WELCOME TO OUR OFFICE

Thank you for choosing Contemporary Obstetrics and Gynecology as your health care provider. We remain committed to providing the best medical care possible. Please complete only the portions of the attached forms that have changed since your last annual exam with us and notify us of any address or insurance changes.

Please understand that payment of your bill is considered a part of your treatment. This document explains our **Financial Policy**, which we ask you to read, sign and return to us the day of your appointment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at time of service.
- We accept cash, checks and major credit cards.

Regarding Insurance
We are participating providers with many insurance companies. For some other insurance companies we accept assignment of benefits. In all cases we require that the guarantor, the person who is financially responsible, is personally liable for a balance not covered by insurance.

It is your responsibility to understand and comply with any predetermination of benefits or referral requirements established by your health insurance carrier. Please be aware that some, and perhaps all of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You must also notify us if your insurance company requires the use of specific participating laboratory, radiology, or hospital facilities.

If your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid, or why it paid less than anticipated for care. If an insurance carrier has not paid within sixty
(60) days of billing, professional fees are due and payable in full from you.

If you have **no insurance**, or an insurance we do not participate with, payment must be made at the time of service unless an acceptable payment agreement has been made with the office manager prior to your visit.

Extended payment arrangements on self-pay accounts must be made prior to elective surgery. For procedures exceeding $300: 75% of the total fee from an office visit must be paid at the time of service or 75% of the total fee for a surgical procedure must be paid prior to the procedure. The remaining balance must be paid over the next three months in equal monthly payments due at the first of every month. Patients who fail to make payments will be sent to a collection agency and may be discharged from p

Divorce Cases: In cases of divorce, the individual who receives the care is responsible for payment or co-pays, coinsurance and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.

Co-Pay Balances
Your insurance company may require us to collect co-pays. Payment of co-pays is expected at time of service. If co-pay balances are not paid on the date of service, a $10.00 billing fee will be charged to your account. **This fee is not covered by insurance so it will be your personal responsibility.**

Finance charges
A $10.00 finance charge will be added to your bill if no payment is made on your account in two months.

Missed Appointments
Unless cancelled at least 24 hours in advance, we reserve the right to charge for a missed appointment. Please help us to serve you better by keeping scheduled appointments. **This fee is not covered by insurance so it will be your personal responsibility.**

Past Due Accounts
Over due accounts will be referred to a collection agency. A $20.00 collection fee will be added to your account.

Returned Checks
A $30.00 fee will be assessed for checks returned to us as unpaid by your bank.

Payment Plans
A payment plan can be arranged prior to your visit. Please call our office and ask to speak with the office manager.

Questions
We welcome you to our practice and look forward to providing your medical care. Please do not hesitate to contact our billing department at 315-685-1691with any questions or concerns.

I have read and acknowledge the financial policy of Contemporary Obstetrics and Gynecology.

Print Name _____

Signature _____

Date _____

PATIENT PERSONAL HEALTH HISTORY
NOB FORM

Name: _____ DOB: _____ Race: _____

Last Menstrual Period: _____ Primary Care Dr.: _____

Employer: _____ Occupation: _____

Father of Baby: _____ Phone# _____

HEALTH CARE PROVIDERS

List any health care providers from whom you are currently receiving treatment of any kind:

Provider: _____ Specialty: _____

Address: _____ Phone# _____

Provider: _____ Specialty: _____

Address: _____ Phone# _____

CURRENT MEDICATIONS

Please list all medications you are currently taking, including aspirin, pain relievers, vitamins, herbal supplements, etc…

Medication	Dosage	Frequency	Prescribing Doctor

ALLERGIES

Medication/Substances	Reaction

LIFESTYLE FACTORS

Do you smoke? ☐Yes ☐No Packs per day _____ Years _____

Did you use to smoke? ☐Yes ☐No Packs per day _____ Years _____

Do you use alcohol? ☐Yes ☐No Drinks per day _____ Per week _____

Do you use illegal drugs ☐Yes ☐No Type _____

Do you exercise regularly? ☐Yes ☐No Type _____

Do you wear a seatbelt? ☐Yes ☐No

Do you have a Living Will? ☐Yes ☐No Do you have a Health Care Proxy? ☐Yes ☐No

REVIEW OF SYSTEMS

Name: _____

Please check the box if you are experiencing or have experienced any of the following symptoms

Constitutional
- Fatigue ☐
- Fever ☐
- Weight gain ☐
- Weight loss ☐

EYES
- Spots before eyes ☐
- Double vision ☐
- Visual changes ☐

ENMT
- Earaches ☐
- Ringing in ears ☐
- Sinus problems ☐
- Dental problems ☐
- Mouth or Tongue sores/lesions ☐
- Sore throat ☐

Cardiovascular
- Painful breathing ☐
- Chest pain ☐
- Difficulty breathing on exertion ☐
- Palpitations ☐
- Swelling of legs ☐

Respiratory
- Cough, chronic ☐
- Spitting up blood ☐
- Shortness of breath ☐
- Wheezing ☐

Gastrointestinal
- Bloody stools ☐
- Constipation ☐
- Diarrhea, frequent ☐
- Nausea ☐
- Vomiting ☐

Musculoskeletal
- Muscle weakness ☐

Genitourinary
- Pain with periods ☐
- Painful intercourse ☐
- Heavy menstrual bleeding ☐
- Blood in urine ☐
- Frequent urination ☐
- Pain with urination ☐
- Urgency ☐
- Leakage of urine ☐

Skin/Breast
- Breast discharge ☐
- Mass in breast ☐
- Pain in breast ☐
- Rashes ☐
- Ulcers ☐

Neurological
- Trouble walking ☐
- Dizziness ☐
- Numbness ☐
- Seizures ☐

Psychiatric
- Anxiety ☐
- Crying, frequent ☐
- Depression ☐

Endocrine
- Dry skin ☐
- Excessive thirst ☐
- Hot flashes ☐

Hemotological/Lymphatic
- Bruises, frequent ☐
- Prolonged bleeding ☐
- Enlarged lymph nodes ☐

IMMUNIZATIONS

Please check the box of the shots you have received and the date (if known)

Chicken Pox	☐	_____	Pneumonia	☐	_____
Hepatitis B	☐	_____	TB Skin Test	☐	_____
Flu shot	☐	_____	MMR	☐	_____
Tetanus	☐	_____			

PERSONAL MEDICAL HISTORY **Name:** _____

Please check the box if you are experiencing or have experienced any of the following symptoms

Allergies	☐	High cholesterol	☐
Anemia	☐	Kidney infection/stones	☐
Anesthesia problems	☐	Mitral valve prolapse	☐
Arthritis/joint pain	☐	Osteoporosis	☐
Asthma	☐	Pneumonia	☐
Bowel trouble	☐	Reflux	☐
Cancer	☐	Rheumatic fever	☐
Chicken Pox	☐	Psychiatric disorder	☐
Chronic lung disease	☐	Seizures/epilepsy	☐
Depression/anxiety	☐	Shingles	☐
Diabetes	☐	Stomach problems	☐
Endometriosis	☐	Stroke	☐
Fractures	☐	Thyroid disease	☐
Glaucoma	☐	Tuberculosis	☐
Heart disease	☐	Ulcers/GERD	☐
Hepatitis/jaundice	☐	Uterine fibroid	☐
High blood pressure	☐	Varicose veins	☐

Do you have any medical condition not noted above: _____

Have you ever had a blood transfusion: YES NO If Yes, when: _____

Reason for Transfusion: _____

FAMILY HISTORY

Please check the box if a family member has a history of the following illnesses

		Relative			Relative
Alcohol/drug abuse	☐	_____			
Anesthesia problems	☐	_____	High Blood Pressure	☐	_____
Blood clots	☐	_____	Osteoporosis	☐	_____
Breast cancer	☐	_____	Ovarian Cancer	☐	_____
Colon cancer	☐	_____	Prostate Cancer	☐	_____
Depression/anxiety	☐	_____	Stroke	☐	_____
Diabetes	☐	_____	Thyroid disease	☐	_____
Heart disease	☐	_____	Uterine cancer	☐	_____

Is there other family history of illness not listed above? _____

Comments: _____

_____

GYNECOLOGIC HISTORY **Name:** _____

Please complete blanks and/or circle the appropriate answers

Menstrual History

Date of last menstrual period _____ Age of first period _____

How often do you get your period _____ Number of days it lasts _____

Flow: heavy moderate light Cramps: YES NO Sometimes

Spotting Between Periods: YES NO Sometimes

Date of Last Mammogram _____ Facility _____

Date of Last Pap Smear _____ Facility _____

Have you ever had an Abnormal Pap: YES NO Treatment _____

Have you ever had a bone density (DEXA) test: YES NO Facility _____

Sexual History

Are you currently Sexually Active: YES NO Age of first coitus: _____

Type of Contraception (birth control): _____

Number of lifetime partners: _____ Date last tested for HIV: _____

History of STD (sexually transmitted disease; GC, Chlamydia, HPV, HSV): YES NO

Rash or viral illness since LMP: YES NO Exposed to TB: YES NO

History of Genital Herpes: YES NO Partner History of Genital Herpes: YES NO

SURGICAL HISTORY

List details of past surgical procedures in the table below:

Operation	Date	Hospital	Surgeon

GENETIC SCREENING **Name:** _____

Including patient, baby's father, or anyone in either family

Age ≥ 35 years	□Yes	□No	Mental retardation	□Yes	□No
Thalassemia	□Yes	□No	If yes, was person tested		
Neural tube defect	□Yes	□No	for Fragile X	□Yes	□No
Congenital heart defect	□Yes	□No	Child(ren) with birth defect	□Yes	□No
Down syndrome	□Yes	□No	Recurrent pregnancy loss	□Yes	□No
Tay-Sachs	□Yes	□No	Still birth	□Yes	□No
Sickle cell disease/trait	□Yes	□No	Medication/drugs/alcohol used		
Hemophilia	□Yes	□No	since last menstrual period	□Yes	□No
Muscular dystrophy	□Yes	□No	If yes, what? _____		
Huntington chorea	□Yes	□No	Any other genetic problems _____		

Comments: _____

OBSTETRIC HISTORY

How many times have you been pregnant: _____

Birth Date month, year	Outcome - Live birth, miscarriage, still birth, termination	# of weeks pregnant	Length of Labor	Sex M/F	Birth Weight	Delivery type – vaginal, cesarean, forceps	Epidural Y/N	Hospital	Pre-term labor Y/N	Complications Y/N	Child's Name

Do you currently have any problems or concerns you would like to discuss with the provider?

_____

_____

Patient Signature: _____ Date: _____

Contemporary Obstetrics & Gynecology
POB North Suite 3A
Community General Hospital
Syracuse, NY 13215

Risk Assessment Questions For Pregnant Women for the elevation of Lead Poisoning

The following questions are suggested by the New York Department of Health and American College of Obstetrics & Gynecology. If you answer yes to any of the following questions it is recommended that you have a blood test to measure the lead content.

1. Do you or others in your household have an occupation that involves lead exposure? No Yes

2. Sometimes, pregnant women have the urge to eat things other than food, such as clay, soil, plaster, or paint chips. Do you ever eat paint chips. No Yes

3. Do you live in an old house with ongoing renovations that generate a lot of dust (e.g.sanding and scraping) No Yes

4. To your knowledge, has your home been tested for lead in the water and, if so were you told that the level was high? (Note: a level over 15 parts per billion(ppb) or micrograms per liter is considered high?) No Yes

5. Do you use any tradition folk remedies or cosmetics that are not sold in a regular drug store or are homemade, which may contain lead? (e.g. Alkohl, Azarcon, Bali goli, Ghazard, Greta, Pay-loo-ah?) No Yes

6. Do you or others in your household have any hobbies or activities likely to cause lead exposure. (making stain glass, copper enameling, bronzc casting, pottery with lead glaze, jewelry with cad solder, glass blowing with leaded glass, print making and other fine arts with lead pigments)? No Yes

7. Do you use noncomercially prepared pottery or lead crystal? No Yes

Signature: _____ Name: _____

Contemporary Obstetrics & Gynecology
764 West Genesee St.
Skaneateles, N.Y. 13152

PATIENT REGISTRATION

Name: _____ Birth Date: _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient's Employer: _____ Phone# _____

Referring or Family Physician: _____ City: _____

Marital Status: S M D W Sep Student Status: Full Time Part Time

Pharmacy: _____ Location: _____

Emergency Contact: _____ Home# _____ Work# _____

Spouse/Nearest Relative: _____ Home# _____ Work# _____

INSURANCE INFORMATION

Primary Insurance: _____ Insured: _____

Policy# _____ Group# _____ Effective Date: _____

Insured's SS# _____ DOB: _____ Employer: _____

Secondary Insurance: _____ Insured: _____

Policy# _____ Group# _____ Effective Date: _____

Insured's SS# _____ DOB: _____ Employer: _____

I hereby authorize the office of Contemporary Obstetrics & Gynecology to furnish information to insurance carriers including periodic quality assurance checks, and I hereby assign payment for medical services provided to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____

CONTEMPORARY OBSTETRICS & GYNECOLOGY
764 W. GENESEE STREET
SKANEATELES, NY 13152
(315) 685-1691

Please complete this section for your file:

Name:_____

Address:_____

Home Phone:_____ Work:_____ Cell:_____

Pharmacy:_____ Address:_____

May we leave medical information or appointment reminders on:

Cell phone	Yes	No
Home phone	Yes	No
Work Phone	Yes	No

Preferred Phone number:_____

Please circle:
May we leave a message regarding a call back on Home, Work or cell.

Person(s) authorized to communicate with (please list first, last name and relationship):

_____ A reminder will be sent to schedule annual exams. Please check mark if you **do not** want a reminder postcard

Acknowledgement of Receipt of
NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act. By signing below you acknowledge that you have read this notice and understand that you may receive a copy of the policy in its entirety upon request.

_____ _____ _____
Print Name Signature Date