PLEASE PRINT VERY CLEARLY

Line items printed in **bold** on this page are required fields, if they apply. Thank you for your assistance.

■ Patient Information

Name (Last, First, Middle) ______________________ **Today's Date** ____________

Birthdate ____________ **Soc. Sec. #** ____________ **Home Phone** ____________

Email address ______________________ **Cell Phone** ____________

Address ______________________ **Work Phone** ____________

City ____________ **State** ________ **Zip** ________

Employer ____________**Occupation** ____________

☐ **Check if minor** (less than18) **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Referring Physician ______________________ **Phone** ____________

■ Spouse / Legal Guardian

Name (Last, First, Middle) ______________________ **Today's Date** ____________

Birthdate ____________ **Soc. Sec. #** ____________ **Cell Phone** ____________

Address ______________________ **Work Phone** ____________

City ____________ **State** ________ **Zip** ________

Employer ____________**Occupation:**____________**Work Phone**____________

■ Emergency Contact

Name (Last, First) ____________**Relationship**________**Phone** ____________

■ Primary Insurance *(If not applicable, please cross out section. If you have tertiary insurance, please ask the receptionist for another page.)*

Insurance Company ______________________

Insurance ID # ______________________ **Group #** ____________

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) ______________________

Relationship to Patient ________ Soc. Sec. # ____________ **Birthdate** ____________

Address ______________________ **Home Phone** ____________

Employer ______________________ **Work Phone** ____________

■ Secondary Insurance *(If not applicable, please cross out section. If you have tertiary insurance, please ask the receptionist for another page.)*

Insurance Company ______________________

Insurance ID # ______________________ **Group #** ____________

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) ______________________

Relationship to Patient ________ Soc. Sec. # ____________ **Birthdate** ____________

Address ______________________ **Home Phone** ____________

Employer ______________________ **Work Phone** ____________

■ Assignment and Release

I hereby authorize payment directly to Muir OB/GYN Medical Group of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

Signature: ______________________ Date: ____________

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): ______________________ Relationship to Patient: ________

BILLING and COLLECTION POLICIES

Our goal is to provide you with high-quality and efficient care. There are many details involved in the process of payment for the services that you receive. In order for this process to flow smoothly, it is essential that you understand what information we must share with each other and with health insurance companies, and what both our responsibilities are.

Upon scheduling and registration we require you to provide your medical insurance card (if you have coverage), photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner or parent, we require you to provide that person's address, date of birth, and phone number as well. Our billing process works better if you provide social security numbers as well.

Health Insurance Cards: Upon scheduling each appointment, our team will ask to verify your insurance information, and will ask to see your insurance card upon check-in at each appointment. Please bring your card to every appointment, and notify the office at your first appointment after if changes. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report such behavior to the authorities. We will not engage in any fraudulent practices under any circumstances.

Keeping Appointments: Should you not arrive for a scheduled appointment, unless that appointment has been cancelled at least 1 full business day in advance, you may be charged $25 for each no-show occurrence. Should this occur more than twice within a 12 month period, you may be dismissed from the practice. By signing below, you accept this policy.

Health Insurance Plans: It is your responsibility to understand the provisions of your health insurance plan and coverage. As helpful as we pride ourselves on being, our team cannot be expected to know the details of your particular plan, as we see hundreds of different plans every week. We recommend contacting your carrier prior to receiving services in order to verify your coverage levels and responsibilities.

Authorizations: You are responsible to obtain all necessary referrals, or other required documentation prior to your appointment. If our team office determines that your plan requires a referral, and you do not provide such referral you may be required to sign a waiver in order to receive services. Additionally, even should our team fail to request such a waiver, you will nonetheless be responsible for all charges that are not paid by your insurance carrier due to lack of authorization. By signing below, you accept these policies.

Copayments: It is our responsibility, as detailed by the terms of our contracts with health insurance companies, to collect any copayment amounts at the time of your appointment. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any copayment amounts at the time of your appointment. Please have your payment ready upon check-in. By signing below, you accept these policies.

Previous balances and/or deductibles: It is our responsibility, as detailed by the terms of our contracts with health insurance companies we participate with, to bill you for any portion of your treatment that your health insurance carrier assigns to your responsibility. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any such portion. If you do not remit full payment on any such bills within a reasonable period and with reasonable notice, your account will be sent to collections (and subject to an additional collection fee, interest and/or legal action will be pursued. You may be dismissed as a patient by our practice for failure to meet your financial obligations. By signing below, you accept these policies.

Health insurance non-payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your responsibility to pay in full. Should your health insurance carrier later pay us for those services you paid for, you will be reimbursed. By signing below, you accept this policy.

Self-pay patients: If you do not have health insurance, have coverage through a carrier with which we do not participate, or are receiving a known non-covered service, it is our policy that you must pay for your service in full before leaving the office. By signing below, you accept these policies.

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to Muir OB/GYN Medical Group for any services furnished to me or my dependents.

Signature of Patient: ______________________________ Date: ____________________

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and indicate relationship to the patient.

PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

♦ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

♦ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: ______________

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: ______________

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: ______________

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

♦ I agree that my PHI may be shared with my spouse.

♦ I agree that my PHI may be shared with the following other people:

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

♦ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Muir OB/GYN Medical Group.

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (print):____

Signature: ____ Date: _______________________

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): __________________ Relationship to Patient: ____________________

Muir OB-GYN Medical Group

Acknowledgement of Receipt of Notice of Privacy Practices

Muir Ob-Gyn, 112 La Casa Via, Suite 200, Walnut Creek, CA 94598

Phone 925/933-4747 Fax 925/935-3559

Kris Pyatt, Privacy Officer

Please sign this form and return to our office at the address or fax number listed above.

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at my next appointment.

Signed:_______________________________ Date: ____________________

Print Name: __________________________ Telephone:___________________

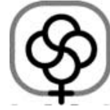
If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: ____

Patient's Date of Birth: ______________________________

 Muir OB-GYN Medical Group

SUMMARY NOTICE OF PRIVACY PRACTICES

This page summarizes how your medical information may be used and disclosed and how you may obtain access to the information. See the full Notice of Privacy Practices for complete details.

Muir Ob-Gyn is committed to protecting your medical information. We are required by law to:

- Make sure that medical information that identifies you is kept private, except as you authorize or as laws require or permit.
- Give you a Notice of Privacy Practice that describes our legal duties and privacy practices with respect to your medical information.
- Follow the terms of the Notice of Privacy Practice that is currently in effect.

We may use and disclose your medical information for treatment, payment and our healthcare operations. We may share your information with individuals/agencies that will be involved in your care (i.e. appointment reminders, health oversight activities, and worker's compensation as appropriate).

We may disclose your information as required by law, such as for public health activities to prevent or control disease, to report abuse situations, to notify people of recall of products, or in response to a court order.

You have a right to:

- Inspect and receive copies of your medical information.
- Request to amend your records if you feel the information is incorrect or incomplete.
- Request special privacy protections and an accounting of certain disclosures of your information that we have made.
- Request restrictions of our use or disclosure of your medical information.
- Receive a paper copy of the complete Notice of Privacy Practices.

All such requests must be submitted in writing on forms provided by Muir Ob-Gyn. For more information on these rights, please see the full Notice of Privacy Practices.

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. Complete information is provided in our full Notice of Privacy Practices.

112 La Casa Via, Suite 200 * Walnut Creek, CA. 94598
350 John Muir Pkwy, Ste 205 * Brentwood, CA 94513
Phone: 925-933-4747 * Fax: 935-3559

Muir OB-GYN Medical Group

112 La Casa Via #200 Walnut Creek, CA 94598

(925)933-4747 (925)935-3559 fax

Medical History Questionnaire

Name: ____________________________ Date of Birth: _________ Today's Date: ___________

How do you wish to be addressed? ______________________ Single Married Widowed Partnered

Race: ______________________ Religion: ____

Occupation: _________________________ Who referred you to us? ____________________________

What is your main reason for coming to see us? ____

____

____

Age at your first period? ___ Last Period date ____

Periods are REGULAR IRREGULAR every ____ to _____ days

Periods are: HEAVY MEDIUM LIGHT VARIABLE Trying to get pregnant now? Y N

Method of Birth Control?: _______________ or Hormone Replacement Therapy? ____________________

Date of last PAP: _______________ Date of last Mammogram: ______________

Have you had a Colonoscopy? Y N When: _____________________

Do you smoke? Y N How many per day? _______ For how many years? ________________

Do you drink alcohol? Y N How many drinks/week? ______ Recreational Drugs? Y N

Do you exercise regularly? Y N Are you sexually active? Y N

Parents', Grandparents', Brothers' and Sisters' Medical History:

Condition	Family member who had this
Hypertension:	
Diabetes:	
Heart Disease:	
Cancer:	
Twins:	
Other:	

NAME:____

Your Medical History:

Please check conditions applicable to you (past and present):

Condition	Details
Diabetes:	
High blood pressure:	
Heart disease:	
Autoimmune disease:	
Renal disease:	
Neurological disease:	
Psychiatric problems:	
Hepatitis:	
Blood clots in legs or lungs:	
Thyroid disease:	
Lung disease or Asthma:	
Breast disorders:	
Serious accidents or trauma:	
Blood transfusion:	
Abnormal PAP test:	
Genital Herpes:	
Gonorrhea or Chlamydia:	
Infertility:	
Chickenpox:	

Other Medical Conditions:____

____

Medication Allergies:____

Surgeries:____

____

Anesthetic complications:____

Other hospitalizations:____

____

Current Medications:____

____

____

Name:____

Your Pregnancy History:

(Only fill out this section if you are or have been pregnant)

Miscarriages(M), Abortions(A), or Ectopic(E) Pregnancies

Please check (M) for pregnancies that ended on their own before 24 weeks, (A) for pregnancy terminations and (E) for ectopic pregnancies

	M A E		Yes No
Date:___________		Pregnancy Duration(weeks)______________Surgery	
Date:___________		Pregnancy Duration(weeks)______________Surgery	
Date:___________		Pregnancy Duration(weeks)______________Surgery	
Date:___________		Pregnancy Duration(weeks)______________Surgery	
Date:___________		Pregnancy Duration(weeks)______________Surgery	
Date:___________		Pregnancy Duration(weeks)______________Surgery	
Date:___________		Pregnancy Duration(weeks)______________Surgery	

Individual Delivery History

*****If not currently pregnant fill out starred lines only**

1. ***Date: ___________ Baby's Weight: ______ ☐ Boy ☐ Girl ☐ Vaginal ☐ Cesarean**
   Duration of Pregnancy (weeks): ___ Length of Labor:______ Hospital:___________________
   Doctor's Name:__________________________ ☐ Epidural ☐ IV pain med.__________________________
   ***Complications of pregnancy or delivery:____**
2. ***Date: ___________ Baby's Weight: ______ ☐ Boy ☐ Girl ☐ Vaginal ☐ Cesarean**
   Duration of Pregnancy (weeks): ___ Length of Labor:______ Hospital:___________________
   Doctor's Name:__________________________ ☐ Epidural ☐ IV pain med.__________________________
   ***Complications of pregnancy or delivery:____**
3. ***Date: ___________ Baby's Weight: ______ ☐ Boy ☐ Girl ☐ Vaginal ☐ Cesarean**
   Duration of Pregnancy (weeks): ___ Length of Labor:______ Hospital:___________________
   Doctor's Name:__________________________ ☐ Epidural ☐ IV pain med.__________________________
   ***Complications of pregnancy or delivery:____**
4. ***Date: ___________ Baby's Weight: ______ ☐ Boy ☐ Girl ☐ Vaginal ☐ Cesarean**
   Duration of Pregnancy (weeks): ___ Length of Labor:______ Hospital:___________________
   Doctor's Name:__________________________ ☐ Epidural ☐ IV pain med.__________________________
   ***Complications of pregnancy or delivery:____**

5. ***Date: ___________ Baby's Weight: ______ ☐ Boy ☐ Girl ☐ Vaginal ☐ Cesarean**

   Duration of Pregnancy (weeks): ___ Length of Labor:______ Hospital:___________________

   Doctor's Name:__________________________ ☐ Epidural ☐ IV pain med.__________________________

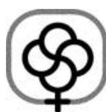
   ***Complications of pregnancy or delivery:____**

6. ***Date: ___________ Baby's Weight: ______ ☐ Boy ☐ Girl ☐ Vaginal ☐ Cesarean**

   Duration of Pregnancy (weeks): ___ Length of Labor:______ Hospital:___________________

   Doctor's Name:__________________________ ☐ Epidural ☐ IV pain med.__________________________

   ***Complications of pregnancy or delivery:____**



112 La Casa Via #200 Walnut Creek, CA 94598
(925)933-4747 (925)935-3559 fax

Pregnancy Supplement

Name:____________________________________ Date of Birth:______________ Today's Date:____________
First Day of Last Period:_________

Baby's Father

Name:___________________________________ Date of Birth:__________ Height:________ Weight:_______
Race:___________________ Occupation:________________Additional Phone Number:_________________
Medical Conditions:____

Risk Factors Check List

The list below contains several risk factors for having a pregnancy requiring special handling. Please check all that apply to you.

If you are:	Check Here:
35 or older by your due date	
Of Jewish parentage (you or your partner)	
Of African-American heritage (you or your partner)	
A smoker	
A caffeine user	
An alcohol user	
A cat owner	
A hot tub user	
A vegetarian	
A raw meat eater	
Taking medications other than prenatal vitamins	
Exposed to unusual environmental situations	
A past or present user of "street drugs"	
A herpes carrier (you or your partner)	
A "DES"* daughter *A medication given to your mother, during her pregnancy with you, if she was threatening to have a miscarriage	

Please specify medications taken since your last menstrual period:____________________________________
____
Alcohol, tobacco or other drugs since last period:____
____
____

Genetic History
Please check any conditions that have occurred in your families

Neural Tube Defects (anencephaly, spina bifida, menigomyeloceole)

Down's Syndrome	**Tay Sachs Disease**	**Sickle Cell Disease or Trait**
Thallasemia	**Hemophilia**	**Huntington's Chorea**
Muscular Dystrophy	**Mental Retardation**	**Fragile X Syndrome**
Cystic Fibrosis	**Still Birth**	**More than 2 Spontaneous Abortions**

Other inherited disorder:____

Any other genetic concerns:____

____

Patient Signature:____ **Date:**_________________