Central Virginia OB/GYN Group, Inc.
1011 Care Way, Suite 200
Fredericksburg, Virginia 22401
540-373-4900

A MEMO TO OUR PATIENTS

We are honored that you have chosen Central Virginia OB/GYN Group, Inc. to provide for your women's healthcare needs. We view this as a great responsibility and privilege. Our goal is to provide you with exceptional healthcare.

In order to provide you with the best possible care, we need your cooperation in maintaining your standard of care. For the health and well-being of our patients, we ask that patients be compliant in recommended treatment, tests and follow up such as:

- Keeping scheduled appointments
- Having recommended lab work performed in a timely manner
- Having recommended radiology tests performed in a timely manner
- Returning for recommended follow up appointments

Your provider is always willing to discuss any options available to provide you with the best medical care possible and will make recommendations based on what is considered the best plan of action for your healthcare needs. Without your cooperation, any of these things could greatly affect our ability to treat you and prevent you from receiving the best care possible.

Patient Printed Name: ____ Date of Birth: ______________

Patient Signature: ____ Date: ____________________

TO CHILD-BEARING AGED PATIENTS

For those patients who are pregnant, or who may become pregnant, our providers do provide patient care for high-risk patients. However, with the varying classifications of "high risk", there may be situations that merit you being referred to other physicians or practices for additional or more intensive prenatal care. These situations are determined on a "case by case" basis and any referrals made are made with the best interest of the mother and baby in mind.

Since we cannot medically assess patients over the phone, once the nurse has taken your medical history, and the provider has reviewed your case, it could be possible you may need to be referred outside of our practice. Should our provider determine that your particular medical situation merits you being referred outside of our practice, we will do our best to facilitate you receiving the care you need.

Thank you, again, for choosing Central Virginia OB/GYN Group. We look forward to a long, healthy relationship serving your healthcare needs.

Patient Printed Name: ____ Date of Birth: ______________

Patient Signature: ____ Date: ____________________

Financial Policies

This is an agreement between Central Virginia OB/GYN and the responsible party:

Missed/Cancelled Appointments, procedures or surgeries: All efforts are made to accommodate our patients request for appointments, procedures or surgery dates/times; therefore, it is important that you make every effort to keep your scheduled appointments. Cancellations of less than 24 hours or missed appointments will be subject to a fee up to $25.00.

Fee for completion of forms, reports, and letters: This is a non-insurance covered service; therefore, a fee of $25.00 is charged for the completion of forms or the writing of letters. All fees are due at the time the form is delivered.

Transferring of Records: All adult patients must sign a record release form if copies of your records are to be sent to another doctor or organization. A medical records copy fee may be assessed for all non-physician requests and is due at the time the records are delivered.

Payment options if you do not have proof of insurance: You are responsible for payment by cash, check or credit card on the day of service.

Monthly Statement: If you have a balance on your account exceeding $2.00, we will send you a monthly statement showing charges to the account: Unless other arrangements are approved in advance, the balance, late fee if any, are due upon receipt. If your account becomes past due, Central Virginia OB/GYN will take all necessary steps to collect this debt. If we have to refer your account to a collection agency or lawyer, you agree to pay all collection, lawyer and court fees that are incurred.

Returned Checks: There is a $25.00 fee for any checks returned by the bank.

Central Virginia OB/GYN files your insurance as a courtesy. We ask that if the account remains unpaid after 45 days that you contact your insurance company for payment.

In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 18% interest annum on all balances which are unpaid sixty (60) days after the services are rendered: plus attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not: plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information of the undersigned and further agrees to pay all costs of obtaining such credit information and/or locating the undersigned, as may be necessary.

The undersigned understands that medical insurance claims may be billed by the provider, as a courtesy, if the provider participates in the patient's insurance plan; and if the patient promptly furnishes the provider with all the correct insurance information. The undersigned is fully responsible for all sums due whether or not insurance coverage is available.

In the absence of prompt payment: the undersign understands that medical, personal and financial records concerning the professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with the federal "health Insurance Portability and Accountability Act:"

I, the undersigned, certify that I ( ) am an active duty member of the US Armed Forces

( ) am not an active duty member of the US Armed Forces

____________________ ____________________________________

Date Responsible Party

CENTRAL VA/OB GYN GROUP

WELCOME TO OUR PRACTICE. AS A NEW PATIENT, PLEASE FILL OUT THE INFORMATION FOUND BELOW TO THE BEST OF YOUR ABILITY.

PATIENT NAME______________________________________DATE OF BIRTH______________SOCIAL SECURITY#________________
EMAIL ADDRESS#___________________________________

GYNECOLOGIC HISTORY

DATE OF LAST PAP SMEAR_________EVER HAD AN ABNORMAL PAP?______EXPLAIN________________
DATE OF LAST MAMMOGRAM______EVER HAD AN BNORMAL MAMMOGRAM?_____EMPLAIN_______
EXPOSURE TO DES________

SEXUAL HISTORY

SEXUAL PREFERENCE-MALE/FEMALE , AGE AT FIRST INTERCOURSE________
FIVE OR MORE SEXUAL PARTNERS IN LIFETIME_________________
EVER HAD A SEXUALLY TRANSMITTED DISEASE (STD)?_____HERPES,GONORRHEA,CHLAMYDIA,GENITAL WARTS OR CONDYLOMA(HPV)
ARE YOU HIV POSITIVE?____OR DO YOU WISH TO BE TESTED FOR HIV OR ANY OTHER INFECTION?_____

OBSTETRICAL HISTORY

TOTAL NUMBERS OF PREGNANCIES_____, #FULLTERMDELIVERIES___,#PRETERMDELIVERIES(<8MOS)___,#MISCARRIAGES____, #TUBALPREGNANCIES____, #STILLBORNS____,#VOLUNTARY TERMINATIONS____,
ANY COMPICATIONS OF PREGNANCY OR DELIVERY____

MEDICAL HISTORY:

PATIENT MEDICAL HISTORY:

DIABETES	NO	YES
HYPERTENSION	NO	YES
CANCER	NO	YES
STROKE	NO	YES
HEART TROUBLE	NO	YES
ARTHRITIS	NO	YES
CONVULSIONS	NO	YES
BLEEDING TENDENCY	NO	YES
ACUTE INFECTIONS	NO	YES
VENEREAL DISEASE	NO	YES
HEREDITARY DEFECTS	NO	YES

PREVIOUS HOSPITALIZATIONS/SURGERIES? SERIUOS INJURIES WHEN?
____
____
____

MEDICATIONS:
____
____
____

DRUG ALLERGIES
____

LMP:____
DO YOU HAVE A LIVING WILL? YES___NO___

PATIENT SOCIAL HISTORY:

MARITAL STATUS: SINGLE__MARRIED__SEPARATED__DIVORCED__WIDOWED__
USE OF ALCOHOL: NEVER__RARELY__MODERATE__DAILY__
USE OF TOABACCO: NEVER__PREVIOUSLY,BUT QUIT__ CURRENT-PACKS/___DAY
EXCESSIVE EXPOSURE AT HOME OR WORK TO:FUMES___DUST___SOLVENTS___AIR BORNE PARTICLES___NOISE___

FAMILY MEDICAL HISTORY:

	AGE	DISEASES	IF DECEASED,CAUSE OF DEATH
FATHER	___	_____________	__________________________
MOTHER	___	_____________	__________________________
SIBLINGS	___	_____________	__________________________
	___	_____________	__________________________
SPOUSE	___	_____________	__________________________
CHILDREN	___	_____________	__________________________

REASON FOR VISIT:
____
____
____

HOW DID YOU HEAR ABOUT THE OFFICE (IE……….NEWSPAPER AD)____

Central Virginia OB/GYN Group, Inc.

Preferred Methods of Communication

Patient Name: ______________________ Date of Birth: _____________________

In an effort to reach you more efficiently to confirm appointments, leave messages regarding your healthcare, and to discuss insurance billing issues, we are asking you to complete the following telephone contact information.

While we prefer NOT to leave messages, we would like to ensure that your medical information is properly handled as required by HIPPA guidelines. By completing the following telephone information, this will give us your authorization to leave messages with those individuals listed at the numbers given below, if applicable. We will not leave messages containing sensitive health related information.

Please list the telephone numbers that are the best way for us to contact you and circle the phone number we should call first.

Home: ____________________________ Leave message on machine Yes No

Work: ____________________________ Leave message on machine Yes No

Cell: ______________________________ Leave message on machine Yes No

Address: ______________________________ Email: ______________________________

____

Please list the names of family or friends with whom you authorize us to speak with relating to your medical care:

1.________________________ Relationship: ____________________ Phone: ___________________

2.________________________ Relationship: ____________________ Phone: ___________________

<u>Please list next of kin:</u> (Person who makes decisions for you, if you are not able)

Name: __________________________________ Relationship: ______________________________

Address: ____ Phone: ______________________________

<u>Please list a person to notify in case of emergency:</u>

Name: ____ Relationship: _______________________________

Address: ____ Phone: _________________________________

I acknowledge that I have been offered Central Virginia's OB/GYN, Inc. Preferred Methods of Communication. Central Virginia's Preferred Methods of Communication describes how medical information about you may be used and disclosed.

By signing below, I understand that all methods that I have indicated above may be used to contact and communicate with me. I am responsible to notify this office of any changes.

____ ____

Patient Signature Date Staff Reviewer Date

Patient Registration Form

<table>
<tr><td colspan="3">Name (Last, First, Middle)</td><td colspan="2">SSN#</td></tr>
<tr><td>Date of Birth:</td><td>Age</td><td>Marital Status</td><td colspan="2">Maiden Name</td></tr>
<tr><td colspan="2">Address</td><td colspan="2">City, State</td><td>Zip Code</td></tr>
<tr><td>Patient Home Phone</td><td colspan="2">Patient Cell Phone</td><td colspan="2">Patient E-mail</td></tr>
<tr><td colspan="3">Patient Business Phone</td><td colspan="2">Patient Occupation</td></tr>
<tr><td colspan="2">Business Address</td><td colspan="2">City, State</td><td>Zip Code</td></tr>
<tr><td colspan="2">Primary Language</td><td colspan="3">Ethnicity</td></tr>
<tr><td colspan="3">Spouse/Parent/Guardian Name (If under age 18):</td><td colspan="2">Employer</td></tr>
<tr><td colspan="2">Address</td><td colspan="2">City, State</td><td>Zip Code</td></tr>
<tr><td>Business Phone</td><td colspan="2">Alternative Phone</td><td colspan="2">Relationship (Parent, Spouse, Guardian)</td></tr>
<tr><td colspan="3">In case of Emergency:</td><td colspan="2">Phone:</td></tr>
<tr><td>Do you have a living will? Y N</td><td colspan="4">Who referred you to our practice?</td></tr>
</table>

<table>
<tr><td colspan="2">Primary Insurance Company:</td><td colspan="2">Secondary Insurance:</td></tr>
<tr><td colspan="2">Address:</td><td colspan="2">Address:</td></tr>
<tr><td colspan="2">City, State, Zip Code:</td><td colspan="2">City, State, Zip Code:</td></tr>
<tr><td>Phone:</td><td>Co-Pay:</td><td>Phone:</td><td>Co-Pay:</td></tr>
<tr><td colspan="2">Policy/Member ID#</td><td colspan="2">Policy/Member ID#</td></tr>
<tr><td colspan="2">Group ID#</td><td colspan="2">Group ID#</td></tr>
<tr><td colspan="2">Name of Insured:</td><td colspan="2">Name of Insured:</td></tr>
<tr><td>Sex:</td><td>Date of Birth:</td><td>Sex:</td><td>Date of Birth:</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="2">Relationship to Patient:</td><td colspan="2">Relationship to Patient:</td></tr>
</table>

*** Payment is due at time of service. *** **Assignment and Release; I, the undersigned certify that I (or my dependent) have insurance coverage as stated above and assign to Central Virginia OB/GYN Group, Inc., all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am fully responsible for all charges not paid by my insurance company. I hereby authorize this practice to release all information necessary to secure the payment of benefits; I authorize the use of this signature on all submissions. I fully understand that any outside lab work performed will be billed by that lab, independently.**

Patient's Signature:	Date:

PATIENT CONSENT FOR USE / DISCLOSURE OF HEALTHCARE INFORMATION

Patient Name: ____

Date of Birth: ____

SSN: ____

Previous / Other Name(s): ____

I understand that the patient's health information is private and confidential. I understand that **Central Virginia OB/GYN Group, Inc.** works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that **Central Virginia OB/GYN Group, Inc.** may use and disclose the patient's personal health information to help provide healthcare to the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosure of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission.

Central Virginia OB/GYN Group, Inc. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I will have a right to read the "Notice" before signing this agreement. If I revoke this consent, **Central Virginia OB/GYN Group, Inc.** does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of **Central Virginia OB/GYN Group, Inc.** "Notice of Privacy Practices". My signature means that I agree to allow **Central Virginia OB/GYN Group, Inc.** to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

Patient / Legally-Authorized Signature: ____

Date: ____

Relationship to patient if signed by anyone other than patient: ___________________________