RWJ OB/GYN associates

Patient Questionnaire

Please, check all that are applicable (within the last 6-12 months)

Constitution

❑ Fever	❑ Fatigue	❑ Chills
❑ Unexplained weight gain	❑ Unexplained weight loss	

Cardiovascular

❑ Chest Pain	❑ Palpitations	❑ Leg Swelling

Respiratory

❑ Shortness of Breath	❑ Chronic cough	❑ Wheezing
❑ Difficult to breath	❑ Coughing blood	

Gastrointestinal

❑ Abdominal pain	❑ Nausea/Vomiting	❑ Heartburn
❑ Diarrhea	❑ Constipation	❑ Bloody stool

GYN/Genitourinary

❑ Blood in urine	❑ Painful urination	❑ Frequent urination
❑ Loss of urine	❑ Abnormal bleeding	❑ Irregular menses
❑ Pain with menses	❑ Pain with intercourse	❑ Pelvic pain
❑ Vaginal discharge	❑ Vaginal itching	❑ Vaginal dryness

Musculoskeletal

❑ Joint pain	❑ Joint swelling	❑ Muscular weakness

Integumentary (Skin)

❑ Breast pain	❑ Breast discharge	❑ Breast lump/mass
❑ Rash	❑ Acne	❑ Change in a mole

Psychiatric

❑ Depression	❑ Anxiety	❑ Suicidal

Endocrine

❑ Heat/cold intolerance	❑ Hot flashes	❑ Dry skin

Hematology/Immunology

❑ Easy bleeding	❑ Easy bruising	❑ Non-healing wounds

- **What would you like to discuss at today's visit?**

_____

- **Please, list all medications you are currently taking.**

_____

- **Please, list all allergies to any medications**

_____

Name (Print):_____ **Signature:**_____

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

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Policy for Payment of Services

Payment is due at the time of service. However, if we participate with your insurance plan, we will file a claim for assignment of medical benefits. Co-payments are due at the time of service. It is your responsibility to know and understand your insurance policy and the coverage of benefits it provides.

I clearly understand that I am responsible for any amount not covered by my insurance for any reason. I will also be responsible for any co-pays, co-insurance, and deductible amounts. Any payments made directly to the patient and owing to the physicians will be remitted immediately to RWJ OBGYN Associates. It is your responsibility to obtain referrals, if necessary, prior to treatment. If incorrect information is given to the office, and benefits are denied, then we cannot change or correct the billing after the fact. It is your responsibility to contact your insurance company.

Financial Responsibility Agreement

I, the undersigned, hereby authorize assignment of medical benefits to RWJ OBGYN Associates, including Drs. Bochner, Lundberg, Segal, Ham, Kim, Colonna, and Caban. This is irrevocable transfer of benefits allowing the right to appeal and litigate. This allows RWJ OBGYN Associates to exercise the right to accept or deny an appeal. I hereby authorize release of all medical and any other information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand if my account becomes delinquent, and is sent to a collection attorney or collection agency, I will be responsible for an additional collection fee of $50 or 20% of the balance owed, whichever is greater.

First Name (PRINT): _____ **Last Name (PRINT):**_____

Patient Signature:_____ **Date:**_____

Revised 10/19/16 EK

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Permission of Patient Contact

- Contact information listed on this form will allow us to contact you with laboratory results and other medically related questions. Please fill out completely for our records.

  Phone Number (**Home**): _____

  Phone Number (**Cell**): _____

  Phone Number (**Work**): _____

  Where should we contact you first? **Home** **Cell** **Work**

- In the event that our staff and/or physicians are unable to reach you concerning your medical status with our office (i.e. lab results, billing statements, etc.), may we leave a message on/with:

  Home Answering Machine? ..... ☐ Yes ☐ No

  Cellular Voicemail? ..... ☐ Yes ☐ No

  Work Voicemail? ..... ☐ Yes ☐ No

- **PLEASE NOTE**: If a person is not listed here, by law we are required to protect your information. We will not discuss any information pertaining to your healthcare to any person not listed here. Please, list the names of any person(s) that may be involved in your healthcare that we may be permitted to discuss your medical status with.

  Name: _____ Relationship to Patient: _____

  Name: _____ Relationship to Patient: _____

- **Pharmacy Information**

  Name: _____

  Address: _____

  Phone Number: _____

I hereby acknowledge that I have been presented with a copy of RWJ OBGYN Associates Notice of Privacy Practices

Patient Name (PRINT): _____ **Date:** _____

Signature: _____ **Relationship:** _____

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Medicaid Policies

I, (Print Name) _____ do hereby affirm and acknowledge that I have been fully informed the RWJ OB/GYN Associates, P.A. does **NOT** participate with any and all Medicaid policies in the United States.

I understand that after my commercial insurance plan has processed claims, I will be responsible for any and all balances resulting from co-insurance, co-pays, and deductibles for services provided by RWJ OB/GYN Associates, P.A., as per my insurance plan's contract with me.

I also acknowledge that nothing can be submitted to Medicaid either by the provider or me.

Patient Signature:_____ **Date**:_____

Revised 10/19/16 EK