Mid Atlantic
Gynecologic Oncology and Pelvic Surgery Associates

Gynecologic Oncology and Pelvic Surgery Associates
Annette Bicher, MD
John C. Elkas, MD, JD
Ruchi Garg, MD
G. Scott Rose, MD
Stephanie Wethington, MD
Jennifer Squires, NP

PATIENT REGISTRATION

Patient Acct#:_____

Doctor:	**Referring Phy.:**

PATIENT INFORMATION

Name:	**Email:**
Address:	**Date of Birth:**
	Social Security #:
City, State:	**Marital Status:** ☐ **married** ☐ **single** ☐ **divorced**
Home Phone:	**Cell Phone:**

DRUG ALLERGIES

Drug Allergies:	**Emergency Contact**
	Name: **Phone:**
Latex Allergy: ☐ **YES** ☐ **NO**	**Relationship:**

RESPONSIBLE PARTY / EMPLOYMENT

Name:	**Employer:**
D.O.B.:	**Phone:**
Address:	**Phone:**
City, State, Zip:	

PRIMARY INSURANCE

INSURANCE CO:	**POLICY #:**
ADDRESS:	**GROUP #:**
SUBSCRIBER:	**DATE OF BIRTH:**

SECONDARY INSURANCE

INSURANCE CO:	**POLICY #:**
ADDRESS:	**GROUP #:**
SUBSCRIBER:	**DATE OF BIRTH:**

I hereby authorize Mid-Atlantic Pelvic Surgery Associates, PC to release any information acquired in the course of my examination or treatment to the insurance company. I understand will file my insurance as a courtesy. I understand that I will be responsible for any out of pocket cost.

Patient Signature: **DATE:**

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SEPTEMBER 4, 2012

OUR OFFICE IS STARTING PREPARATIONS TO HAVE ELECTRONIC MEDICAL RECORDS IN PLACE. WE WOULD LIKE TO OBTAIN ADDITIONAL PERSONAL INFORMATION THAT IS NOT CURRENTLY ON OUR PATIENT PROFILE FORM TO COMPLY WITH THE MEANINGFUL USE GUIDELINES.

PLEASE PROVIDE US WITH THE ANSWERS TO THE THREE ADDITIONAL QUESTIONS BELOW TO COMPLETE YOUR REGISTRATION PROCESS WITHIN OUR SYSTEM.

PATIENT NAME:

DATE OF BIRTH:

1) PREFERRED LANGUAGE:

2) RACE:

☐American Indian or Alaska Native

☐Asian

☐Black or African American

☐Native Hawaiian or Other Pacific Islander

☐White

3) ETHNICITY:

☐Hispanic

☐Non-Hispanic

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RELEASE OF PATIENT INFORMATION CONSENT FORM

PATIENTS NAME: _____

PATIENTS DOB: _____ SOCIAL SECURITY: _____

RELEASE INFORMATION TO VOICE MAIL

In the event we are unable to speak to you directly may we leave a message on your voice mail regarding test results or prescription information? **If yes** please provide us with the phone number(s). **If no** please do not put in any phone number(s).
1._____2._____3._____

RELEASE INFORMATION TO FAMILY/FRIENDS

You have my permission to contact the following individual(s) listed below for whom I designate to be informed of my medical care.

1. _____ At _____ Relationship: _____
2. _____ At _____ Relationship: _____
3. _____ At _____ Relationship: _____

RELEASE INFORMATION TO OUTSIDE PHYSICIANS

You have my permission to send medical information to the following physicians if requested by their office.
Please provide **both first & last name of each physician, phone number and specialty**.

DOCTOR NAME	PHONE	SPECIALTY
_____	_____	_____
_____	_____	_____
_____	_____	_____

RELEASE INFORMATION TO PHARMACY

You have my permission to send any prescriptions needed to the pharmacy listed below.
Pharmacy Name: _____ Pharmacy Phone: _____
Pharmacy Address: _____

_____ _____
(Patient Signature) (Date)

AUTHORIZATION FOR MAGOPSA TO COLLECT PERSCRIPTION MEDICATION HISTORY THROUGH EMR

I authorize MAGOPSA to access medication recognition history through EMR.

_____ _____
(Patient Signature (Date)

_____ _____
(Witness Signature) (Date)

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Name	Birthdate:
Marital Status	Occupation:
Reason for visit	Employer:
Referred By	Primary Care Physician:
Other Physicians	

List drug allergies: _____

FAMILY HISTORY Specify ANY relative with the following Conditions		
	LIVING	DECEASED
	Relationship	Relationship
Cancer: Breast		
Ovaries		
Uterus		
Colon		
Lung		
Other		
Diabetes:		
Heart Attack:		
High Blood Pressure:		
Stroke:		
Epilepsy:		
Kidney Disease:		
Emotional Problems:		
Asthma:		
Migraine:		

Habits:	
Do You Smoke?	How Much:_____ How many Years:
Do you drink alcohol?	How much:_____ How Often:
Do you take drugs?	How Often:
Do you Drink Coffee?	How Much:

SURGERIES	
Appendix:	Breast:
Gall Bladder:	Tumors:
Tonsils:	Hemorrhoids:
Kidney Stones:	C-Section:
Hernia:	Ovaries:
Spine:	Uterus:
Other:	Other:

Please Check Any of the Following You Have Had:	
Hypertension	Back Problems
Diabetes	Broken Bones
High Cholesterol	Skin Problems
Glaucoma	Breast Disease
Cataract	Stroke
Heart Disease	Head Injury
Murmur	Seizures
Vascular Disorders	Depression
Asthma	Substance Abuse
Lung Disease	Thyroid Disorder
Kidney Disease	Bleeding Disorder
Bladder Problems	Blood Clots
Bowel Problems	Blood Transfusion
Gallbladder Disease	Anemia
Liver Disease	Cancer
Hepatitis, Jaundice	Yeast
Ulcers	Chlamydia
Others	Others

GYNECOLOGIC HISTORY	
Age at Onset of Menstrual Period:	
Date of Last Period:	
Period comes Every _____Days	
Flow: Heavy ____ Medium _____Light____	
Date of Last Pelvic Exam:	
Date of Last Pap Smear:	
Method of Contraception:	
# of Sexual Partners in the last 6 months:	
# of Pregnancies____ # of Miscarriages_____	
# of Live Births____ # of Abortions_____	
# of Live Children_____	
Date of Last Mammogram:_____	
Do you perform monthly Breast exams?	
Yes_____	No_____
Abnormal Pap Smears	
Genital Warts	Vaginitis
Herpes	Trichomonas
Gonorrhea	Syphilis

Reviewed By:_____

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Name: _____ Date: _____ Age: _____

Please List Any Problems You Would Like to Talk About or Be Examined for:

1. _____

2. _____

3. _____

4. _____

Please Check Any of the Following Problems You Have or Recently Had:
(Established Patients Please Check Problem s Since Your Last Visit to this Office)

☐Irregular Periods	☐Dry Mouth	☐Frequent Urination	☐Headaches
☐Change in Menstrual Flow	☐Problem Swallowing	☐Urinary Urge	☐Weakness
☐Bleeding Between Periods	☐Palpitations	☐Painful Urination	☐Numbness
☐Bleeding During/After Sex	☐Chest Pain	☐Nightly Urination	☐Mood Changes
☐Painful Menstruations	☐Swelling of Feet and Arms	☐Involuntary Urine Loss	☐Sleep Problems
☐Pain with Sexual Intercourse	☐Loss of Consciousness	☐Bloody Urine	☐Lack of Energy
☐Vaginal Discharge	☐Shortness of Breath	☐Joint Aches, Pain	☐Depression
☐Vaginal Dryness	☐Chronic Cough	☐Joint Swelling	☐Memory Loss
☐Hot Flashes	☐Bringing Up Mucus	☐Muscle Aches, Pain	☐Feel Hot or Cold
☐Change in Sexual Desire	☐Constipation	☐Rash	☐Usually Thirsty
☐Fever	☐Diarrhea	☐Skin Lesions	☐Easy Bruising
☐Weight Loss	☐Bloating	☐Breast Lumps	☐Easy Bleeding
☐Weight Gain	☐Abdominal Cramps, Pain	☐Breast Tenderness	☐Swollen Lymph Glands
☐Change in Appetite	☐Blood in Stool	☐Nipple Discharge	
☐Blurred Vision	☐Nausea or Vomiting		
☐Double Vision	☐Heartburn		
☐Eye Problems			☐**All blanks are negative**
FOR ESTABLISHED PATIENTS ONLY			
Last Menstrual Period:	Last Pap:	Last Mammogram:	Last Colon Exam:
Last Chest X-ray:			
Referred by:	**Primary Care Physician**		**Other Physicians:**

Please List Illnesses, Surgery, Hospitalization and New Allergies Since Your Last Visit: _____

_____

_____

Please List NEW Medications and Those you Stopped Since Your Last Visit:

New	Stopped

Please List Changes in Marital Status, Employment, Drug Use: _____

_____

Please List Cancer Diagnosed in Your Family since Your Last Visit: _____

_____

Reviewed By: _____

Phone: 571-308-1830 www.magopsa.com **Fax: 571-308-1843**

ANNANDALE OFFICE
3289 Woodburn Rd
Suite 320
Annandale, VA 22003

FREDERICKSBURG OFFICE
4501 Empire Court
Fredericksburg, VA 22408

SHADY GROVE OFFICE
9905 Medical Center Dr
Suite 303
Rockville, MD 20850

RESTON OFFICE
1800 Town Center Dr
Suite 311
Reston, VA 20190

Winchester Office
190 Campus Boulevard,
Suite 410
Winchester, Virginia 22601

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FINANCIAL POLICY

Our practice is doing everything possible to decrease the cost of your medical care. You can help a great deal by reducing the number of invoices sent to you. The following is a summary of our financial and payment policy that will be go into effect as of **June 23, 2015**.

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE – Payment of patient due balance is required at the time services are rendered. This includes applicable deductibles, coinsurance and copayments for participating insurance companies, as required by your insurance plan. We will attempt to verify eligibility and benefits prior to your appointment to provide an estimate of your portion due and require a deposit &/or payment arrangements for
planned surgery or treatment, or if there are specific limitations to your plan, such as pre-existing exclusions &/or high deductibles.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling their next appointment. We accept cash, personal checks, VISA and MasterCard. There is a $25.00 service charge for all returned checks.

We participate with most major insurance plans including: Medicare, CareFirst, Anthem, United Healthcare, Aetna and Cigna. If your insurance plan is not listed, it is your responsibility to contact them to determine if they will cover services provided by our physicians.

We will bill all participating insurance companies for you. If you have obtained your insurance through a Health Insurance Exchange, as a requirement of the Affordable Care Act, there may be limitations to the network of physicians that participate with your specific plan. Please contact your insurance representative to see if they will provide coverage for services with one of our physicians.

If you need assistance, please contact one of our Billing Representatives between 8:00 a.m. and 4:00 p.m., Monday through Friday at 571-308-1830 ext. 407.

MANAGED CARE:

If you are enrolled in a managed care insurance plan (**i.e. HMO, PPO, POS)** that requires a referral for specialty care, you must obtain a referral from your PCP prior to seeing one of our physicians.

CANCELLATION POLICY

We have a 24- hour cancellation policy. It is each patient's responsibility to notify this office at least 24 hours in advance, should you need to cancel or reschedule your appointments. This will ensure that the time can be made

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available to other patients. Any appointments missed or cancelled less than 24 hours in advance will be subject to a $ 50.00 fee for an office visit and $100.00 for a scheduled in-office procedure.

FINANCIAL POLICY continued

A cancellation fee for scheduled surgery of $100.00 will also be charged for cancellations of less than a week prior to the scheduled date unless medically necessary.

FMLA and DISABILITY FORMS

There will be a charge for the completion of FMLA and Disability forms. Disability form fee is $25.00 with a maximum of $50.00 per year. FMLA form fee is $40.00. Forms will not be processed until fees are paid. All forms will be complete within one week.

I have read, and understand the Mid Atlantic Gynecologic Oncology and Pelvic Surgery Associates Financial Policy (MAGOPSA). I agree to assign insurance benefits to MAGOPSA whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for all costs of collections, which can be as high as 35% of the outstanding balance.

Patient Name
(Print)_____

Patient Signature _____

or

Authorized Representative/Guarantor _____

Date: _____

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Privacy Statement and Patient Confidentiality

Mid Atlantic Gynecologic Oncology & Pelvic Surgery Associates (MAGOPSA) is committed to treating and using protected health information (PHI) in a confidential and responsible fashion. In consideration of this, a Notice of Privacy Policies has been developed for our patients. Every MAGOPSA patient is provided with a copy of these policies when arriving for an appointment. The Notice of Privacy Policies describes the personal information collected and how and when this information is used and disclosed. This Notice also describes patient's rights as they relate to their protected health information. This notice applies to all protected health information as defined by federal regulations. Mid Atlantic Gynecologic Oncology & Pelvic Surgery Associates is committed to full compliance with the Health Insurance Portability and Accountability Act of 1996.

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FMLA and Disability Forms

1) All forms must be faxed to 571-308-1239 or emailed to Jessamine.froilan@magopsa.com.
2) If you have an appointment please do not leave your forms with your physician. You may leave them with the receptionist at the time of check-in or check-out.
3) Make sure to put your name and date of birth on all the forms and indicate where the forms are to be sent upon completion. All forms will be completed within 1 week.
4) There is a fee of $25.00 for short term disability and physician certificate forms with a max of $50.00 per year and a fee of $40.00 for the completion of FMLA forms. Please include a signed authorization from your disability company. Forms with no accompanying authorization will not be processed. You will be called to collect the fee and your receipt will be mailed to you. Forms will not be processed until fees are paid.

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Medication List

Patient: _____ **DOB:** _____

Drug	Dose	Prescribing Info	Indication	Start/Stop Date

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