NAMASTE
OB/GYN, PLLC

NAMASTE OB/GYN REGISTRATION FORM

Patient's Last Name:	Maiden:	First:	MI:
Address:			Zip:
Home phone:	Cell phone:	Work phone:	
Birth date:	Age:	Gender:	Marital status:
Social Security #:	Employer:	Occupation:	Spouse name & DOB:
Email:	Race:	Ethnicity: ○ Not Hispanic	○Hispanic ○ Latin

ADDITIONAL INFORMATION

Primary Care Physician: Phone: Referred by:

Pharmacy Name: Phone: Address:

To enhance your care, we access your prescription history and pharmacy benefit files that are available electronically based on pharmacy, state, and insurance data. Please indicate here if you wish to deny this access. ○I elect to OPT-OUT

MEDICAL INFORMATION DISCLOSURE

May we disclose your appointment information or medical information to members of your family? ***circle one:***

Name:_____ Relationship:_____Phone#_____; Medical *info only Appointment info only*

Name:_____ Relationship:_____Phone#_____; Medical *info only Appointment info only*

INSURANCE INFORMATION *(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)*

Please indicate **primary insurance** name:

Subscriber's name:	Subscriber's S.S. #:	Employer:	Birth date:	Relationship to patient:

Name of **secondary insurance** name (if applicable):

Subscriber's name:	Subscriber's S.S. #:	Employer:	Birth date:	Relationship to patient:

AUTHORIZATION OF TREATMENT, ASSIGNMENT OF BENEFIT, & FINANCIAL POLICY

I authorize Namaste OB/GYN to provide medical treatment. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Namaste OB/GYN for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. I understand that payment for today's visit and future visits are due at the time of treatment. I understand that Namaste OB/GYN is part of a single multi-specialty physician group Advanced Health and that any physicians I see in this network may have access to some of my medical history. We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing. If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we must refer your account to a collection agency, you agree to pay all the collection costs which are incurred. If we must refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ **Patient/Guardian signature**	**Date**

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Name_____DOB_____

Medical Information

SURGICAL HISTORY

Tubal Surgery [ ]	Hysterectomy [ ]	C-Section [ ]	Heart/Bypass [ ]
Appendectomy [ ]	Gallbladder [ ]		
Other:			

OBSTETRICAL HISTORY

YEAR	DELIVERY TYPE	WEIGHT	WEEKS	MALE OR FEMALE	NAME	COMPLICATIONS

DRUG ALLERGIES

CURRENT MEDICATION

MEDICATIONS	STRENGTH	DOSAGE SCHEDULE

Review of Systems (check all that apply)

Gynecologic
- ☐ Abnormal Vaginal Discharge
- ☐ Itching/irritation
- ☐Irregular Bleeding
- ☐Unexplained vaginal bleeding
- ☐ Heavy Menstrual periods
- ☐ Painful Menstrual Cramps
- ☐ Pelvic pain
- ☐ Pelvic pain with intercourse
- ☐ Post-menopausal bleeding
- ☐ Vaginal Dryness
- ☐ Mood swings
- ☐ Decreased Libido
- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Memory Loss
- ☐ Trouble Sleeping

Breast
- ☐ Lumps
- ☐Pain
- ☐ Discharge
- ☐ Self-Exams
- ☐ Breast-feeding

Urinary
- ☐ Pain with urination
- ☐ Increased frequency of urination
- ☐ Blood in urine
- ☐ Leaking urine

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐Heartburn
- ☐Decreased appetite

Hematologic/Endocrine
- ☐ Easy Bruising
- ☐ Excessive sweating
- ☐ Night sweats
- ☐ Excessive thirst
- ☐ Temperature intolerance

Neurologic
- ☐ Headache
- ☐ Migraines
- ☐ Ringing in ears
- ☐ Sleep disturbances
- ☐ Depression
- ☐ Anxiety

Skin/musculoskeletal
- ☐ Rash
- ☐ Joint pain
- ☐ Back pain

General
- ☐ Weight loss/gain
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Trouble Sleeping

Chest
- ☐ Chest pain or discomfort
- ☐ Shortness of Breath
- ☐Palpitations
- ☐ Cough
- ☐ Difficulty breathing

Ears, Nose, Throat
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Difficulty swallowing
- ☐ Sore throat
- ☐ Hoarseness

Patient Financial Policy

This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.

In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.

HEALTH INSURANCE - It is YOUR responsibility to:

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

It is OUR responsibility to:

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.
- Provide MVA patients a courtesy health insurance claim form for their records upon request.

PAYMENT OPTIONS: Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you.

We accept the following: Cash Check Credit Card *(Visa, MasterCard, Discover, American Express)*

A twenty-five dollar ($25.00) returned check fee will be assessed to the patient account per incident.

For convenience, payments may be made online at **www.ePayItOnline.com.** To utilize this service you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance. ***Patients who no-show may be subject to a no-show fee.***

PENDING APPROVALS FOR SERVICES: In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

_____ Initials

Patient and/or Debtor Signature: _____ Date _____/_____/_____

Additional financial explanations are continued on the back side of this page

AdvancedHEALTH

General Consent For Treatment

As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ **(initial)**

I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.

Name of Patient: _____

Signature of Patient: _____ Date: _____

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____

AdvancedHEALTH

Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials:_____

Reason: _____

_____

AdvancedHEALTH