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 Medical History Form

Name: _____
Date of Birth: _____
Today's Date: _____

Latex Allergy: Yes or No (please circle)

Medications and Dose (including supplements and herbs):

_____
_____
_____
_____

Allergies to Medications: _____
_____
_____

History: Please check and explain only the items that apply to you.

Genetic Disease _____
Heart Disease/Mumur _____
High Blood Pressure/Stroke _____
Seizures/Epilepsy _____
Migraines _____
Depression, Anxiety, or Psychiatric Illness _____
Lung Disease/Asthma/TB _____
Phlebitis/Pulmonary Embolism _____
Kidney Disease _____
Thyroid Disease _____
Hepatitis/Liver Disease _____
Diabetes _____
Anorexia/Bulimia _____
Cancer _____
Other Major Illnesses/Medical Problems _____

Family History: Please specify anyone in your family and indicate their relation and age at diagnosis

Breast Cancer _____
Ovarian Cancer _____
Diabetes _____
Uterine Cancer _____
Colon Cancer _____

Surgical History: Please list any surgeries you have had and when.

_____
Have you or any of your family members ever had any difficulties with anesthesia? _____

Social History: (please circle)

Do you smoke? Yes or No (# cigs/day) _____
Do you use alcoholic beverages? Yes or No (how many per week) _____
Do you use or have you used street drugs? Yes or No (which ones) _____

Gynecological History: Please explain the following.

Have you ever had an abnormal papsmear? _____
When did you get your first period? _____ How far apart are your periods? _____ How many days do you flow? _____
Flow: Light Moderate Heavy
Are you post-menopausal? _____ since when? _____
Have you ever used hormone replacement? _____
Do you get recurrent vaginal infections? _____
Have you ever been a victim of abuse? (sexual, physical or emotional) _____ Do you feel safe in your current relationship? _____
Have you had DES exposure? _____
Present Contraception _____

Date of last papsmear: _____
Date of last colonoscopy: _____
Date of last mammogram: _____
Date of last bone density: _____

Previous Pregnancies:

No:	Year	Miscarriage	Vaginal	C/Section	Labor (# of hrs)	Sex of Baby	Birth Weight
1							
2							
3							
4							

Any other pregnancy history? _____
Initials: _____

Your Family History is important to us: This information will provide an accurate Cancer Risk Assessment

Patient Name: _____ Date of Birth: _____

Instructions: Please complete the following cancer family history for **YOU and / or YOUR FAMILY**. Please list the relationship to you and age of diagnosis. The following people from your MOTHER OR FATHER'S SIDE should be considered:

Mother/Father/Sister/Brother/Children/Aunts/Uncles/Grandparent/Niece/Cousin/Great Grandparent

Have you or any of your relatives been tested for a hereditary cancer syndrome? YES NO
Have you ever been diagnosed with cancer? What site: _____ What age: ____

		COLON AND UTERINE CANCER	SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Uterine (endometrial) cancer before age 50				
Y	N	Colorectal cancer before age 50				
Y	N	2 or more uterine and colorectal cancer in the same person or on the same side of the family				
Y	N	3 or more of the following cancers: uterine, colorectal, stomach, ovarian, kidney/urinary tract, brain, small bowel, pancreas, biliary tract in the same person or on the same side of the family				

		BREAST AND OVARIAN CANCER (HBOC)	SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Breast cancer at age 50 or younger				
Y	N	Ovarian cancer at any age				
Y	N	2 Primary (unrelated) breast cancers in the same person or on same side of the family				
Y	N	3 or more Hereditary Breast & Ovarian Cancer Associated cancers-- at any age				
Y	N	Triple Negative Breast cancer				
Y	N	Male breast cancer at any age				
Y	N	Prostate or Pancreatic cancer				
Y	N	Jewish Ancestry				

		POLYPOSIS SYNDROME	SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	10 or more polyps found in a lifetime				

		HEREDITARY MELANOMA	SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Multiple Melanomas and/or Melanoma & Pancreatic cancer in the same person or on the same side of the family				

Is there any other cancer in you or any family members not listed above? If yes, please provide the family member's relationship to you, the site of their cancer and their age when they were diagnosed with cancer:

_____

Patient's signature: _____ **Today's Date:** _____

FOR OFFICE USE ONLY

- ☐ Candidate for further risk assessment &/or genetic testing
- ☐ Follow-up appointment recommended
- ☐ Patient offered genetic testing:
  - ☐ Accepted
  - ☐ Declined
  - ☐ Doesn't meet criteria for testing

_____ _____
Healthcare Professional's Signature Date