Patient Assignment of Benefits Form

Name: _____ **D.O.B.**_____

Assignment of Benefits: I assign my benefits to be paid directly to AFA OB/GYN or Emerson Practice Associates/Megan Loring, MD and understand that I am financially responsible for all services that are not covered.

Signature: _____

HIPAA Privacy Policy: I acknowledge that I have read the practice's Notice of Privacy Practices.

Signature: _____

Release of Information: I authorize AFA OB/GYN and Emerson Practice Associates/Megan Loring, MD to release any information required to process this claim to my insurance company or other party involved in reimbursement for the claim, which may include:

*Information about genetic testing
*Information related to communications with a psychotherapist, psychologist, social worker, or other allied mental health professional or human services professional
*Information about research involving controlled substances
*Abortion consent forms
* Mammography records
*Information about family planning services
*If I am a minor, information about my treatment and diagnosis (except to my parents)

Signature: _____

Phone number our staff is able to leave detailed medical information: _____

I authorize AFA OB/GYN and Emerson Practice Associates/Megan Loring, MD to release my medical information including office visits, lab results, and treatment plan to the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize AFA OB/GYN and Emerson Practice Associates/Megan Loring, MD to release my medical information to the person(s) listed above which may contain information regarding: (please initial)

_____ STD results, HIV/AIDS testing _____Drug, alcohol, or mental health treatment

Signature: _____ **Date:**_____

AFA Obstetrics & Gynecology, PC Patient Financial Policy

We have adopted the following financial policy to avoid any misunderstanding between you and this office. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions about bills or billing pertaining to your care received from AFA Obstetrics and Gynecology, PC please call our billing department at 978-371-1396 option 5.

Please return this form to the receptionist once you have reviewed and signed it. A copy will be provided to you upon your request.

Insurance: We participate in most managed care plans. If you are insured by a plan we do not participate with payment is required at each visit. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your own coverage. We will process your insurance claim for you if you assign the benefits to us. In other works, you give us permission to bill your insurance company directly and they will pay us directly. You will be responsible for providing correct insurance information at each visit. You are responsible for obtaining referrals for services if required by your plan. All medical treatment and services that are not covered by your plan will be your responsibility. Patients are responsible for all deductibles, co-payments, non-covered services and out of network services. All co-payments are due at the time of the visit. Ultrasounds and lab work, although located in our office, are an outside service and billed independently from AFA Obstetrics and Gynecology, PC.

No Insurance Coverage: Full payment is expected at the time of service. We accept cash, checks, Visa and MasterCard.

Minor Patients: The adult accompanying the patient and the parent or guardian will be responsible for all services rendered to minor patients.

Delinquent Accounts: Payment is due upon receipt of a statement. If your account becomes delinquent, we will make every effort to collect the debt incurred prior to being sent to a collection agency and possibly being dismissed from the practice.

I have read and fully understand the financial policy and agree to the terms.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Name of Patient (print) Date of Birth

PATIENT CONSENT FOR MASS HIWAY

The Massachusetts Health Information Highway (Mass HIway) is the secure statewide computer network that allows for the electronic transfer of medical information between healthcare providers that is intended to improve the quality and safety of patient care. I have received and had an opportunity to review the "Mass HIway: Fact Sheet for Patients" provided to me by a physician practice affiliated with Emerson Hospital and Emerson Physician Hospital Organization (the "Practice"). I hereby give the Practice permission to use MassHIway to:

1. Send to the Mass HIway my name, date of birth, gender, email, home address, phone number, and medical record number so that my other providers using Mass HIway know I received care from the Practice and can ask for my medical information when needed for my care.

2. Request, send, and receive my medical information from and to my other providers who also use the Mass HIway. I understand that this information may include information about mental health, HIV test results, sexually transmitted diseases, domestic violence, sexual assault, substance abuse records, reproductive health concerns and genetic testing results.

3. I understand that I may withdraw my permission for the Practice to share information ("Opt-out") at any time by submitting a request in writing. The Opt-out notice can be sent to the Practice.

Print Patient Name	Patient Date of Birth
Signature of Patient or Patient's Legal Representative	Date of Signature
Print Name of Patient's Legal Representative (if applicable)	Relationship to Patient

AFA OB/GYN
Obstetrical Medical History

Patient Name: _____ Date of Birth: _____

Date Form Completed: _____

*If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

PERSONAL HEALTH HISTORY

1. Are you allergic to any medications ☐Yes ☐No Latex Allergy Yes ☐ No
If yes, please list:

_____

_____

2. Please Mark any condition that you have or have had in the past:

☐Cancer ☐HIV/AIDS ☐Diabetes ☐Pulmonary Embolism
☐Epilepsy/Seizers ☐Thyroid disorder ☐Eating disorder ☐ Hepatitis/ Liver Disease
☐Heart Disease/Murmur ☐Headaches/ Migraines ☐Depression, Anxiety, or Psychiatric Illness ☐ Other Major Illnesses/ Medical Problems
☐High blood Pressure ☐Arthritis or Lupus ☐Asthma, Lung Disease, or TB
☐Kidney disease ☐Frequent infections ☐Anemia
☐Hepatitis ☐Bowel disease ☐Herpes
☐vonWillebrand's disease or other bleeding disorders ☐Sexually transmitted diseases
☐Blood clotting disorder (e.g. phlebitis) ☐Recurrent urinary tract infections
Describe, if needed:

_____

_____

3. Please indicate any surgeries that you have had:

_____

_____

4. Please describe any health problems or symptoms that you are having at this time:

_____

_____

5. Do your or any family member have a history of problems with anesthesia?Yes ☐No
If yes, please describe:

_____

_____

6. Do you have any religious objections to any form of medical treatment(e.g. refusal of blood transfusion)?☐Yes ☐No
If yes, please describe:

_____

_____

7. Family History:

Breast Cancer _____ Uterine Cancer _____

Ovarian Cancer_____ Colon Cancer _____

Diabetes _____

OBSTETRICAL HISTORY

Please complete the following table about your previous pregnancies in chronological order.
Please date all pregnancies including miscarriages.

No	Month/Year	Sex	Weight	Weeks at Delivery	Hours in Labor	Type of Delivery	Baby's Name	Problems

MENSTRUAL HISTORY

Date of Last Period _____ Date of Period prior to last period _____
Was it normal? □Yes □No
How many days between the start of one period to the start of the next? _____
Did you use any contraception? □Yes □No Date of last use_____

GYNECOLOGIC HEALTH HISTORY

1. When was your last Pap test? _____

Have you ever had an abnormal Pap test? □Yes □No
If yes, when and how were you treated?
_____
What was the diagnosis?
_____

2. Have you ever had gonorrhea □, chlamydia □, or pelvic inflammatory disease?
If yes, when, how, and where you treated? _____

3. Have you ever had herpes? □Yes □No
If yes, how often do you have outbreaks? _____
Have you ever had syphilis? □Yes □No
If yes, how, when and where were you treated? _____

4. Have you ever used an IUD (intrauterine device) for contraception? □Yes □No
If yes, please indicate when:
_____
Did you have any problem with the IUD?
If yes, please describe:
_____

5. Have you been treated for infertility? □Yes □No
If yes, please describe when and treatment received:
_____
_____

6. Do you have any other concerns related to your past health history? □Yes □No
If yes, please list:
_____
_____

EXPOSURES AFFECTING HEALTH

1. Do you smoke cigarettes? □Yes □No
If yes, how many packs per day? _____

2. Do you drink alcoholic beverages? □Yes □No
If yes, how often?
_____

What type of drinks?

_____

3. Please list any medications taken since your last period, including prescriptions, over-the counter drugs, multivitamins, other supplements, and any herbal medicines:

_____

4. Please list any recreational substances used since your last period (e.g., cocaine, marijuana):

_____

5. Do you have any reason to believe you may have been exposed to AIDS (e.g., a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bisexual male, exposure to an intravenous drug user)? □Yes □No

6. Are you ever exposed to chemicals or radiation (e.g., X-rays)? □Yes □No
If yes, please describe:

_____

7. Are you on a restricted diet? □Yes □No
If yes, please describe:

_____

8. Have you received the Tdap (Tetanus-Diptheria-Pertussis) vaccine? □Yes □No
If yes, when: _____

9. Have you ever had MRSA (Methicillin-resistant Staphylococcus aureus)? □Yes □No
If yes, when? _____

FAMILY HISTORY & GENETIC SCREENING

1. Have you or has the baby's father had a child born with a birth defect?Yes □No
If yes, please describe:

_____

2. Did either you or the baby's father have a birth defect? □Yes □No
If yes, please describe:

_____

3. Please describe any abnormalities that have occurred in children of your family or the baby's father's family (e.g., mental retardation, birth defects, deformities, or inherited diseases such as hemophilia, muscular dystrophy, or cystic fibrosis):

_____

_____

4. Do you or does the baby's father have a history of pregnancy losses (miscarriages or stillborn)? □Yes □No
If yes, have either of you had genetic counseling? □Yes □No
If yes, have either of you had chromosomal testing? □Yes □No
Where and what were the results?

_____

5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please check if you are, or the baby's father is, of one of these backgrounds:
Eastern Europe Jewish ancestry □Yes □No
If yes, have you had Tay-Sachs screening tests? □Yes □No
If yes, have you had a Canavan screening test? □Yes □No
Date _____ Result_____

African American□ Yes □No
If yes, have you had sickle cell screening? □Yes □No
Date _____ Result_____

European Ancestry □Yes □No
If yes, have you had cystic fibrosis screening? □Yes □No

Mediterranean Ancestry or Southeast Asian Ancestry □Yes □No
If yes, have you had screening for inherited forms of anemia such as thalassemia ?□Yes □No

6. Please list any other concerns you have about birth defects or inherited disorders:

_____

_____

7. Will you be 35 years or older at the time the baby is born? □Yes □No

8. Will the father be 50 years or older? □Yes □No

PSYCHOSOCIAL SCREENING

1. Do you have any problems (job, transportation, etc.) that prevent you from keeping your health care appointments? □Yes □No

2. Do you feel unsafe where you live? □Yes □No

3. In the past 2 months, have you used any form of tobacco? □Yes □No

4. In the past 2 months, have you used drugs or alcohol (including beer, wine, or mixed drinks? □Yes □No

5. In the past year, have you been threatened, hit, slapped, or kicked by anyone you know? □Yes □No

6. Has anyone forced you to perform any sexual act that you did not want to do? □Yes □No

7. On a 1-5 scale, how do you rate your current stress level? Low 1 2 3 4 5 High

8. How many times have you moved in the past 12 months? _____

9. Is this a planned pregnancy? □Yes □No
Is this a wanted pregnancy? □Yes □No

PRENATAL GENETIC SCREENING

Genetic screening includes you, the baby's father, or anyone in either family.

	Yes	No
Patient (only) is 35 years of age or older?	_____	_____
Italian,Greek, Mediterranean, or Asian background?	_____	_____
Neural tube defect (meningocele, myelomeningocele, anencephaly)?	_____	_____
Congenital heart defect?	_____	_____
Down Syndrome?	_____	_____
Jewish or French Canadian (TaySach's)?	_____	_____
Sickle Cell disease or trait?	_____	_____
Hemophilia?	_____	_____
Muscular Dystrophy?	_____	_____
Cystic Fibrosis?	_____	_____
Huntington's Chorea?	_____	_____
Mental retardation?	_____	_____
If yes, was the person tested for Fragile X?	_____	_____
Autism?	_____	_____
Other inherited genetic or chromosomal disorders?	_____	_____
More than 3 first trimester spontaneous abortions or stillbirth?	_____	_____
Do you have cats or other household pets?	_____	_____
Other significant family history?	_____	_____

Print name _____

Patient Signature_____ Date_____