PATIENT INFORMATION

Who is your Preferred Provider at Metro OB/GYN?_____
(Quien es su Doctor preferido aquí en Metro OB/GYN?)

Name_____
(Nombre) (Last/Apedillos) (First/Nombre) (Middle/Segundo Nombre)

Preferred Name_____ Maiden Name_____
(Nombre preferido) (Apellido de Soltera)

Address_____
(Direccion) (Street/Calle y Número) (# de Apt) (City/Ciudad) (State/Estado) (Zip code/Codigo Postal)

Date of Birth _____/_____/_____ Age_____ Race_____ SS#_____/____/_____
(Fecha de Nacimiento) (Mes) (Dia) (Año) (Edad) (Raza) (Seguro Social)

Home Phone # (____) _____ Cellular Phone # (____) _____
(Telefono Casa) (Telefono Celular)

Employer_____ Work Phone #(_____)_____
(Lugar de Trabajo) (Telefono de Trabajo)

Occupation/Student_____
(Profesion/Estudiante)

Permission to leave message at home?Yes/No Cell phone? Yes/No At work?Yes/No
(Permiso para dejar mensaje en la casa?) Si/No (Telefono Celular) Si/No (En el trabajo?) Si/No

Marital Status: M S W D or Sep
(Estado Civil) C S B D o Separado

Primary Language_____Email Address_____
(Lenguaje Primario) (Correo electrónico)

Primary Insurance _____ Insured Name_____
(Aseguransa Principal) (Nombre de Asegurador(a)

SS#____/____/_____ Date of Birth____/____/____ Policy #_____
(Seguro Social) (Fecha de Nacimiento) (Mes) (Dia) (Año) (Numbero de Polica)

Group #_____Insured Relationship to patient_____
(Relacion a paciente)

Secondary Insurance _____ Insured Name_____
(Aseguransa Secundaria) (Nombre de Asegurador(a

SS#____/____/_____ Date of Birth____/____/____ Policy #_____
(Seguro Social) (Fecha de Nacimiento) (Mes) (Dia) (Año) (Numbero de Polica)

Group #_____Insured Relationship to patient_____
(Relacion a paciente)

Patient's Name_____
(Nombre de Paciente)
Spouse's Name_____ **SS#** _____/____/_____ **Date of Birth**___/___/____
(Nombre de Pareja) (# Seguro Social) (Fecha de Nacimiento) (Mes) (Dia) (Año)
Spouse's Work Place_____ **Phone # (____)** _____
(Lugar de Trabajo de Pareja) (Teléfono)
Emergency contact name_____ **Emergency phone # (___)** _____
(Contacto de Emergencia) (Teléfono de Emergencia)
Relationship_____

Preferred Pharmacy_____**Phone Number#(___)**_____
(Farmacia Preferida) (Telefono de Farmacia)
Address_____
Primary Care Provider_____
(Doctor Primario)
Were you referred? Y N If so who referred you? _____
(Fue usted referido aqui?) S N (Si, quien la refirió?)

I agree to be financially responsible for all charges not covered by my insurance for service received from Metro OB/GYN, LLC., I authorize the physicians or designees staff to provide the necessary medical treatment and the release of any medical information to process my claims.
Estoy de acuerdo en ser financieramente responsable de los cargos no cubiertos por mi aseguransa, por servicios recibidos por Metro OB/GYN, LLC. Yo autorizo a los médicos o al personal asignado para proveer el tratamiento médico necesario y suministrar toda información medica necesaria para procesar mi reclamación.

Signature_____ **Date**_____
(Firma) (Fecha)

If patient is a minor (under age 18). I understand that I am financially responsible for all charges not covered by the insurance. I authorize medical treatment necessary and the release of any information to process the claims. Si el paciente es menor de 18 años, entiendo que soy financieramente responsable de los cargos no cubiertos por la aseguransa. Yo autorizo el tratamiento médico necesario y doy permiso para suministrar la información para procesar la reclamación.
Parent or Guardian_____ **Relationship**_____
(Nombre de Padre o Guardian) (Relacion con Paciente)
Birthdate___/____/____ **SS#**____/____/____
(Fecha de Nacimiento) (Mes) (Dia) (Año) (# Seguro Social)
Address_____
(Direccion) (Street/Calle y Número) (City/Ciudad) (State/Estado) (Zip code /Codigo Postal)
Phones #'s Home (____) _____**Work (____)** _____
(Telefonos Casa) (Trabajo)
Cell (____) _____
(Celular)

Signature_____ **Date**_____
(Firma) (Fecha)

Patient Name:	Patient Date of Birth:

We appreciate your continued support of Metro OBGYN. Our partnership with you in your ongoing healthcare is most important to us. Retaining your trust in releasing your health information is our goal. Without your authorization, we are limited to releasing your information only to you. Please complete the following form.

Please contact me as follows:

☐ Home Telephone ☐ Cell Phone

_____

☐ Leave message—Appointment time/date
☐ Leave message—Provider name/telephone
☐ Leave message—Normal lab/test results
☐ Do not leave a message of any kind

Work/Other Telephone

_____

☐ Leave message—Appointment time/date
☐ Leave message—Provider name/telephone
☐ Leave message—Normal lab/test results
☐ Do not leave a message of any kind

Other Instructions:

_____

_____

_____

Medical information/messages may be left with the following people only:

_____

_____

_____

Patient Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

New Patient Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare Metro OBGYN, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- □ a basis for planning my care and treatment.
- □ a means of communication among the many health professionals who contribute to my care.
- □ a source of information for applying my diagnosis and surgical information to my bill.
- □ a means by which a third party payer can verify that services billed were actually provided.
- □ a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been given a *Notice of Information Practices* that provides a more complete description of information and uses and disclosures. I understand that I have the following rights and privileges:

- □ to review the notice prior to signing this consent
- □ to object to the use of my health information for directory purposes
- □ to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations

I understand that Metro OBGYN, LLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action. I also understand that by refusing to sign this consent, or by revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Metro OBGYN, LLC reserved the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Metro OBGYN, LLC change their notice they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use of disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **ACCEPT / DECLINE** the terms of this consent. **(Must circle whether you accept or decline these terms.)**

_____ _____

Patient's Signature Date

Pharmacy Benefit Management (PBM) Consent Form

(E)LECTRONIC – Prescribing

E-Prescribing – A physician's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Medication History Transactions – Provides the physician with information about medication that the patient is already taking, prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent you are agreeing that Metro OBGYN can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

_____

Patient's Name (Please print)

_____

Patient's Date of Birth

_____

If you agree: Signature of Patient (Signature of Parent or Guardian if the patient is under age 18)

_____

Date

I decline the request.

_____

If you decline: Signature of Patient (Signature of Parent or Guardian if the patient is under age 18)

_____

Date

Waiver of Liability

I understand that if the services performed today are not totally covered under my health insurance policy, or by Medicaid/Medipass, then I will be responsible for any or all of the remaining charges that are incurred.

Signature of Patient: _____

Date: _____

If the patient is a minor (under age 18) the parent or guardian will please sign:

Signature of parent/legal guardian: _____

Date: _____

Interpreter's Statement:

For use if an interpreter is provided to assist the individual in understanding the information described above.

I have translated the information orally or with sign language to the patient. To the best of my knowledge and beliefs the patient understands this explanation.

Interpreter's Signature: _____

Date: _____