Patient Information

Last Name_____First Name_____ Middle Initial_____

Street Addresss_____City_____

State_____ Zip_____ Home Phone_____Cell Phone_____

Can we call you at work? _____ Work Phone_____

Date of Birth_____ Social Security Number* _____ * Because we extend credit to you when we bill your insurance, we require your Social Security Number. It is protected by the law.

E-Mail address _____ Your pharmacy name_____

Emergency Contact_____ Phone_____ Relationship (i.e., husband) _____

If you wish us to share protected health information (PHI) about you with anyone else, please tell us who and your

relationship to that person_____

This PHI can be shared from this date_____ through this date_____.

Payment Information

You, our patient, are responsible for payment, unless you are under the age of 18, which means your guardian is responsible for payment. We bill your insurance on your behalf. If you are under 18, we provide the name of the person responsible for payment (i.e., Mary Smith, mother) and phone number _____

We will need to copy your insurance card. If you aren't the insurance subscriber, please tell us:

Name of Subscriber_____ Relationship to you _____

Subscriber's Date of Birth_____

We request a credit card be provided for all cash-pay and high-deductible insurances:

Card number_____Exp. date_____

Security code _____ Card holders name_____

This card will be verified by our receptionist for validity. Verfied by: _____

Notice of Office Policies

1. Patients may be charged $25 for appointments that are missed and/or not cancelled 24 hours before the time of the appointment, per individual insurance regulations. Please note that our office works hard to schedule appointments to minimize the amount of time you must wait for the physician. When you fail to appear for your appointment or cancel the day of your appointment, you have left an open space that could have been filled by another patient. This is counterproductive for our office and for other patients who may have needed that time period. This policy is not unusual. The American Medical Association Code of Ethics clearly states, "A physician may charge a patient for a missed appointment or one not cancelled 24 hours in advance if the patient is fully advised that the physician will make such a charge." Please consider this notice your notification of our policy.
2. If you would like our nurse present in the examination room during your physical exam, you must notify either the doctor or the nurse prior to the exam. We will be happy to accommodate your request.
3. I have included my credit-card information above and authorize its billing for unpaid balances.

By signing this below, you accept the policies stated above, which includes credit-card billing, You affirm that you've read and agree to our office policies, including the Financial Statement, which is in our office, on the website or you may request a copy, if needed.

Signed_____ Date_____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Samuel S. Badalian, M.D., P.C., for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Samuel S. Badalian, M.D., P.C. I understand that diagnosis or treatment of me by Samuel S. Badalian, M.D., P.C., may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Samuel S. Badalian, M.D., P.C., is not required to agree to the restrictions that I may request. However, if Samuel S. Badalian, M.D., P.C., agrees to a restriction that I request, the restriction is binding on Samuel S. Badalian, M.D., P.C.

I have the right to revoke this consent, in writing, at any time, except to the extent that Samuel S. Badalian, M.D., P.C., has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Samuel S. Badalian, M.D., P.C., Notice of Privacy Practices prior to signing this document. A copy of the Samuel S. Badalian, M.D., P.C., Notice of Privacy Practices will be provided to me upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the Samuel S. Badalian, M.D., P.C. The Notice of Privacy Practices for Samuel S. Badalian, M.D., P.C., is also provided in the office. This Notice of Privacy Practices also describes my rights and the Samuel S. Badalian, M.D., P.C., duties with respect to my protected health information.

Samuel S. Badalian, M.D., P.C., reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Date

Financial/Credit Policy

To Our Patients:

In order to ensure a positive patient-physician relationship, we want to be sure you understand and agree to our Financial/Credit Policy. **Please be aware that you are ultimately responsible for the balance of your account for any professional services rendered, regardless of insurance.**

Insured patients: We will bill your insurance company for our services on your behalf. However, you ensure that your insurer pays its share of these services. If your insurer fails to pay, you will be responsible for full payment of all charges, unless limited by law (Medicare, Medicaid). Unpaid balances may be sent to an outside collection agency.

Patient balances: We will bill you for balances after insurance payment. If the balance is more than you can pay within 30 days, you must contact the office manager to make payment arrangements, which may include a **1.25% per month interest on unpaid balances due after 45 days (annual rate of 15%).**

Once unpaid balances reach 90 days, the account may be turned over to an outside collection agency. **If that occurs, you will be responsible for all costs related to collection, including but not limited to court costs and attorney fees that may ensue**. This also may include collection fees not in excess of 50% of the unpaid balance.

Insurance deductibles and co-pays: You are responsible for paying deductible amounts and co-pays on the day of service. For surgical services, payment is due at your pre-operative visit.

Non-covered services: Payment is due at the time of service. We will give you a 10% discount (discount only applies to services that are excluded from insurance coverage). If you fail to pay for these services, the discount is void and the account may be sent to an outside collection agency, which may include additional fees.

Uninsured established patients: If you are an uninsured, established patient, you must pay in full at the time of your visit. We will give you a 10% discount for payment at time of service. If you fail to pay for these services, the discount is void and the account may be sent to an outside collection agency, which may include additional fees.

Uninsured new patients: We request that you bring a minimum of $200 to your first appointment. If the treatment costs less than $200, we will refund the difference. However, if the service amounts to more than $200, you must pay a minimum of $25 or 25% of the balance due (whichever is greater) each time we send you a bill. Failure to do so may result in the account being turned over to a collection agency, which will cause you additional charges.

Missed appointments*:* Patients may be charged $25 for appointments that are missed and/or not cancelled 24 hours before the time of the appointment, per individual insurance regulations.

Payment may be made by cash, check, money order, VISA, Mastercard or Discover. Returned checks are subject to a $20 processing fee, plus the amount of the balance due.

Failure to abide by these guidelines may cause us to be unable to provide medical services to you. However, you will remain financially responsible for all balances due.

Samuel S. Badalian, M.D., P.C.

Policy effective June 1, 2014

Patient's Name _____ Birth Date _____

Today's Date _____ Revised Dates _____

A. Please list all medications you are ALLERGIC to:

B. Please list all medications and vitamins you are CURRENTLY TAKING:

C. Additional information and comments:

Today's date:_____

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

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

What is your occupation:_____

Reason for visit: Annual exam and pap smear? ☐ Yes ☐ No Other reason, please explain _____

_____

What other physicians do you see? Please list below:

Name:_____Phone:_____

Name:_____Phone:_____

Menstrual History:

Date of last menstrual period_____Age when period first began_____Number of days between 1st day or each period_____Number of days of flow_____If applicable, age at menopause _____

Are you bothered by: ☐ Cramps ☐ Clots ☐ Mood changes

Do you take: ☐ Birth control pills ☐ Hormones ☐ Estrogen Date of last pap smear_____

Have you ever had an abnormal pap smear ☐ Yes ☐ No If yes, when _____

Sexual History and Contraception

Are you sexually active? ☐ Yes ☐ No What method of birth control do you use? _____

What other methods have you tried? _____

At what age did you first have intercourse?_____How many partners have you had?_____

Any problems or pain with intercourse? ☐ Yes ☐ No Is your current partner ☐ Male ☐ Female

Please check if you have had any of the following:

☐ Yeast ☐ Bacterial Vaginosis ☐ Herpes ☐ Gonorrhea ☐ Chlamydia ☐ Trichamoniasis

Have you ever suffered from sexual abuse? ☐ Yes ☐ No If yes, by whom?_____

Obstetrical History

How many times have you been pregnant?_____

How many were: Full Term_____Premature Delivery_____Miscarriage_____Ectopic Pregnancy_____Abortion_____

How many children to you have?_____Were there any complications with pregnancy/delivery? ☐ Yes ☐ No

If yes, please explain_____

Are there any future pregnancy plans? ☐ Yes ☐ No

General Health History

When was your last mammogram?_____Have you ever had a breast sonogram or biopsy? ☐ Yes ☐ No

Have you ever had a DEXA (bone density) scan? ☐ Yes ☐ No

Do you have the following checked regularly? Teeth_____Eyes_____Cholesterol_____

Are you up-to-date with immunizations? Last tetanus_____Last flu_____Last pneumonia _____

Do you smoke? ☐ Yes ☐ No

If yes, how many packs a day?_____How long have you smoked?_____When did you start? _____

If you quit, when did you quit?_____If you're still smoking, do you want to quit? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No If so, what kind?_____

How much coffee/tea/soda (with caffeine), chocolate do you consumer per day?_____

How much alcohol (how many drinks) do you drink in an average week?_____

Do you exercise? ☐ Yes ☐ No If yes, what do you do, and how often?_____

Do you always wear seat belts ☐ Yes ☐ No

Do you have any unusual stress? ☐ Yes ☐ No Explain:_____

Surgical History:

Have you ever had surgery? ☐ Yes ☐ No If yes, please explain:_____

_____

Health History:

Please list illnesses that your immediate family has/may have:

Mother:_____ Father:_____ Siblings:_____

Medical:

Please check Yes/No if you have had any of the following:

Head injury	☐Y ☐N	Blood in urine	☐Y ☐N
Headache	☐Y ☐N	Burning with urination	☐Y ☐N
Seizures/other neurological problems	☐Y ☐N	Hepatitis or other liver problems	☐Y ☐N
Sinus infections	☐Y ☐N	Pelvic/abdominal pain	☐Y ☐N
Thyroid disease	☐Y ☐N	Urine leakage	☐Y ☐N
Heart attack	☐Y ☐N	Irregular periods	☐Y ☐N
Stroke	☐Y ☐N	Bleeding between periods	☐Y ☐N
High cholesterol	☐Y ☐N	Heavy periods	☐Y ☐N
Heart murmur	☐Y ☐N	Painful intercourse	☐Y ☐N
Other heart disease	☐Y ☐N	Infection of tubes/ovaries	☐Y ☐N
Blood clots in arms/legs	☐Y ☐N	Infertility	☐Y ☐N
Varicose veins	☐Y ☐N	Abnormal vaginal discharge	☐Y ☐N
Swelling of legs	☐Y ☐N	Endometriosis	☐Y ☐N
Chest pain	☐Y ☐N	Hot flashes	☐Y ☐N
Chronic cough	☐Y ☐N	Night sweats	☐Y ☐N
Asthma	☐Y ☐N	Breast problems	☐Y ☐N
Tuberculosis	☐Y ☐N	Cancer (any type)	☐Y ☐N
Lung disease	☐Y ☐N	Diabetes (sugar)	☐Y ☐N
Shortness of breath	☐Y ☐N	Breast problems	☐Y ☐N
Weight loss of gain	☐Y ☐N	Depression/anxiety	☐Y ☐N
Poor appetite	☐Y ☐N	Trauma	☐Y ☐N
Nausea/vomiting	☐Y ☐N	Broken bones	☐Y ☐N
Diarrhea	☐Y ☐N	Osteoporosis	☐Y ☐N
Stomach problems	☐Y ☐N	Arthritis	☐Y ☐N
Blood in stool	☐Y ☐N	Anemia	☐Y ☐N
Colonoscopy	☐Y ☐N	Bleeding disorders	☐Y ☐N
Gallbladder disease	☐Y ☐N	Chicken pox	☐Y ☐N
Kidney stones or disease	☐Y ☐N	Drug or alcohol abuse	☐Y ☐N
Bladder infections	☐Y ☐N		