



Group #: _____ Name: _____ MR#: _____ Date: _____

University Associates in Obstetrics & Gynecology
P.O. Box 417978
Boston, MA 02241-7978

GUARANTEE OF PAYMENT

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, co-payments, any service that is not covered by your insurance plan, and any service that your insurance company has determined not to be "medically necessary".



I have read and understand this information. I understand that my insurance company may deny coverage and request that University Associates in Obstetrics & Gynecology perform this medical service anyway. I agree to be personally and fully responsible for all charges. I understand that the provider named above is relying on this promise and is rendering services without requiring payment at the time of service based on such reliance.

Signature of Patient or Legally Authorized Representative Print Name Date

Witness Print Name Date



New Patient Medical History

Name: _____ Date of Birth: ___/___/___ Age: ____ Sex: ____

How did you hear about our practice? _____

Pharmacy Name: _____ Pharmacy Address: _____

Please briefly state in the box below the reason for your visit

Past Medical History			
<i>Condition / Disease</i>	<i>Year Began</i>	<i>Condition / Disease</i>	<i>Year Began</i>
<input type="checkbox"/> Breast Cancer		Other(s):	
<input type="checkbox"/> Ovarian Cancer			
<input type="checkbox"/> Heart Attack			
<input type="checkbox"/> COPD, Emphysema or Asthma			
<input type="checkbox"/> Thyroid Disease			
<input type="checkbox"/> Hypertension			
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> Depression			

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures			
<i>Operation / Hospitalization / Injury</i>	<i>Month / Yr</i>	<i>Operation / Hospitalization / Injury</i>	<i>Month / Yr</i>

Family Medical History				
<i>Condition / Disease</i>	<i>Mother</i>	<i>Father</i>	<i>Sister</i>	<i>Brother</i>
<input type="checkbox"/> Breast Cancer				
<input type="checkbox"/> Ovarian Cancer				
<input type="checkbox"/> Congestive Heart Failure (CHF)				
<input type="checkbox"/> Hypertension				
<input type="checkbox"/> Heart Attack				
<input type="checkbox"/> Stroke				
<input type="checkbox"/> Heart Disease				
<input type="checkbox"/> Thyroid Disease				
<input type="checkbox"/> Asthma				
<input type="checkbox"/> Depression				

Other Physicians and Specialists

Medication/Food Allergies or Intolerances*List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)*

Medication / Food	Reaction	Medication / Food	Reaction

Current Medications

Medication	Dosage	Medication	Dosage

Social History

Marital Status: Single Married Divorced Widowed			
Work Status: Employed Unemployed Retired Disabled Hours worked per week:			
Do you drink alcohol? Yes No		Number of drinks per week?	
Are you a smoker? Yes No		If yes, how many packs per day?	
Are you a former smoker/former? Yes No		If yes, what year did you quit?	
Do you exercise? Yes No		If yes duration/frequency?	

GYN OB History

First day/month of last menstrual period:	Is your period painful? Yes No
Age of first menstrual period:	# of days period lasts: Cycle length:
Date of last Pap/Results:	Date of last Mammo/Results:
Age you first had intercourse:	Number of sexual partners:
Have you ever been pregnant: Yes No	# of pregnancies:
Type of delivery:	Complications:
Have you ever had a STD: Yes No	If you have had a STD explain:
Method of Birth Control:	Hormone Therapy: Yes No
Are you in an abusive relationship?	Do you feel threatened?

Additional Notes

Providers Signature: _____

Date: _____



STONY BROOK
Community Medical, PC

PATIENT REGISTRATION

PATIENT INFORMATION

Name: (Last, First, MI)			
Address:			
City:	State/Province:	Zip:	Country:
Mailing Address (if different from above):			
Home Phone:	Work:	Mobile:	
Email:	SSN:	Birth Date:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Marital Status:	Single <input type="checkbox"/>	Married <input type="checkbox"/>	Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown <input type="checkbox"/>
Race:	White <input type="checkbox"/>	Hispanic <input type="checkbox"/>	Black/African American <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/>
	Other <input type="checkbox"/>	Asian <input type="checkbox"/>	Native Hawaiian <input type="checkbox"/> American Indian <input type="checkbox"/>
Ethnicity:	Hispanic/Latino <input type="checkbox"/>	Not Hispanic/Latino <input type="checkbox"/>	Other <input type="checkbox"/> Language:
Contact Preferred:	Home <input type="checkbox"/>	Work <input type="checkbox"/>	Mobile <input type="checkbox"/>
Allow Call for Appointment Reminder:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Leave Message: Yes <input type="checkbox"/> No <input type="checkbox"/>
Primary Care Physician:	Referring Physician:		

EMPLOYER INFORMATION

Employer Name:	Phone Number:		
Address:			
City:	State/Province:	Zip:	Country:

EMERGENCY CONTACT INFORMATION

Name:	Relationship to Patient:
Phone:	Email:



STONY BROOK
Community Medical, PC

POLICY INFORMATION

Patient is Guarantor(Insurer):	Yes <input type="checkbox"/>	No <input type="checkbox"/>	(if patient is guarantor information is the same as page 1)
Guarantor Name:		Relationship to Patient:	
Guarantor Address:			
City:	State:	Zip:	Country:
Guarantor Home Phone:		Work:	Mobile:
Guarantor Birth Date:	Guarantor Sex: M <input type="checkbox"/> F <input type="checkbox"/>		Guarantor SSN:
Guarantor Employer Name:			Phone Number:
Guarantor Address:			
City:	State:	Zip:	Country:
Primary Insurance			
Policy Number:	Insurance Company Group Name:		
Effective Date:	Expiration Date:	Policy Copay:	
Secondary Insurance			
Policy Number:	Insurance Company Group Name:		
Effective Date:	Expiration Date:	Policy Copay:	
Tertiary Insurance			
Policy Number:	Insurance Company Group Name:		
Effective Date:	Expiration Date:	Policy Copay:	



NOTICE OF PRIVACY PRACTICES

Purpose of this notice: To describe how your medical information is used, whom it is disclosed to and how you gain access to it.

Stony Brook Community Medical as a healthcare provider is permitted by law to collect, use and disclose your “protected health information” or medical record for the purpose of treatment, payment, internal business operations or as required by law for reporting purposes.

You have certain rights including access to your information and some control over who has access to your information.

Stony Brook Community Medical, PC agrees to abide by the terms of this notice but reserves the right to change the terms at any time. Should we do so, we will notify you in writing.

Use and Disclosure of Protected Health Information (PHI): When you sign a consent form to be treated, your protected health information is used to treat you, to bill you or your insurance company for your care and to make decisions on how to provide healthcare services for you, your family and the community we take care of. Your physician, office staff and others outside of Stony Brook Community Medical i.e. your insurer are allowed access to this information.

Some examples of uses and disclosures of your protected health information are for:

- Treatment by your doctor
- Law enforcement
- Workers compensation
- Appointment reminders
- Payment for your treatment by you or your insurance
- Reporting adverse events of medication or medical devices to the FDA
- Reporting health risks
- Response to legal proceedings
- Organ or tissue donation
- Coroners, funeral directors
- Stony Brook Community Medical to determine if we meet the needs of our patients

Any other uses and disclosures not specified require an authorization, including for marketing purposes and disclosures that constitutes the sale of PHI.

Patient Rights:

- A. You have the right to inspect and to obtain a copy of your protected health information for as long as the group maintains your record.
*We are permitted by NYS law to charge you a fee of 75 cents per page
- B. You have the right to restrict or to limit the use of your protected health information that we use for treatment, payment or operations.
*Stony Brook Community Medical reserves the right to deny you treatment should you restrict the use of your protected health information for treatment, payment or operations, unless the requested restriction relates to disclosures to a health plan and the Protected Health Information relates to a health care service or item which you have paid for in full and out of pocket.
- C. You can restrict the release of your health information to family or friends unless they have your written or verbal permission.
- D. You have the right to request an accounting of disclosures made of your health information.
*Your request must be submitted in writing, specifying dates and time periods as far back as six years from today, as long as the events in question happened after April 12, 2003.
- E. You have the right to amend your protected health information.
*To amend your health information, your request must be given in writing along with a reason for doing so. Your request can be denied if the information originated outside Stony Brook Community Medical, PC.
- F. You have the right to request confidential communications as long as it is done in writing
*For example, you can specify that we only contact you at work, at home or by mail, etc.
- G. You have the right to receive notifications whenever a breach of your unsecured PHI occurs.

If you feel your privacy rights have been violated, you may file a complaint, which will be forwarded to our Compliance Officer.



**Acknowledgement of Receipt of
Stony Brook Community Medical's Privacy Practices**

I, the undersigned, acknowledge that I have received a copy of Stony Brook Community Medical's Notice of Privacy Practices. Should I have any questions about the policy, I will discuss them with my Physician or the group's *Compliance Officer*.

Print Name: _____

Date of Birth: _____

Signature: _____

Date: _____

Authorization for the Release of Patient Health Information to a Second Party

I authorize the release of my Patient Health Information to my
(Fill in name(s) of all that apply.)

Spouse, _____

Family Member, _____

Friend, _____

School/College Health Services, _____

Other, _____

By signing below, I acknowledge that this authorization is valid until it is revoked by me.

Patient Signature: _____

Date: _____

Parent/Guardian Signature (if patient a minor): _____

Print name of Parent/Guardian: _____



Group # _____ : Patient Name: _____ MR#: _____ Date: _____

CLINICAL PRACTICE MANAGEMENT PLAN

Patient's Name: _____
Last First Middle

RELEASE OF INFORMATION

I hereby authorize and direct University Associates in Obstetrics & Gynecology, University Faculty Practice Corporations having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

X _____
Signature of Patient or Authorized Representative Date

UNIFORM ASSIGNMENT

I hereby assign, transfer and set over to University Associates in Obstetrics & Gynecology, University Faculty Practice Corporations sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care, to cover the cost of care and treatment rendered to myself or my dependent.

In addition, I also assign, transfer and set over to all of the other University Faculty Practice Corporations from which I may require medical care, sufficient monies and/or benefits to which I may be entitled. These other University Faculty Practice Corporations are as follows: Stony Brook Anaesthesiology, Stony Brook Dermatology, Stony Brook Family Medical Group, Stony Brook Internists, New York Spine and Brain Surgery, Neurology Associates of Stony Brook, University Associates of Obstetrics and Gynecology, Stony Brook Preventative Medicine Services, Stony Brook Ophthalmology, Stony Brook Orthopaedic Associates., Stony Brook Children's Services, Stony Brook Psychiatric Associates., Stony Brook Radiation Oncology, Stony Brook Radiology, Stony Brook Surgical Associates, and Stony Brook Urology.

X _____
Signature of Patient or Authorized Representative Date

Account Representative: _____