Patient Information Page

Last _____ MI _____ First _____ Date of Birth _____ Age _____

SS # _____ Home phone _____/_____/_____ Cell phone _____ Work phone _____ Email Address _____

Street Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Preferred Language _____

Marital Status _____ Race _____ Ethnicity _____

Emergency Contact _____ Emergency Phone # _____ How Did You Hear About Us _____

Insurance & Subscriber Information

Primary Insurance Co. _____ Insured's Name _____ Relationship _____ Sex _____

Insured's Employer/Employer Phone # _____ Insured's SS # _____ Insured DOB _____

Secondary Insurance Co. _____ Insured's Name _____ Relationship _____ Sex _____

Insured's Employer/Employer Phone # _____ Insured's SS # _____ Insured DOB _____

Assignment & Financial Responsibility

I hereby assign, transfer and set over to Huey & Weprin OB/GYN, Inc., all of my rights, title and interest to my medical reimbursement benefits under my insurance policy given at the time of service. I authorize the release of any medical information needed to determine these benefits. This information shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all services, deductibles, co-pays, non-covered services, and missed appointment fees.

Signature: _____ Date: _____

Consent to Share Information with Outside Medical Entities

In order to provide you with the very best care, it may be necessary for our offices to access your medical records from outside medical facilities, including but not limited to the Kettering and Premier Health Networks. Do you consent to the sharing of data and medical records with outside facilities?

YES _____ NO _____

Signature: _____ Date: _____

HWC Women's Research Center Opt In

Our providers frequently are involved as Clinical Investigators in the research arm of the practice: "HWC Women's Research Center" located at our Englewood office. These clinical studies are sponsored and monitored by Pharmaceutical and Medical Device companies in many areas of Women's Health. Would you like us to contact you regarding participation in clinical trials or studies?

YES _____ NO _____

Signature: _____ Date: _____

HUEY & WEPRIN
• OB / GYN •

Dr. Stuart Weprin • Dr. Seema Sharma • Dr. Whitney Crye • Dr. Kelsey Madsen • Jill Goff, C.N.P. R.N.F.A. • Lisa McGarry, C.N.P.

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Englewood, OH

937.771.5100 • Phone
937.832.3014 • Fax

3533 Southern Blvd, Ste 3100
Kettering, OH

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

Please list the family members or other persons, if any, whom Huey & Weprin OB/GYN Inc. may inform about your medical condition and your diagnosis: **(Please list name and relationship)**:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____

Billing address if different from home:

_____

_____

_____

Home phone number: _____

Cell phone number: _____

Work phone number: _____

Family doctor: _____

Office phone Number: _____

Can pharmacy RX be called in? ☐ YES ☐ NO

If yes, pharmacy name: _____

Pharmacy number: _____

Do you have an Advanced Care Directive? ☐ YES ☐ NO
If yes, DNR ____ Non Surrogate Decision Maker ____ or
Surrogate Decision Maker _____

Please mark one:

OK to leave message on home answering machine:

☐ YES ☐ NO

OK to leave message with person answering home phone:

☐ YES ☐ NO

OK to leave message on cell voice mail:

☐ YES ☐ NO

OK to contact at work:

☐ YES ☐ NO

OK to leave message at work number:

on voice mail:

☐ YES ☐ NO

with person answering work phone:

☐ YES ☐ NO

Signature of Patient _____ Date _____

Signature of Parent/Guardian _____ Date _____

THIS AUTHORIZATION EXPIRES ONE YEAR FROM DATE SIGNED

Updated 11/17/2020

Financial Policy

Welcome

Thank you for choosing Huey and Weprin OB/GYN as your healthcare provider. We are committed to providing you with the best possible care and to your treatment being successful. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment of your bill is considered part of your overall treatment. In order to keep your cost of healthcare to an absolute minimum, we have adopted the following policies.

Fees and Payments

Fees are standardized and are based on the complexity of your visit. Payment in full is required at the time of service and can be made with cash, personal check, money order, Visa, MasterCard, or Discover.

Hospital Affiliations

We are associated with Kettering Medical Center and Miami Valley Hospital. We are proud to partner exclusively with Kettering Medical Center on Southern Boulevard for all our deliveries for our prenatal patients.

Required at Check - In

Each time you check in for your appointment you will be required to verify your personal contact information, present a current copy of your insurance Card, and pay any outstanding balance as well as today's visit.

Insurance Plans

Your insurance is a contract between you, your employer, and the insurance company; we are not a party to that contract. We must emphasize that as healthcare providers, our relationship is with you, not with your insurance company. Before your visit, please contact your insurance company to verify we are participants in your plan and the services you intend to receive are covered. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that services are rendered. In order for us to file a claim, you must present a current copy of your insurance card at each visit and communicate any changes in your personal contact information. Charges over 90 days will no longer be submitted to your insurance.

Most insurance policies specify that some of the cost of the patient's care is the patient's responsibility. This can be accomplished through any combination of co-payments, coinsurance, or deductibles. Co-payments are due when you check in for your appointment or an additional $10 service fee will be added to your bill. Coinsurance and deductibles are calculated by your insurance company and reported to us on your explanation of benefits. Once we are notified, we will add the appropriate charge to your account and send you a statement. This charge is payable upon receipt of the statement.

Not all services are a covered benefit in all policies so it is very important that you understand the provisions of your individual policy. Some insurance companies arbitrarily select certain services they will not cover and so we cannot guarantee payment of all claims by your insurance company. Some common examples of non-covered services are contraception and infertility treatments. In, addition, some plans don't cover any preventive or prenatal care. If your insurance company pays only a portion of your claim or rejects your claim, they will notify you through an explanation of benefits. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.

Self-Pay

Patients without insurance are considered self-pay patients. Self-pay patients are given a discount of 40% off of the charge amount. When possible, a fee range will be given upon check - in (or when you make your appointment), along with any anticipated additional charges. The full cost of the visit will be due at the time of service. Office supplied medication and devices are not eligible for an additional discount.

Medicare

We gladly accept patients with Medicare and will bill our services at the allowed rate. You will be required to sign an Advanced Beneficiary Notice (ABN) at every visit. This form will explain which services Medicare may not cover and that you may be responsible for those charges. Any lab work will also have a separate ABN to fill out.

Annual Exams

Please verify that your insurance will cover this preventative service before making your appointment. Depending on your age and the plan, these services may not be covered. Also, some insurance companies are very strict in enforcing time limits between visits and may not cover your visit if you are even one day early.

Payment Plans

Payment plans are available for qualifying balances and must be arranged through the billing manager. Payments are due monthly in the full agreed upon amount. An account with delinquent payments on a payment plan will be unable to schedule future appointments until the account is brought up to date. Three missed payments, consecutive or otherwise, may result in

the account being turned over to an outside collection agency and dismissal from the practice.

Obstetrical Payment Plans
At the beginning of your obstetrical care, we will contact your insurance company and compile an estimate of your portion of your total care. Because this cost may be significant, we arrange monthly payments leading up to the 24th week of pregnancy. Please contact our Patient Account Representative for details at (937) 832-8848.

Surgical Payment Plan
Prior to scheduling an office or hospital procedure, we may contact your insurance company and compile an estimate of your portion of care. This amount is due prior to your procedure. Because this cost may be significant, we offer the option monthly payments leading up to your procedure. Please contact our Patient Account Representative for details at (937) 771-5100 ext. 623.

Miscellaneous Charges
Returned check charges - Non Sufficient Funds (NSF) checks are subject to a $30 fee (in addition to fees from your bank).

Collection charges
Accounts that are not paid in a reasonable amount of time may be sent to an external collections agency and reported to the credit bureau. Information sent to the collection includes descriptions of services rendered and balances owed as well as contact information. In addition to your outstanding balance, a 33% surcharge will be added to cover our cost and you will be dismissed from the practice.

Medical Records Charge
There is a charge if you would like a copy of your medical records sent to yourself or another physician, however, if collaborating physician (primary care or specialist) requests specific portions of your chart to assist in your care, there is no charge.

Lab Charges (GenPath/LabCorp)
Depending on your insurance, you may get a separate bill from the lab facility that performs your lab work. Please contact the lab facility directly to discuss any questions with your bill.

Cancellation Charges or Missed Appointment
Cancellations require a notice of 24 business hours or you will be charged a $35 cancellation fee. There is also cancellation or missed appointment fees for the following:

○ Ultrasounds (24 Business Hours)	$50.00
○ Sonohystogram (24 Business Hours)	$100.00
○ No Shows	$35.00
○ Uro's (72 Business Hours)	$100.00
○ Surgery cancellation (5 business days)	$200.00

_____ _____
Patient Signature Date

_____ _____
Witness Date

H & W Financial Policy 11/17/2020

Review of Systems

Patient: _____

Please indicate if you have any of the symptoms below:

ROS:

General / Constitutional:
Do you have a fever? Yes ___ No ___
Chills? Yes___ No ___

Endocrine:
Do you have cold intolerance? Yes ___ No ___
Difficulty sleeping? Yes ___ No ___
Excessive thirst? Yes ___ No ___

Respiratory:
Do you have any chest pain? Yes ___ No ___
Shortness of breath? Yes ___ No ___

Breast:
Do you have any discharge? Yes ___ No ___
Bleeding? Yes ___ No ___
Lumps? Yes ___ No ___
Pain? Yes ___ No ___

Gastrointestinal:
Do you have any nausea? Yes ___ No ___
Constipation? Yes ___ No ___
Diarrhea? Yes ___ No ___

Neurologic:
Do you have fainting? Yes ___ No ___
Difficulty speaking? Yes ___ No ___
Seizures? Yes ___ No ___

Psychiatric:
Do you have depression? Yes ___ No ___
Anxiety? Yes ___ No ___
Suicidal ideation? Yes___ No ___

Health Education:
Have you received the Gardasil (HPV) vaccination? Yes ___ No ___ When ____
Influenza (Flu)vaccination? Yes ___ No ___ When ____
Hepatitis vaccination? Yes ___ No ___ When ____
Pneumoccocal (Penumonia) Vaccine? Yes ___ No ___ When ____
Herpes Zoster (Shingles)Vaccine? Yes ___ No ___ When ____
Are you up to date on diabetes screening? Yes ___ No ___
Lipid screening? Yes ___ No ___
Are you, or have you ever been a smoker? Yes___ No ___
Have you had a drink containing alcohol in the last 12 months? Yes ___ No ___

Cancer Self-Management:
Have you had a mammogram? Yes ___ No ___
Colonoscopy? Yes ___ No ___