



Welcome Registration Form

Patient Information	Today's Date
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First Name	Middle Name	Last Name				
Street Address		Apt #	City	State	Zip Code	
Phone Numbers		Work		Home		
Cell						
DOB	SSN					
Email			Name of Employer			
Circle One:	Minor	Single	Married	Divorced	Widowed	Separated

Insurance Information		
Primary		
Insurance Company	Policy #	Group #
Primary card holder's name		Relationship to patient

DOB	SSN	Phone (H)
Name of Employer		Phone (W)

SECONDARY		
Insurance Company	Policy #	Group #
Primary card holder's name		Relationship to patient

DOB	SSN	Phone (H)
Name of Employer		Phone (W)

I assign all medical/surgical benefits to which I am entitled, including private insurance to Columbia Shores Comprehensive Obstetrics and Gynecology, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information related to the diagnosis and treatment, including records protected by Federal Regulations, 42 CFR part 2, as required to qualify for health benefit payment. I will receive a separate bill for any Cultures/Biopsy's and Urine Samples sent to an outside lab. I understand that I am financially responsible for all charges incurred from medically treatment at this facility, whether they are paid by my insurance carrier or not. If, for any reason, it becomes necessary for this office to engage an attorney or collection agency to secure payment from me, I agree to pay all reasonable interest charges, attorney fees, and collection costs. If legal action becomes necessary, venue shall be in Benton County.

Patient Signature (Responsible Person)	Date
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Columbia Shores

Comprehensive Obstetrics & Gynecology, PLLC
138 Keene Rd. Richland WA 99352
Phone 509-628-8866

PAYMENT POLICY AGREEMENT

I understand that I am financially responsible for payment for services rendered by Columbia Shores Comprehensive Obstetrics and Gynecology regardless of coverage by my insurance carrier. Payment for services are due in full on the date of service if I do not carry health insurance or within 30 days of the receipt of statement (service charge \$1 per statement) after my health insurance carrier has paid unless other arrangements are made. If it becomes necessary to engage an attorney or collection agency, I will be responsible for those costs.

A 1½% service charge will be added to my account balance after 30 days and each month thereafter. I understand that I am responsible for all service charges. If my account remains unpaid for 60 days, I understand that it may be sent to a collection agency. I understand that if my account becomes 60 days delinquent and is sent to collections, confidential and personal information about my account will be disclosed to the collection agency to be used for the sole purpose of collection on the unpaid charges. It is my responsibility to inform Columbia Shores Obstetrics and Gynecology if my address or phone number changes.

I understand that Columbia Shores Obstetrics and Gynecology has a written policy in place that safeguards the privacy and security of my private and personal health information. This consent permits Columbia Shores Obstetrics and Gynecology to disclose and to exchange my personal health information with my health insurance carrier and others as necessary for treatment, payment and health care operations.

_____ Please initial

NO SHOW / RESCHEDULE FEE POLICY

Columbia Shores Obstetrics and Gynecology has a No Show/Reschedule Fee. This fee is not a covered benefit with any insurance. The fee is the patient's/guarantor's sole responsibility.

No Show/Same day Reschedule fees are as follows: \$35 for an office visit and \$75 for a scheduled ultrasound /procedure. When time allows, we will confirm your appointment. Please do not rely on these courtesy calls.

**The fee will be waived if a 24 hour notice is given prior to scheduled appointment time. **

We realize circumstances beyond your control may arise, such cases will be reviewed and the fee may be waived depending on the situation.

_____ Please initial

Authorization for Co-Participant of Health Care

I, _____
Print Patient Name Date of Birth Phone Number

Authorize Columbia Shores Comprehensive Obstetrics & Gynecology, PLLC to share information regarding my health care as indicated below.

You authorize the above mentioned provider and or facility to discuss your protected health care information with the person/ (s) designated below.

Please list the individual/ (s) you wish to participate in your care:

Co-Participant Name	Contact Number	Relation
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Co-Participant Name	Contact Number	Relation
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I understand that my co-participant/ (s) must present suitable photo identification when requesting this release of confidential information in person. They must also know pertinent information about me when requesting this release of confidential information over the phone.

_____ Please initial

I also acknowledge that I have read and understand the No Show/Reschedule/and Financial responsibility policies. I also understand and have signed or declined the Co- Participant of health care form.

Patient Signature: _____ Date: _____

Parent/Legal Guardian/Responsible Other Signature _____

Thank you for your cooperation, Columbia Shores Obstetrics and Gynecology, PLLC.

Columbia Shores Obstetrics and Gynecology

NOTICE TO INDIVIDUALS OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Columbia Shores Obstetrics and Gynecology, PLLC we believe that individuals have a right to adequate notice of our policies, procedures and practices with respect to uses and disclosures of protected health information. Columbia Shores Obstetrics and Gynecology, PLLC is required by law to maintain the privacy of your health information and to provide you with a notice of our legal duties and privacy practices. We are required to and will abide by the terms in the Notice of Privacy Practices in effect at the time it is provided to you. You have the right to request a paper copy of this Notice of Privacy Practices at the time it is provided to you. You have the right to request a paper copy of this Notice of Privacy Practices even if we have provided a copy to you electronically by e-mail.

Columbia Shores Obstetrics and Gynecology, PLLC will not use or disclose your individually identifiable or protected health information other than to carry out health care treatment, payment, and/or operations for you, or as required by law. An example of treatment is a visit to our office for the purpose of diagnosis or care of a health issue wherein doctors, nurses, laboratory technicians, medical students and others will share the information about you in the course of your treatment. Payment includes sharing protected health information with an insurer or a third party that may be responsible for collecting payment for a health plan. Healthcare operations means sharing protected health information for the purpose of quality review.

Columbia Shores Obstetrics and Gynecology, PLLC will use and disclose protected health information to business associates in the course of providing treatment, securing payment for such treatment, and/or to facilitate health care operations of our practice, to facilitate the requirements of our business associates' contracts and to comply with requests from other covered entities to carry out treatment, payment or health care operations.

Except for the purposes described above, Columbia Shores Obstetrics and Gynecology, PLLC will only use or disclose protected health information with your express written authorization and you may revoke the authorization at any time in writing. The revocation will apply only to future uses and disclosures.

Any information Columbia Shores Obstetrics and Gynecology, PLLC provides to a third party other than to our business associates or other health care providers with a treatment relationship to you will be de-identified or stripped of any and all personal data which could be used to identify a specific individual.

Columbia Shores Obstetrics and Gynecology, PLLC may contact you to provide appointment reminders or to provide you with information about alternative treatments or other health-care services we provide. When you provide alternate communication requests to us, we will make every effort to accommodate your request.

You may request that certain uses and disclosures of your protected health information be restricted. To do so, you must provide the request in writing using the Request for Restriction on Use or Disclosure form available from our office. Columbia Shores Obstetrics and Gynecology, PLLC will determine if the information constitutes required information to carry out treatment, payment or health care operations. If, in our sole opinion, your request does not involve information that is required by us to carry out treatment, payment or health care operations, we will accept your request for restriction and will notify you if your request will be honored within 30 days or as required by law.

With respect to your protected health information, you have the right to request and receive the following from Columbia Shores Obstetrics and Gynecology, PLLC:

- Inspection and copying -- You may request that we amend or correct your health information that has been collected by Columbia Shores Obstetrics and Gynecology, PLLC for you to inspect or copy. Such requests will be honored within 30 days or as required by law, and you will be notified in writing of Columbia Shores Obstetrics and Gynecology, PLLC, receipt of the request and the date upon which the information will be available to you.
- Amendment or correction -- You may request that we amend or correct your health information that has been collected by Columbia Shores Obstetrics and Gynecology, PLLC. Upon agreement by your health care provider, request to amend health information will be honored within 30 days or as required by law, and you will be notified in writing of Columbia Shores Obstetrics and Gynecology, PLLC's actions taken.
- Accounting of the disclosures -- You may request that we supply you with a listing of the disclosures of your protected health information which have been made by Columbia Shores Obstetrics and Gynecology, PLLC except those made for treatment, payment or health care operation, those required by the Final Privacy Rule or made pursuant to other honored within 30 days or as required by law, and you will be notified in writing of the date on which the accounting will be available to you. At a minimum, the accounting of disclosures will include the following information:
 - Date of each disclosure
 - Name and address of the organization of person who received the protected health information
 - A brief description of the information disclosed.

Columbia Shores Obstetrics and Gynecology, PLLC, has also required in our business associate contracts that they offer a means to provide such a listing for you.

If you believe that your privacy rights have been violated, you may send questions or complaints about this notice or Columbia Shores Obstetrics and Gynecology, PLLC's privacy practices to us and/or to the Secretary of the Department of Health and Human Services (HHS). Such communication with Columbia Shores Obstetrics and Gynecology, PLLC, should be directed to: Chief Privacy Officer, Columbia Shores Obstetrics and Gynecology, PLLC, 138 Keene Rd A Richland WA 99352. The address of the Secretary of Health and Human Services is 200 Independence Ave. SW, Washington DC 20201. Columbia Shores Obstetrics and Gynecology, PLLC, will not retaliate against you for filing a complaint with the Secretary of HHS.

Columbia Shores Obstetrics and Gynecology, PLLC, reserves the right to revise this Notice of Privacy at any time without prior notification. You may request a copy of the revised notice and we will provide it to you.

For additional information, please write us at Columbia Shores Obstetrics and Gynecology, PLLC, 138 Keene Rd., Richland WA 99352, Attention HIPPA Privacy Contact or call 509-628-8866 and ask to speak with our HIPPA Privacy Contact.

This Notice of Privacy Practices is effective as of 7-16-2007.

I the undersigned, acknowledge that I have read, received and understand the Notice of Privacy Practices. I the undersigned have the right to refuse to sign this authorization and that my treatment, payment for my health care and health care benefits will not be affected if I do sign this form.

Signed: _____ Date: _____

Personal History

Patients Name: _____ Date of Birth _____

Ethnicity: _____ Religion: _____

Marital Status: _____ Spouse/Significant Other Name: _____

What method of birth control are you using? None Pill IUD Diaphragm Vasectomy Tubal Ligation Other _____

Medical/Health History: _____

Surgical History

Date	Procedure	Hospital	Doctor

Current Medications: (Please include Vitamins and Birth Control)

Medication	Dosage	How often do you take

Are you allergic to any medications? If yes, please list which medication and reaction _____

Age 1st Period began _____ Have your periods stopped _____

First day of your last period _____ Days flow _____ Number of day's between periods _____

Any recent changes to periods Yes No Do you have pain with periods Yes No. If yes, which days and how strong: _____

Age you became sexually active _____ Number of partners in lifetime _____

Any history of Sexually Transmitted Diseases Yes No. If yes, When and what type _____

Any history of Abnormal pap smears Yes No. If yes, when and what treatment _____

Do you have hot flashes Yes No. Do you leak urine when coughing, sneezing, laughing Yes No. Do you have an urge to urinate prior to leaking? Yes No

CONTINUE ON BACK

Test	Date	Result (Normal or Abnormal)
Pap		
Mammogram		
Colonoscopy		
Bone Density		

Total Number of Pregnancies _____ **List in order from First to Last (including miscarriages)**

Birth Day	Weeks Delivered	How long was Labor	Baby's Weight	Male/Female
Baby 1				
Baby 2				
Baby 3				
Baby 4				

What type of pain medication:

Baby 1: Spinal Epidural IV Meds General None. Babies Name _____

Baby 2: Spinal Epidural IV Meds General None. Babies Name _____

Baby 3: Spinal Epidural IV Meds General None. Babies Name _____

Baby 4: Spinal Epidural IV Meds General None. Babies Name _____

Type of Delivery:

Baby 1: Vaginal Vacuum C-Section Forceps VBAC Miscarriage Ectopic Abortion
If C-Section, Why _____

Baby 2: Vaginal Vacuum C-Section Forceps VBAC Miscarriage Ectopic Abortion
If C-Section, Why _____

Baby 3: Vaginal Vacuum C-Section Forceps VBAC Miscarriage Ectopic Abortion
If C-Section, Why _____

Baby 4: Vaginal Vacuum C-Section Forceps VBAC Miscarriage Ectopic Abortion
If C-Section, Why _____

Please List Any Complications during pregnancies

Baby 1 _____
Baby 2 _____
Baby 3 _____
Baby 4 _____

Preterm Labor, if yes at how many weeks : **Baby 1** Yes _____ No. **Baby 2** Yes _____ No. **Baby 3** Yes _____ No.
Baby 4 Yes _____ No

Do you Drink Yes No. If yes, How much _____ How Often _____

Do you Smoke Yes No. If yes, How much _____

Any History of Drug Use Yes No. If yes, When _____ Which Drugs _____

Do you exercise? Yes No. If yes, How often? _____ What type of exercise? _____

Family History of health problems _____

Signature of person completing this form _____ **Date** _____

OB History Form

Patient's name: _____ Date of Birth _____

Please circle any symptoms you have experienced with this pregnancy

Vaginal Bleeding, Discharge, Constipation, Abdominal Pain, Fever, Nausea, Vomiting, Headaches, Urinary Problems, Rash

Please explain _____

Other illness or injury _____

Column 1: Please mark all that apply and Explain if needed

Column 2: Do you, the baby's father or any blood relative have any of the following, please explain

Column 1	Column 2
Hepatitis	Neural Tube Defect
Kidney Disease	Down Syndrome
Psychological Disorder	Sickle Cell Disease or Trait
Rheumatic Fever	Hemophilia
Seizures	Muscular Dystrophy
TB	Cystic Fibrosis
Thyroid Problems	Diabetes
Varicose Veins	High blood pressure
Trauma	Huntington Chorea
Domestic Violence	Mental Retardation, if yes was person tested for Fragile X
Auto Immune Disorder	Other inherited genetic or chromosomal disorder
History of Blood Transfuse	Patient or baby's father had child with birth defects not listed above
Neurological/Epilepsy	More than 3- First Trimester miscarriages, or a stillbirth
Anesthesia Complications	Thalassemia
Uterine Anomaly/DES	Congenital Heart Defect
Other	

Explanation _____

Were you on birth control at the time of conception, if yes what type Yes _____ No

If needed, is a blood transfusion acceptable Yes No