship to Patient: _______________________________+_________
Address: ________________________________ City: ____________________ State: ________ Zip: _________________
Home: ( ) ______-_________ Cell: ( ) ______-__________ Work: ( ) ______-__________
Email Address of Guarantor/ Person Financially Responsible: ____

Primary Insurance	**Secondary Insurance**
Insurance Company: ________________________________	Insurance Company: ________________________________
Policyholder Name: ________________________________	Policyholder Name: ________________________________
Member or Policyholder ID #: _________________________	Member or Policyholder ID #: _________________________
Policyholder Date of Birth: ___________________________	Policyholder Date of Birth: ___________________________
Insurance Co. Phone #: _______________________________	Insurance Co. Phone #: _______________________________
Group #: ____	Group #: ____
Relationship to Patient: _____________________________	Relationship to Patient: _____________________________

Consent for Treatment, Authorization, Assignment of Benefits, and Referral Release

CONSENT FOR TREATMENT: I consent and authorize Roper St. Francis Physician Partners ("RSFPP") physician or designated qualified assistant to provide me medical treatment and to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the RSFH Notice of Privacy Practices, a copy of which has been made available to me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I understand that my medical information, including complete medical records, test results, and billing information, may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all my rights and allow payment to be made directly to RSFPP for all medical or surgical benefits otherwise payable to me under terms of my insurance.

PAYMENT GUARANTEE: I understand and agree that I am responsible for paying all co-payments, co-insurance, deductibles, and non-covered services rendered by RSFPP, including charges for services not covered by my insurance. I consent and authorize RSFPP and third party agents of RSFPP to contact me by telephone at any number associated with me, including a wireless number, and to use a pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep RSFPP informed of changes to my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

This consent for treatment, authorization, assignments of benefits and referral release is valid for one year from date signed.

Print Patient's Name: ____

Patient's Signature: ____ Date: _____ /_____ /____________

Print Legal Guardian's Name: ____

Legal Guardian's Signature: ____ Date: _____ /_____ /____________

Ongoing Communication Regarding Your Healthcare

ONGOING COMMUNICATION: DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL(S) WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITIONS? IF YES, TO WHOM?

By listing an individual and/or entity below, you authorize ALL RSFPP physician offices to release and/or discuss your health information with the individual and/or entity you have listed. You may list a specific date range or an event or choose all health information.

Beginning date or event to be released: ________ End date or event to be released: ________ Or all healthcare information ________

Authorized Individual or Entity	Phone Number	Relationship	Address
____________________________	(_____)______________	______________	____
____________________________	(_____)______________	______________	____

*****Any revocation or modification to your authorization regarding an individual or organization must be submitted in writing.

** A separate **Authorization to Release Information Form** must be completed to release and/or discuss your health information with any individual(s) and/or entity(s) not listed in the section above. ***Authorization is not required for treatment purposes.***

*** To request restrictions of the use and disclosure of your information, you must complete a separate **Request to Restrictions Form.**

Prescriptions

For your convenience, please specific any individuals you authorize to pick up your prescriptions from RSFPP provider(s).

Name of Individual	Phone Number	Relationship	Address
____________________________	(_____)______________	________________________	______________________________
____________________________	(_____)______________	________________________	______________________________

A Note About Our Billing Practices

Sorting out your insurance policy and medical bills can be a challenge these days. Here are some key things you should know as a patient of Roper St. Francis Physician Partners OB/GYN.

Payment at time of service
In general, payment such as copays, deductible and coinsurance that apply to your services are due at checkout on the day of your visit. We will make an attempt to collect just the right amount but sometimes your insurance company will process your claim differently than we expect, and you may be billed after the fact for a remaining balance. If you are having a financial hardship, please talk to the staff about other arrangements. If you don't have insurance, we do offer a self pay discount on most services. Just so you know, contracts with your insurance company do not allow us to "waive" your copay.

Your insurance plan and you
There are so many health insurance plans out there in our marketplace, from states all around the country and with varieties of benefit packages. Because of this, we rely on you as the patient to know the basics of your insurance plan – what's covered, what's not, when you need a referral and the dollar amount and/or percentage you'll need to pay out of pocket for services.

If you have **Medicare** you may be asked to sign an ABN or "Advanced Beneficiary Notice" for services you receive that are either not covered by Medicare, only covered every so often or only with a particular diagnosis. **Please carefully review the ABN before you sign it and ask if you have any questions!**

Preventive vs. Sick Care: about your annual GYN exam
Many insurance policies cover preventive (also called routine or well) care differently from sick/problem visit care. Some may not cover preventive care at all – or vice versa may pay 100% up to a certain dollar limit – but only if it's coded as preventive or routine. This is an area where you should be especially familiar with your insurance company's benefits. When we bill your insurance company, the codes we submit must be consistent with nationally accepted coding practices, which means we cannot bill a visit with a certain code that is incorrect, just to get the claim processed in your favor. If your doctor collects a pap smear at your visit, we may bill a special code for collection of the pap in addition to the charge for your visit.

When you come for your annual/yearly and you also have a problem…
Many patients aren't aware that if your doctor provides evaluation and management of a problem you are having, during the course of your routine annual exam, he or she may charge a preventive/well service along with any "sick" services (in billing terms this is called a "split visit"). By addressing these issues during the preventive care exam, we hope to avoid the inconvenience by asking you to return for a separate visit. Your insurance company may have special guidelines when it comes to processing these charges together on the same day.

Lab bills
If your physician collects a sample and sends it to a lab (pap smear, biopsy, culture etc.), you may receive a bill from the pathology laboratory and/or pathologist physician. Unless you tell us otherwise, we'll send your specimen to Coastal Pathology or Roper St. Francis Healthcare Laboratory. Some insurances require that all labs be done by a designated laboratory. We expect you to know your insurance's preferred lab and tell your medical assistant or nurse at your visit.

Billing quality
Our office works hard to bill your services according to national coding guidelines and standard insurance company regulations. There are times when you receive your EOB (Explanation of Benefits) from your insurance company – or a bill from your doctor (Physicians Billing) – and you feel something is wrong. If you think your insurance company processed your claim incorrectly, please feel free to give them a call and question it. If you think the charges we submitted may be incorrect, you may call our office and request that a certified coder review the doctor's documentation to ensure your visit was billed correctly. And finally, if you receive a bill and need to establish a payment arrangement or request financial assistance, Physicians Billing will work with you to do so.

Questions?
At Roper St. Francis Physician Partners OB/GYN, we hope to keep open communication with you about billing and insurance. We appreciate you as a patient and don't want billing issues to get between you and excellent care. If you have any questions – before, during or after your visit – please don't hesitate to ask. Thank you for choosing Roper St. Francis Physician Partners OB/GYN!

Referral
We are not considered a primary care office. However, we are happy to provide you a referral for a provider in the area if you need one. Roper St. Francis has many great Internists and Family Practice providers who are happy to serve you and your family.

Acknowledgement
I have read and understand the billing practices described above.

______________________	______________________	__________
Patient Name	Patient Signature	Date

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Today's Date: ________________

About You:

Name:____ Date of Birth:____________________________

Preferred/Nick Name:_______________________

Reason for today's visit: _____________________________ Referred by: ____________________________

Menstrual History

- First day of Last Menstrual Period: _____________
- Age at first Period: ______________ Age at last Period/Menopause: ____________
- How often do your periods start? ________________ How many days do they last? ________________

Health Screenings:

- Date of last Pap Smear (cervical cancer screen):_______________
- Have you ever had an abnormal pap smear? Y or N
    - If yes, did it require any treatment (eg, colposcopy, freezing, LEEP, etc…) _________________
- Date of last Mammogram (breast cancer screen): _____________
    - Have you ever had an abnormal mammogram/breast biopsy? Y or N
- Date of last Colonoscopy:________________ Date of last Bone Density Scan:________________

Gyn History:

- Are you currently sexually active? Y or N If yes, with Men/Women/Both? _________________
- Current birth control method: (eg, pills, ring, IUD, vasectomy/BTL, condoms, etc…) __________________
- Have you ever been diagnosed/treated for an STD/STI in the past? Y or N
    - If yes, which?_____________________
- Have you received the HPV vaccine (Gardasil or Cervarix)? Y or N

OB History:

Total Times Pregnant: ____________ Total # Miscarriages: ____________

Total Full Term Deliveries: _________ Total # Induced Abortions: ________

Total Pre-Term Deliveries: _________ Total # Living Children: ___________

Date	Gender	Weight	Full- or Preterm	Delivery Type (vaginal, c-section, vacuum, forceps)	Complications?

Lifestyle Questions:

- Relationship Status (ie, single, married, divorced): ________________________
- What is your sexual orientation? ___________________ Gender Identity? __________________________
- What do you currently do for a living? __________________________________
- Do you smoke/vape or use tobacco products? _____________________________
- Do you drink alcoholic beverages? _______________________ How Often? ______________________
- Do you use recreational drugs? ___________ Please Describe: _________________________________

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Medical History: Please list any chronic or major medical conditions for which you have been treated *(common examples: hypertension, high cholesterol, thyroid disorders, migraines, breast cancer, etc…)*

Medications: Prescription and Over the Counter, attach additional sheets as necessary

Name of Medicine	Dosage/Strength	How often?

Allergies/Intolerances:

Drug/Substance	Reaction

Hospitalizations/Surgeries:

Date	Operation or Reason for Hospitalization

Family Medical History:

Relationship	Significant Health Problems