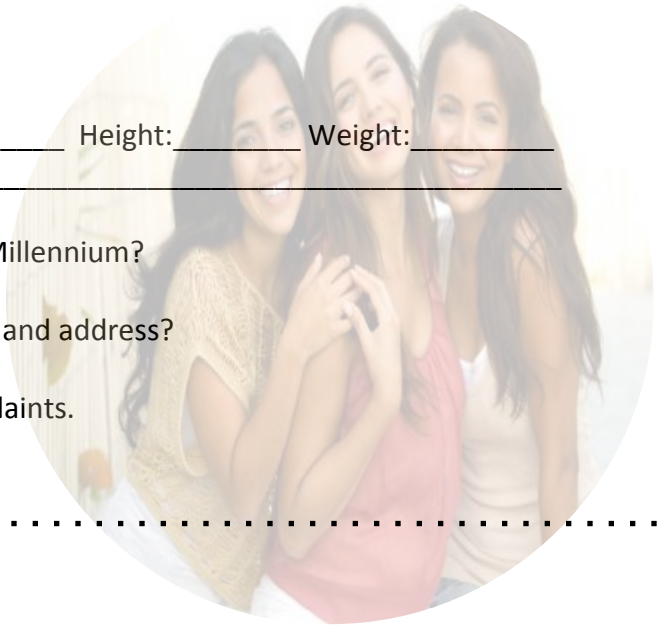
Millennium
Pregnancy & Gynecology

www.gynnow.com
703-224-9999



Date_____
Name:_____ DOB:_____ Height:_____ Weight:_____
Preferred Pharmacy name/ Phone number/ Address:_____
Best e-mail address:_____
Who referred you to our practice or how did you hear about Millennium?

Do you have a primary care doctor? If yes, what is their name and address?

What is the reason for your visit? Provide any details or complaints.

Previous Pregnancy History:

Were you pregnant before? Yes / No How many times?

Year of child's birth:	Pregnancy Outcome: (full term, miscarriage, abortion)	C-section or Vaginal:	Fetal Weight:

*Please list any additional pregnancies on the back of this form

List your previous gynecological history:

Last Menstrual Period (Date):_____
Last Pap Smear (Year and Result): _____
Last Mammogram (Year and Result):_____
Birth control method:_____
Please list any additional gynecological problems or past procedures:

Medical History:

Allergies:

List any additional medical problems or conditions:

Are you taking any medications? Yes / No
If yes, please list medication and dose:

Surgical History:

Please list any surgeries and years:

Social History:

Do you smoke? Yes / No
If yes, how much? _____ Pack(s) x Day
Do you drink alcohol? Yes / No
Do you use any recreational drugs? Yes / No

Family History:

Do you have a family history of cancer? Yes / No
If yes, please list who and which type:

Do you or your partner have a family history of genetic problems or birth defects? Yes / No
If yes, please explain:

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PATIENT INFORMATION **DATE:** _____

Name _____ **Home Phone** _____

Social Security #_____ **Cell Phone** _____

Age _____**Birthdate**_____ **Single**___ **Married** ___ **Widowed** ___ **Divorce** ___

Street Address _____ **Apt #**_____

City _____ **State** ____ **Zip Code** _____

Responsible Party (If a minor) _____ **Relationship** _____

EMAIL: _____ **how did you hear about us?** _____

EMPLOYMENT HISTORY

Patient Employed By_____

Business Address _____

Occupation _____ **Business Phone** _____

Spouse Name (or responsible party) _____ **Birthdate** _____

Occupation_____ **Business Phone**_____

INSURANCE INFORMATION Do you have Medical Insurance? NO __ YES __ Medicaid ___ Other ___

PRIMARY Insurance _____

Insurance Address _____**State** ___ **Zip Code** _____

Subscriber's ID# _____ **Group #**_____

Subscriber's Name _____ **Birthdate** _____

Relationship to Patient _____ **SS#** _____

SECONDARY Insurance _____

Insurance Address _____**State** ___ **Zip Code** _____

Subscriber's ID# _____ **Group #**_____

Subscriber's Name _____ **Birthdate** _____

Relationship to Patient _____ **SS#** _____

EMERGENCY CONTACT

In case of emergency, who should be notified? _____

Telephone # _____ **Cell #** _____ **Relationship** _____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I, the undersigned have insurance coverage with _____ and assign directly to MILLENNIUM GYNECOLOGY all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize MILLENNIUM GYNECOLOGY to release all information necessary to secure the payment of benefits. I authorize on all my insurance submissions whether manual or electronic.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account. I have completed the registration information sheet and certify the information is true to the best of my knowledge. I will notify the office of any changes in address, telephone numbers or insurance.

_____ _____

Signature of Insured/Guardian **Date**

NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING

A Virginia Law was enacted in 1989 that allows healthcare providers to test their patients for HIV antibodies when a healthcare worker is exposed to blood/body fluid of a patient in manner which transmit human immune deficiency virus which causes AIDS. In the event of such exposure, you will have deemed to have consented in such testing and to have consented to the release of the test results and appropriate counseling. If the test results are POSITIVE, we are required by law to notify the Virginia Department of Health.

_____ _____

Signature of Insured/Guardian **Date**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to MILLENNIUM GYNECOLOGY for any services furnished by my physician. I authorize any holder of medical information about me to be release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" as indicated in ITEM 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature **Date**

COLLECTIONS

IF YOU ARE TURNED OVER TO COLLECTIONS FOR NON-PAYMENT A 30% CHARGE WILL BE ADDED TO YOUR ACCOUNT BALANCE.

_____ _____

Signature of Insured/Guardian **Date**

STATEMENT OF UNDERSTANDING

Please initial each statement that you have read, understand and agree to comply with each item:

_____ I understand that Millennium Pregnancy and Gynecology is a multi-physician practice with both male and female physicians.

_____ I understand that there is no guarantee that I will be delivered by a female physician.

_____ I understand that Millennium Pregnancy and Gynecology delivers at **Inova Fairfax Hospital**.

_____ I understand that there is a **($25.00)** administration fee for medical record requests, FLMA forms and letters that must be paid before medical records can be released.

_____ I understand that there is a **15 minute grace period** for appointments and if I am late my appointment will be rescheduled for another day.

_____ I understand that there is a **$50.00** charge for **no-show** appointments.

_____ **I understand refusing to sign this document I will not be seen.**

_____	_____
Print Name (Patient)	Print Name (Interpreter)
_____	_____
Signature (Patient)	Signature (Interpreter)
_____	_____
Date	Date

BILLING PROCEDURES

This office bills your primary insurance company as a courtesy. Even though you have insurance coverage this account is your responsibility. I, the undersigned agree to pay a fee of **$35.00** for any check returned by my financial institution for insufficient funds. Furthermore, I agree to pay a **$50.00** non-cancellation fee should I fail to cancel a previously made appointment prior to my scheduled appointment time. In the event that this account is turned over to an attorney or collection agency for collection, I agree that the jurisdiction for said collection shall be Prince William or Alexandria Counties, that I shall pay **100%** attorney's fees, interest on the unpaid principal balance at the rate of **18%** per annum, and all costs.

I understand and agree that I am financially responsible for co-payments, deductibles and on-allowed charges, as per my insurance company, to be paid to Millennium Gynecology within thirty **(30)** days of initial patient billing.

MISSED APPOINTMENT FEE

The staff at Millennium Gynecology respects your time and we ask for the same courtesy. Missed appointments (no-shows) affect our ability to provide timely attention to "our patients" When a patient does not show up for their appointment, another patient loses an opportunity to be seen. If you are unable to make your appointment, we respectfully ask that you notify our office at least 24 hours in advance. A phone call to the office to explain why you cannot keep the appointment might prevent a no-show from being recorded against you.

SOCIAL SECURITY NUMBER REQUEST

1. Your Social Security number **will not** be used as the identification number for your account.
2. Your Social Security number **will not** be transmitted via mail or the internet to any insurance company other than those with which require it to file a claim on your behalf.
3. Our office strictly adhered to all **HIPAA** (Health Insurance Protection and Accountability Act), and **FDCP** (Fair Debt Collection Practices) regulations, and the **EPIC** (Electronic Privacy Information) Privacy Act.
4. Your name and address or Social Security number **will not** be sold, given out, or made public unless specifica required by law. If necessary, it will be given to our attorney or collection agency for skip tracing and collection measures, if your account is not paid. Our attorney or collection agency is considered a "Business Associate" of our practice and as such must comply with the federal "Fair Debt Collection Practice Act" and the "Health Insurance Protection and Accountability Act."

You have the right to refuse to provide us with your Social Security number, but **WE** reserve the right to **refuse** services to you if you do not provide us with your Social Security number.

I hereby declare that any and all information provided is true and correct. I understand and I may request a copy of this agreement. I have read and understand this agreement.

_____ _____

Patient Printed Name Patient Signature

_____ _____

If patient is a minor signature of guardian, state relationship Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES

I, _____, have received a copy of Millennium
(Print Name)

Pregnancy & Gynecology Notice of Privacy Practices.

_____ _____
(Signature) (Date)

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us of obtaining acknowledgement
_____ Other (Please Specify)

NOTE: In conveying inaccurate information I the patient will not post negative information on the website or any social media that may convey a negative experience especially those that are inaccurate. I understand I will be held liable legally and financially for such improper posting.

_____
Initial

HIPAA PATIENT QUESTIONAIRE

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____ Telephone/CELL #_____

Name: _____ Telephone/CELL #_____

Name: _____ Telephone/CELL #_____

2. Please list the family members or others, if any, whom we may inform about your medical condition (ONLY IN AN EMERGENCY):

Name: _____ Telephone/CELL #_____

Name: _____ Telephone/CELL #_____

Name: _____ Telephone/CELL #_____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent (if other than your home)

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4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked (CONFIDENTIAL). YES _____ NO _____
5. Please print the telephone number or email address where you want to receive calls about your appointments, lab and x-ray results or other healthcare information (if other than home telephone number: (_____) _____
6. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? YES _____ NO _____
7. I understand the Policy Protection Act and have been offered a copy of the Practice's Notice of Privacy Practices.

_____

Patient Name: (Guardian if under 18 years)

_____

Patient Guardian Signature Date

HIPAA NOTICE OF PRIVACY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
This notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations "HIPAA." It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECCH Omnibus Rule requirements.

1. YOUR RIGHTS

You have the right to request restrictions on the uses and disclosures of your health information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your health information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to request that we amend your health information that is incorrect or incomplete. We are not required to change your health information and will provide you a written information about our denial and how you can disagree with the denial.

You have the right to inspect and copy your health information. You may request your records in digital format (if available) and have your records sent digitally (if available) to another provider with written authorization.

You have the right to receive an accounting of disclosures of your health information made by us, except that we do not have to account for disclosures authorized by you; made for treatment, payment, health care operations provided to you; provided in response to an authorization made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at **(703) 224-9999.**

2. WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS WITHOUT OBTAINING YOUR PRIOR AUTHORIZATION AND HERE IS ONE EXAMPLE OF EACH:

We may provide your health information to other care professionals – including doctors, nurses and technicians – for purposes of providing you with care.

Our billing department may access your information – and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accounts in the event we need the information in order to address one of our business functions. Our attorneys are required to maintain confidentially whey they receive patient information.

3. WE MAY ALSO USE OR DISCLOSE YOUR HEALTH INFORMATION UNDER CERTAIN CIRCUMSTANCES WITHOUT OBTAINING YOUR PRIOR AUTHORIZATION.

However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your health information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

To Notify and/or Communicate with YOUR FAMILY. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to FAMILY and FRIENDS form.

AS REQUIRED BY LAW

For Health Oversight Activities. We may use or disclose your health information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your health information, as directed in the course of any civil or judicial proceeding.