Columbia Shores
Comprehensive Obstetrics and Gynecology, PLLC

Welcome Registration Form

Patient Information					Today's Date
First Name	Middle Name				Last Name
Street Address		Apt #	City	State	Zip Code
Phone Numbers Cell	Work				Home
DOB	SSN				
Email					Name of Employer
Secect 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 medical 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

PAYMENT POLICY AGREEMENT

I understand that I am financially responsible for paymant 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 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. Account balances / and or payment plans are to be paid in full one month prior to delivery date.

A 1 1/2 % 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 Comprehensive Obstetrics and Gynecology if my address or phone number changes.

I understand that Columbia Shores Comprehensive 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 Comprehensive 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 Comprehensive 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, $75 for a scheduled office ultrasound/procedure, and $150 for a scheduled hospital surgery.
The fee will be waived if a 24 hour notice is given prior to a 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, _____ Date of Birth _____ _____
Phone Number

Authorize ***Columbia Shores Comprehensive Obstetrics and Gynecology*** to share information regarding my health care as indicated below.
I authorize the above mentioned provider and/or facility to discuss my 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

_____ Co-Participant Name _____ Contact Number _____ Relation _____

I understand that my co-participant/(s) must provide suitable photo identification when requesting this release of confidential information in person. They must also know pertinent information about 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 the health care form.

Patient Signature: _____ Date: _____

Parent/Legal Guardian/Responsible Other Signature: _____

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

Columbia Shores Comprehensive 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 Comprehensive 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 Comprehensive 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 Comprehensive 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 Comprehensive Obstetrics and Gynecology, PLLC will only use or disclose protected health information with you 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 Comprehensive 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 Comprehensive Obstetrics and Gynecology, PLLC may contact you to provide appointment reminders or to provide you with information about alternative treatments or other healthcare 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 much provide the request in writing using the Request for Restriction on Use or Disclosure form available from our office. Columbia Shores Comprehensive 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 Comprehensive 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 Comprehensive 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 Comprehensive Obstetrics and Gynecology, PLLC.
  Upon agreement by your health care provider, request to amend health information will be honored within 30 days or as request by law, and you will notified in writing of Columbia Shores Comprehensive 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 Comprehensive 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 Comprehensive 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 Comprehensive 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 Comprehensive Obstetrics and Gynecology, PLLC, should be directed to: Chief Privacy Officer, Columbia Shores Obstetrics and Gynecology, PLLC, 138 Keene Rd Richland WA 99352. The address of the Secretary of Health and Humans Services is 200 Independence Ave. SW, Washington DC 20201. Columbia Shores Comprehensive Obstetrics and Gynecology, PLLC, will not retaliate against you for filing a complaint with the Secretary of HHS.

Columbia Shores Comprehensive 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 Comprehensive 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.

Name (Print) Date

I am providing correct insurance information to Columbia Shores Comprehensive Obstetrics and Gynecology, PLLC. I know that it is unlawful to willingly withhold any additional insurance information that I am knowingly currently enrolled in or in the process of attaining. I am aware that Columbia Shores Comprehensive Obstetrics and Gynecology, PLLC does not accept STATE INSURANCE, MEDICARE, or UNITED health insurance. If my insurance status changes at any time during my care under this office, I am required by law to provide that insurance information. I know that I am not able to see the physician once my insurance has changed to STATE, MEDICARE, or UNITED. We do not have cash pay benefits. If you fail to disclose insurance membership, this allows for grounds for immediate discharge.

Name (Print) Date

Name (Signature)

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

Columbia Shores
Comprehensive Obstetrics and Gynecology, PLLC

Gynecology Intake Form

Name:

Date of birth:

Who is your family doctor or referring doctor?

What brings you in to see us today?

When was your last period? **(LMP)**

Was it normal? ☐ Yes ☐ **No**

At what age did your periods start? (Menarche)

How many days from the beginning of one period to the next? (Frequency)

Are they regular? ☐ Yes ☐ **No**

How many days do your periods last? (Duration)

What is the amount of flow during your cycle? ☐ Light ☐ Medium ☐ Heavy

Do you have any symptoms, such as pain, during your menses? ☐ Yes ☐ **No**

If yes, describe the symptom/pain, rate from 1-10 (10 being the worst pain) and note which days the symptoms are the greatest.

When was your last pap smear?

What was the result of the last pap? ☐ Normal ☐ **Abnormal**

Have you ever had an abnormal pap? ☐ Yes ☐ **No**

If yes, what was the result? ☐ Level I ☐ Level II ☐ Level III

When was your last mammogram?

What was the result of your last mammogram? ☐ Normal ☐ **Abnormal**

When was your last colonoscopy?

What was the result of your colonoscopy? ☐ Normal ☐ **Abnormal**

Prior Pregnancies

How many times have you been pregnant?

How many were full term? How many were preterm? (Before 37 weeks)

How many tubal pregnancies? How many miscarriages before 20 weeks?

How many still births after 20 weeks? How many abortions?

Please list each of your pregnancies. Please also list any miscarriages or abortions.

#	Date	Type of delivery i.e. Vaginal /cesarean/ Forceps/ Vacuum/ Miscarriage	Male Or Female M/F	Baby's weight at birth	Any complications?	How many weeks at delivery? (40 for full term)	Preterm labor Y/N	Type of pain medication used during delivery	Child living? Y/N
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Menopause

Do you have any menopausal symptoms? ☐ **Yes** ☐ **No**

If yes please describe.

When did your menopausal symptoms start?

Are you taking Hormone Replacement Therapy? ☐ **Yes** ☐ **No**

If yes, which one.

Do you have any health concerns, such as diabetes or high blood pressure?

What medications and dosage do you take?

Medication	Dosage	How often

Do you have any allergies?

Allergy	Reaction

What surgeries have you had done?

Date	Surgery	Type of anesthesia	Hospital

If you had a hysterectomy do you still have your cervix? ☐ **Yes** ☐ **No**

If you had a hysterectomy do you still have your ovaries? ☐ **Yes** ☐ **No**

Family history of health problems.

Health problem (ie cancer, diabetes, blood clots)	Relation

Do you smoke? ☐ **Yes** ☐ **No** If yes, for how long.

Have you ever smoked**?** ☐ **Yes** ☐ **No** If yes, for how long.

When did you stop smoking?

Do you drink alcohol? ☐ **Yes** ☐ **No** If yes, for how long?

How much do you drink a day?

Do you do use any recreational or illegal drugs? Type?

What type of work do you do?

Are you sexually active?

Do you have any pain or problems with sex? ☐ **Yes** ☐ **No**

If yes please describe

How many partners have you had in the last… 6 months? 1 year? 2 years?Lifetime?

What type of birth control do you use

Do you leak urine? ☐ **Yes** ☐ **No**

Do you have any other concerns?

Name: (Please Print)

Signature: Date

Pregnancy Intake Form

Current/Past Medical Conditions

Date of last Pap Smear:

Have you ever had an abnormal pap? ☐ **Yes** ☐ **No**

Is yes, what was it?

Social History:

Are you: ☐ **Married** ☐ **Divorced** ☐ **Single** ☐ **Significant other**

Do you have any religious preference?

Do you use tobacco? ☐ **Yes, current user** ☐ **Yes, former user** ☐ **No**

If yes, how often?

Do you use alcohol? ☐ **Yes, current user** ☐ **Yes, former user** ☐ **No**

If yes, how often?

Do you do any other drugs? ☐ **Yes, current user** ☐ **Yes, former user** ☐ **No**

If yes, what kind and how often?

Do you drink caffeine? ☐ **Yes, current user** ☐ **Yes, former user** ☐ **No**

If yes, how often?

Are you currently: ☐ **Employed** ☐ **Stay at home mom** ☐ **Unemployed** ☐ **Retired** ☐ **Student**

If employed, what is your occupation?