OGEECHEE OB-GYN, P.C. PATIENT REGISTRATION

Name _____ Birthdate _____
Last First Middle Initial

Address _____
Street / P. O. Box City State / Zip

Email Address _____ Race _____ Ethnicity-Hispanic/Other/Refused

Social Security # _____ Home Phone # _____

Cell Phone # _____ Work Phone # _____

Employer _____ Occupation _____

Spouse/Parent Name _____ Birthdate: _____

Emergency Contact (nearest friend / relative not living with you) _____

Emergency Contact's Numbers _____

Primary Care Physician _____ Referred by _____

Insurance Information

PRIMARY Insurance _____

Policy Number _____ Group Number _____

Subscriber _____ Relationship to Patient _____

Subscriber Social Security # and Birthdate _____

SECONDARY Insurance _____

Policy Number _____ Group Number _____

Subsriber _____ Relationship to Patient _____

Subscriber Social Security # and Birthdate _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES – I hereby acknowledge that a copy of the Notice of Privacy Practices for Ogeechee Ob-Gyn, P.C. document has been made available to me.

AUTHORIZATION FOR RELEASE OF INFORMATION – I hereby authorize this practice to furnish any medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of care.

ASSIGNMENT OF BENEFITS – I hereby authorize payment directly to this practice, including major medical and / or surgical benefits. I understand that I am fully responsible for charges not covered by this assignment.

GUARANTEE OF ACCOUNT – I understand that I am financially responsible for all charges for services rendered to me, or my dependent, including the balance remaining after payment of possible insurance benefits.

_____ _____

Signature of patient or guarantor Date

Ogeechee OBGYN Patient Health History

Name: _____ **Date of Birth:** _____

Primary Care Provider/Referring Physician: _____

Pharmacy of Choice: _____

Medication Allergies: _____

Please check if you currently have any of the following medical conditions:

☐ Anemia ☐ Anxiety ☐ Asthma ☐ Cardiovascular Disorder ☐ COPD

☐ Heart Disease ☐ Depression ☐ Diabetes ☐ Heartburn ☐ High Cholesterol

☐ Cancer ☐ HIV + ☐ High Blood Pressure ☐ Liver Problems ☐ Kidney Problems

☐ Kidney Stones ☐ Thyroid Disease ☐ Vascular Disease ☐ Substance/Drug abuse

Other conditions not listed _____

Please list all current **medications, dosage** and the **person who prescribes it**

Surgical History

☐ Hysterectomy ☐ Vaginal ☐ Abdominal ☐ Supracervical Year _____

☐ C-section Year(s) _____

☐ Tubal Ligation Year _____

☐ Breast Surgery ☐ Lumpectomy ☐ Mastectomy Year _____

Please list any other surgeries and year performed:

Last Pap Smear Date _____ Results _____ Where was it done _____

Last Mammogram Date _____ Results _____ Where was it done _____

Last Bone Density (DEXA) Scan Date _____ Results _____

Last Colonoscopy Date _____ Results _____

Have you had the Human Papilloma Virus (HPV) vaccine? _____

Occupation: _____

Name: _____ Date of Birth: _____

Family History- Please check if any of your family members have had the following:

☐ Breast Cancer Relationship _____ Age at Diagnosis _____

☐ Ovarian Cancer Relationship _____ Age at Diagnosis _____

☐ Uterine Cancer Relationship _____ Age at Diagnosis _____

☐ Colon Cancer Relationship _____ Age at Diagnosis _____

☐ Bleeding or Blood Clotting Disorder Relationship _____ Age at Diagnosis _____

☐ Diabetes Relationship _____

☐ Heart Disease/Heart Attack/Stroke Relationship _____

☐ Have either of your parents ever had a hip fracture? _____

Any known genetic or hereditary diseases or disorders in your family? _____

Menstrual/Obstetric History

Age of first menstrual cycle _____ Date your last period **STARTED** _____ **OR Age at Menopause** _____

Are your periods regular? (occurring every 21-35 days) _____

How many days do you usually bleed during your period? _____

Do you have very heavy bleeding or very painful cramping with your periods? _____

Current birth control method? _____ Would you like to start or change methods? _____

Have you ever had any sexually transmitted diseases? _____

Would you like to be screened today for sexually transmitted diseases? _____

How many times have you been pregnant? _____ How many living children do you have? _____

Number of miscarriages? _____ Number of elective abortions (termination of pregnancy) _____

Are you currently pregnant? _____ Have you ever had difficulty getting pregnant ? _____

Social History

Do you drink alcohol? _____ If yes, how many drinks and how often? _____

Do you currently smoke? _____ If yes, how many packs per day? _____

Have you ever smoked? _____ How many years? _____ When did you quit? _____

Do you use illegal drugs? _____ If yes, what type? _____

Relationship Status: In a Relationship

Are you in a situation/relationship where you are physically, sexually or emotionally abused? _____

Do you feel safe in your current home? _____

OGEECHEE OB-GYN, P.C.
Patient Questionnaire

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

Name _____ Phone # _____

Name _____ Phone # _____

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

Name _____ Phone # _____

Name _____ Phone # _____

III. 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.

_____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL".

No

V. Please print the telephone number, if any, where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number.

(___) _____

VI. Can confidential messages (ie, appointment reminders) be left on your home answering machine or voicemail?

Yes

VII. If you do not have voicemail, can a confidential message be left at your place of employment?

No

PATIENT NAME: _____ (guardian if under 18 years)

_____ _____

PATIENT / GUARDIAN SIGNATURE DATE

_____ _____

WITNESS DATE

*NOTE: This document expires one year from signature date.

Ogeechee OB-GYN
Appointment Cancellation and No-Show Policy
Acknowledgement

(updated 12/17/2019)

Because quality care for our patients is our priority, Ogeechee OB-GYN requires review and acknowledgment of our policies below.

1. **Missed Appointments-**We understand that there are times when you must miss an appointment due to emergencies or unforeseen work or family obligations. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving much needed treatment. We require 24-hour's advance notice if you are unable to keep a scheduled appointment. If an appointment is not cancelled at least 24 hours in advance, you will be charged a $25.00 no-show fee. This fee is not covered by insurance or Medicaid and you will be responsible for paying the balance in full before you are able to be rescheduled. Note: After three (3) no-show/missed appointments, you may be dismissed from the practice.

2. **Scheduled Appointments-**We understand that delays may happen on the day of your scheduled appointment. Because we make every effort to keep the patients and providers on schedule, it is imperative that you arrive at your scheduled appointment time (or 15 minutes early to complete paperwork). Arriving late to your scheduled appointment causes the providers and timely patients to be pushed behind. If you arrive fifteen (15) minutes past your scheduled appointment time, we reserve the right to reschedule your appointment.

3. **Surgery Schedules-**Due to the large block of time needed for surgery, last minute cancellations can cause added expenses and additional work for the office. We require a ten (10) day advance notice if you decide to cancel your surgical procedure. **If you fail to cancel surgery within the required time frame, fail to show up for the scheduled procedure, or show up late for a scheduled procedure you will be charged a $150.00 fee. This fee will not be covered by insurance or Medicaid and you will be responsible for paying the fee.** Showing up late for a scheduled surgery may result in your procedure being cancelled and it may only be rescheduled on a case by case basis. Missing a scheduled surgery may result in discharge from the practice.

4. **Account Balances-**We will require that patients who are uninsured/self-pay bring a minimum payment of $250.00 for their first appointment. Due to insurance contracts, we must collect **ALL CO-PAYMENTS and COINSURANCE**. Payment will be collected PRIOR to services being rendered. **If you do not have your co-payment, your appointment will be rescheduled.** Accounts with balances will be collected at each appointment. Unpaid account balances greater than sixty (60) days will be turned over to an outside collection agency. **If your balance is over $100.00, you must make payment arrangements prior to future appointments being made.**

Patient Name	**Birthdate**
Patient Signature/Guardian Signature	**Date**
Witness Name/Signature	**Date**

OGEECHEE OB-GYN, P.C.

Obstetrics, Gynecology and Infertility

Benjamin T. Oldham, M.D., F.A.C.O.G. Chelsea J. Mikell, M.D.

Tressa G. Cheney, F.N.P. Shannon N. Hall, P.A.C. Nikiya L. Lewis, D.N.P

PATIENT CARE / FINANCIAL AGREEMENT

As a courtesy to the patient, we attempt to obtain insurance information and verify benefits prior to service. However, it is ultimately the responsibility of the patient to understand her coverage benefits and restrictions. Certain services and/or diagnosis may not be covered by your health insurance policy. **IN THE EVENT OF DENIAL OR NON-COVERED SERVICES, THE PATIENT IS STILL FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED.** It is the responsibility of the patient to provide proof of insurance at the time of service. If you fail to provide accurate insurance data at the time of service, you will be responsible for any balance resulting from failure to provide this information. **FOR PATIENTS HAVING SECONDARY MEDICAID COVERAGE, YOU MAY STILL BE RESPOSIBLE FOR INSURANCE CO-PAYMENTS AND ANY BALANCE RESULTING FROM NON-COVERED SERVICES OR FAILURE TO PROVIDE ACCURATE INSURANCE INFORMATION AT THE TIME OF SERVICE.**

Many insurance companies have separate deductibles and benefits for surgical procedures and laboratory services. When a biopsy, blood work, or a pap smear is performed in the office, the specimen is sent to a separate laboratory facility for processing and examination. This charge is separate from our fees. Ogeechee Ob-Gyn, P.C. utilizes LabCorp as the primary reference lab for diagnostic testing. To assist the office in reporting lab results, the patient must address a follow-up card. With your authorization, results and follow-up instructions will be mailed to you. It is your responsibility to notify us if you do not receive either the card or a phone call regarding results within three weeks by calling 912-871-6206. Ogeechee Ob-Gyn, P.C. also utilizes **East Georgia Regional Medical Center** for diagnostic testing and procedures. THE PATIENT IS RESPONSIBILE FOR ANY BALANCE RESULTING FROM NON-NETWORK RESTRICTIONS. We believe that you are entitled to make informed decisions regarding your medical care. To assist you in making an informed decision, we hereby notify you that Dr. Benjamin T. Oldham has an ownership interest in East Georgia Regional Medical Center, which is a physician-owned hospital, pursuant to 42 C.F.R. * 489.3.

Patients are responsible for their co-payment and/or deductible at the time services are rendered. Co-payments not paid on the date of service will result in a $10.00 service fee. **Uninsured patients must make a minimum payment of $250.00 and sign a payment contract for any outstanding balance.** Monthly payments are required on all accounts to avoid collection action. We accept cash, check or credit card. There is a $50.00 fee associated with returned checks. **PLEASE NOTE THAT IF ANY OUTSTANDING BALANCE IS FORWARDED TO OUR COLLECTION AGENCY, THE ACCOUNT WILL BEAR INTEREST IN ACCORDANCE WITH GEORGIA LAW AND A $50.00 SERVICE CHARGE, REASONABLE ATTORNEY'S FEES, AND ALL COST TO COLLECT THE ACCOUNT.**

Appointments must be cancelled 24 hours in advance. A $25.00 charge will be incurred for patients failing to keep their appointment or failing to cancel 24 hours in advance.

I have read and understand the above office practices. I agree to the practices described above as part of my patient care through Ogeechee Ob-Gyn, P.C.

Patient Name (printed)	Date of Birth
Patient Signature	Date
Witnessed	Date

1310 Brampton Avenue Statesboro, Georgia 30458
Phone 912-871-6206 Fax 912-681-8558

www.ogeecheeobgyn.com

Welcome to the Ogeechee OB-GYN Patient Portal/Secure Messaging System

We are pleased to offer our patients a secure and confidential way to communicate with the healthcare team of Ogeechee OB-GYN through our Secure Messaging System. Patients must be registered on the secure patient Portal to have full access to our online patient services, which include:

* Requesting appointments
* Obtaining test results
* Requesting refills on medications
* Asking general nursing questions
* Communicating directly with your providers
* Making payments on accounts and assistance with billing issues

Using the Secure Messaging System is the most efficient, confidential way to communicate with your healthcare team. Registration is quick and the system is easy to use. A member of our office staff will be happy to assist you with registering today. In order to sign up for secure messaging, please have the following information ready:

NAME

BIRTHDAY

EMAIL:

USER ID:

PASSWORD:

MOTHER'S MAIDEN NAME:

A PET NAME: