Temecula Valley OB/GYN Medical Associates, Inc.
OBSTETRICS • GYNECOLOGY • INFERTILITY

Medical Center Drive, Suite 100
Murrieta, CA 92562
(951) 677-4748 FAX (951) 677-6529

PATIENT REGISTRATION FORM

NEW PATIENT ☐ UPDATE ☐ Doctor: Account: Date:

PATIENT INFORMATION

Patient Name _____ (Last / First / Middle) Age _____ DOB _____ Sex _____

Address _____ City _____ Zip _____

Please indicate, in the boxes below, which order you would like us to contact you (1st, 2nd and 3rd choice)

☐ Home Phone # _____ ☐ Cell Phone # _____ ☐ Alternate Phone # _____

Social Security _____ Verified _____ Marital Status _____

Patient's Employer _____ Occupation _____

Local Friend or Relative Name _____ _____ (Home Phone) _____ (Work Phone)

This information **MUST** be supplied.

Emergency contact other than spouse _____ (Name) _____ (Relationship) _____ (Phone)

Would you like access to our patient portal? (To view your health records) _____ YES _____ NO

If **YES** please provide your email address _____

Please confirm your email **(print clearly)** _____

PRIMARY INSURANCE INFORMATION

Insurance Co Name _____

Subscriber Name _____ DOB _____ Relationship to PT _____

Identification No _____ Group No _____

Effective Date _____ Social Security # _____

Insured Employer _____ Work Phone _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Co Name _____

Subscriber Name _____ DOB _____ Relationship to PT _____

Identification No _____ Group No _____

Effective Date _____ Social Security # _____

Insured Employer _____ Work Phone _____

DEMOGRAPHIC QUESTIONS (FEDERALLY MANDATED THAT WE ASK BY LAW)

What do you consider your race to be? ____American Indian or Alaska Native ____Filipino ____Asian ____Caucasian ____Hispanic/Latina ____African American ____Native Hawaiian/Pacific Islander ____Other

Marital Status: ____Single ____Married ____Divorced ____Widow ____Domestic Partner ____Other

What is your preferred Language? _____

Preferred Method of contact: ____Cell ____Home ____Mail Only Decline to specify the above____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Temecula Valley OB/GYN Medical Associates, Inc. to examine and treat the above patient and will assume full responsibility for payment of all services. In the event of default, I also agree to pay for collection costs and attorney's fees that may be required to effect collection of the amount. The undersigned hereby authorizes Temecula Valley OB/GYN Medical Associates, Inc. to furnish necessary information to the involved insurance company, and further authorizes and assigns payment and surgical benefits due under the insurance policy.

Responsible Party Signature _____ Date _____

Relationship to Patient _____

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Account # _____

Acknowledgement of Having Read the HIPAA Privacy Notice Notebook

Our HIPAA Privacy Notice Notebook is in each exam room. As you are waiting for the Doctor, please read it. After you have finished, hand this signed sheet to the nurse and she will place it in your chart. Thank you.

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have read the HIPAA Privacy Notice Notebook for the medical practice of Temecula Valley OB/GYN Medical Associates, Inc. I am aware that if I would like a copy of the Privacy Notice, I can request it at the front desk.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

Temecula Valley OB/GYN
Medical Associates, Inc.

OBSTETRICS • GYNECOLOGY • INFERTILITY

PATIENT RIGHTS AND RESPONSIBILITIES

To comply with new federal regulations (HIPAA), this office has established procedures to make your identity and medical records secure. Our only use of your personal information is for billing purposes and for proper medical treatment. We must have on record, a signed acknowledgement that you have read your rights and responsibilities as patients and that you understand them. Please contact the office staff if you have any questions.

PATIENT RIGHTS

- To receive service within a reasonable period of time.
- To receive medically necessary services.
- To be treated with respect and courtesy.
- To receive all available information about your care and treatment, including risks and options.
- To have all medical and personal records treated as confidential.
- To participate in treatment decisions
- To refuse treatment.
- To receive impartial access to treatment.
- To receive a second opinion regarding any treatment plan.
- To review or to receive a copy of your medical records subject to legal restrictions and reasonable copying charges.
- To request review of your medical records by the physician, and to request corrections if necessary.
- To be given information on how to file a complaint/grievance.

Please sign and return this form to the front desk

_____
Patient's Name

_____
Date

PATIENT RESPONSIBILITIES

- Having appropriate identification, insurance membership cards, coverage stickers, etc., at the time of the appointment.
- Keeping appointments or contacting this office in advance to cancel an appointment.
- Fulfilling financial obligations at the time of service such as deductible or Co-pay fees.
- Providing complete and accurate information.
- Following the health plan you and the physician agree on.
- Being considerate of others.
- Providing legal documentation of guardianship of a minor being treated.
- Providing a list of persons who may receive medical information about you, on your behalf, in an emergency.
- If it becomes necessary to contact you by phone, do we have your permission to leave messages regarding lab results and/or appointments on your answering device, or with another person who answers the phone? ☐ YES ☐ NO
- What is the best time of day to reach you? _____
- Where do you prefer to receive calls?

  ☐ Home ☐ Work ☐ Cell

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In order for us to notify you in an expedient manner, we would like to notify you by phone with any questions, appointment confirmation calls, and any normal results that we may have.

I give Temecula Valley OB/GYN Medical Associates permission to leave a **CONFIDENTIAL** voice message on the telephone number below.

( ) -

Signed: _____ Date Signed: ____/____/____

Printed: _____ Date of Birth: ____/____/____

Witness Signature: _____ Date: ____/____/____

Temecula Valley OB/GYN
OBSTETRICS~GYNECOLOGY~INFERTILITY

25460 Medical Center Dr, 100
Murrieta, CA 92562
(951)677-4748 fax (951)677-6529

THIRD PARTY RELEASE OF INFORMATION

_____ _____

PATIENT NAME (PRINT) ACCOUNT NUMBER

I,_____, give Temecula Valley ob/gyn permission to release any and all medical/billing/and personal information including HIV results to the following…

(Example… Spouse, parent, guardian, agency, or insurance)

NAME_____ PHONE_____

NAME_____ PHONE_____

NAME_____ PHONE_____

COMPANY NAME_____ PHONE_____

I may be contacted at _____ with any questions.

_____ _____

Social Security Number Date of Birth

_____ _____

Patient Signature Today's Date

_____ _____

Witness Signature Today's Date

Joseph Glaser, MD

Debra Lebo, DO Charles Yang, MD Tammy Hayton, MD

Kendra Jones,MD Elizabeth Locascio, DO Emily Thomson, DO

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Please read the following financial policies of this office:

NOTE: YOU WILL RECEIVE A SEPARATE BILL FROM THE LABORATORY FOR ANY LABORATORY SERVICES ORDERED (I.E., PAP SMEAR, URINALYSIS, BIOPSIES, CULTURES, BLOOD WORK, ETC.). **THESE CHARGES ARE NOT INCLUDED IN OUR BILL**. IF YOUR INSURANCE COMPANY IS CONTRACTED WITH A SPECIFIC LABORATORY FOR PAP SMEARS, BLOOD WORK, ETC., YOU MUST NOTIFY US AT THE TIME OF SERVICE. YOU ARE RESPONSIBLE FOR INFORMING THE NURSE BEFORE THE END OF YOUR APPOINTMENT.

PRIVATE INSURANCE: As a courtesy, we will bill your insurance company. We will, however, collect all percentages and/or deductibles at the time of your visit. If your insurance company requires their insurance claim form be utilized, rather than the universal HCFA 1500, it will be the patient's responsibility for providing the form prior to their office visit. If such a form is unavailable, then we will collect all charges and then you will be responsible for billing your insurance company.

MEDICARE: This office will bill for all of your charges. Please show your Medicare card at the window. We ask that you pay any Medicare deductible that has not been met and your 20% Medicare co-payment at the time of your visit. You will receive an itemized bill which, when attached to the Explanation of Medicare Benefits, will provide your secondary insurance with sufficient information to process your claim. If your secondary insurance does not respond to our billing, we will transfer the remainder of the charge to you. If you find yourself having to bill your secondary again, at your request, we will assist you with any information you need.

SURGERY: The office will bill for all surgery charges. Please assign authorization of payment directly to the physician. Prior to your surgery, please make arrangements for payment of any deductibles and/or co-payments. If you are not covered by insurance, payment in full will be expected on the day of your pre-operative appointment. Please be aware that there may be an assistant fee, anesthesiologist fee, laboratory fee, and radiologist fee, etc.

PREFERRED PROVIDER ORGANIZATIONS (PPO or HMO): If you are covered by an insurance company that we are contracted with, please present your membership card at the front desk. We will bill your insurance company. Any co-payment will be expected at the time of your visit. Please be aware that a prior authorization may be necessary for your visit and must be obtained prior to your visit. Prior authorization is a requirement of many HMO's and their procedures and policies MUST be followed.

SECONDARY INSURANCE: Our office will bill your secondary insurance as long as the secondary allowable is greater than the primary allowable. Our office will bill your secondary insurance as a courtesy to you one time. If your secondary insurance does not respond to our billing, we will transfer the remainder of the charge to you. At your request, we will assist you with any information you may need to bill your secondary again.

CASH: If you do not have insurance, you will be expected to make payment at the time of service. Please stop at the front desk after each Gynecological or Obstetrical visit.

ALL OBSTETRICAL PATIENTS: An account will be established on your first visit. If you have pregnancy health insurance coverage it will not be billed until you have delivered. However, any additional fees not included in your obstetrical care, such as ultrasounds, are due and payable at the time of service. You will also be responsible for all co-payments and deductibles to be paid in full by your 30th week of pregnancy. Payment arrangements should be arranged on your first visit. If you are a member of a PPO or HMO, your co-payments will be expected at each visit, if applicable. An obstetrical contract will be generated and explained to you at check out.

If you have any questions, please feel free to stop at the front desk. We are here to help you in any way possible.

I have read the above information and understand my financial obligation to Temecula Valley OB/GYN Medical Associates, Inc.

_____ _____

Patient / Guardian Signature Date

_____ _____

Witness Date

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Consent for Testing Blood

To Detect Antibodies to the

Human Immunodeficiency Virus (HIV)

I have been informed that my blood will be tested for antibodies to the Human Immunodeficiency Virus (HIV), the probable agent of AIDS. I have been informed about the limitations and implications of the test. I have had a chance to ask questions which were answered to my satisfaction. I understand that the test's accuracy and reliability are not 100 percent certain.

I have been informed that the test is performed by withdrawing blood from my arm and testing the blood specimen.

By my signature below, I acknowledge that I have been given information concerning the benefits and risks, and that I either accept or decline to have my blood tested for antibodies to the HIV.

_____ _____
Patient Name (Please Print) Date

Accept: _____
Patient/Guardian Signature

Decline: _____
Patient/Guardian Signature

_____
Relationship to Patient

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GENETIC QUESTIONAIRE

PATIENT NAME: _____ PHYSICIAN: _____

DATE: _____ ACCOUNT: _____

These questions will help in the care of your pregnancy. Your answers may indicate whether certain tests would be helpful in evaluating the health of your unborn baby. Have you, the father of the baby, or anyone in either of your families ever had any of the following? Please specify for each "yes" (✓) answer, the problem and the relationship of the affected person to you or the baby's father.

YES	NO	FACTOR	EXPLANATION	RELATIONSHIP
		Will you be 35 years or older when the baby is due?		
		Mental retardation		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Down Syndrome or any other chromosome abnormality		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Birth defects (i.e., cleft lip or palate, limb defects)		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Spina Bifida (open spine), anencephaly, neural tube defect		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Hydrocephalus (water on the brain)		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Congenital blindness or deafness		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Blood disorders (anemia)		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Cystic Fibrosis		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Epilepsy or seizures		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Heart defects		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Hemophilia (bleeding)		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Huntington's Chorea		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Kidney problems		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Mental illness (schizophrenia or manic depression)		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Muscular Dystrophy		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Neurofibromatosis		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:
		Stillbirth		☐ Yourself ☐ Your: ☐ Baby's Father's:
		3 or more miscarriages		☐ Yourself ☐ Your: ☐ Baby's Father's:
		Birth defects or inherited disorders not listed above		☐ Yourself ☐ Baby's Father ☐ Your: ☐ Baby's Father's:

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GENETIC QUESTIONAIRE (continued)

PATIENT NAME: _____ **ACCOUNT:** _____

1. What countiries are your ancestors from originally? Please be specific (i.e., England, Africa, Vietnam)

   Mother of baby: _____ Father of baby: _____

2. Certain genetic diseases are more common in certain ethnic groups.

   a. Are either you or the father of the baby of Jewish or French Canadian ancestry? ☐ Yes ☐ No

      If yes, have you ever been tested for Tay Sach's disease? ☐ Yes ☐ No
      Please indicate by whom and the result: _____

      _____

   b. Are either you or the father of the baby of African American ancestry? ☐ Yes ☐ No

      If yes, have you been tested for sickle cell trait? ☐ Yes ☐ No
      Please indicate by whom and the result: _____

   c. Are either you or the father of the baby of African American, Asian, Middle Eastern, East Indian or Mediterranean (Greek, Italian, etc.) ancestry? ☐ Yes ☐ No

      If yes, have you been evaluated for thalassemia trait? ☐ Yes ☐ No
      Please indicate by whom and the result: _____

3. Are you and the baby's father related, such as first or second cousins? ☐ Yes ☐ No
4. Are you an insulin dependent diabetic? ☐ Yes ☐ No
5. Have you had any occurrences in this pregnancy, such as bleeding, spotting, fever or illness? ☐ Yes ☐ No

   If yes, please specify: _____

   _____

6. Have you been exposed to any X-rays during your pregnancy? ☐ Yes ☐ No

   If yes, please indicate the type of X-ray, how many and whether or not you were shielded: _____

7. Excluding prenatal vitamins, have you taken any medications or recreational drugs since your last menstrual period? ☐ Yes ☐ No

   If yes, please include medication/drug name, dosage/amount and approximate time and duration taken: _____

   _____

8. Do you smoke cigarettes? ☐ Yes ☐ No **If yes**, how many per day? _____
9. Have you used alcohol since your last mentrual period? ☐ Yes ☐ No

   If yes, please include amount and approximate time and duration used: _____

   _____

If there has been alcohol usage, drug or teratogen exposure during the pregnancy, the UCSD Teratogen Registry is available to evaluate the potential risk to the fetus. They may be contacted at (619) 294-6084.