Welcome to Virtua OBGYN Cherry Hill!

We are honored you have chosen us as your provider for your obstetrical and gynecological care. We strive to create a warm, friendly environment in which we can partner with our patients to help them achieve their healthcare goals. We are a group of specialty trained Board Certified/Board Eligible OBGYN who are dedicated to providing you with the highest quality care. Our compassionate, knowledgeable, and professional support team of medical assistants, front desk staff, and receptionists will be available to assist and guide you through your visit.

Our doctors deliver babies and perform surgeries at Virtua Hospital in Voorhees, NJ - a state of the art facility located in Southern New Jersey. Virtua has a mission of helping our patients be well, get well and stay well. We focus on making our healthcare personalized and promoting wellness for the women who entrust us with their healthcare.

We offer many comprehensive gynecologic services including annual exams and family planning. Our physicians are able to perform many office procedures and minimally invasive surgeries including robotic surgery. Also, we offer obstetric care that includes bedside ultrasound, breastfeeding support, and prenatal education classes.

We value your time, which is why we ask that you arrive at least 15 minutes before your first scheduled appointment. This allows us time to process your insurance information before your appointment, so you can be seen by the provider in a timely manner. If you need to reschedule or are unable to keep your appointment, a 24-hour notice is expected.

We understand you have many choices and appreciate you selecting our practice. Please let us know if there is anything we can do to accommodate your needs and make your experience as pleasant as possible. We look forward to caring for you.

OBGYN Health Assessment

Date: _____

Name: _____ **Date of Birth:** _____ **Gender:** _____

Preferred Phone: _____ **Home Address:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Referring Doctor: _____ **Address:** _____ **Phone:** _____

***How may we help you today*?** _____

_____

Date of Last	**Results**
Menstrual Period:	
Pap Smear:	
Mammogram:	
DEXA	

Allergies to Medications, X-Ray Dyes, Latex, Tape or Other Substances	**Reaction**

Current Medications (Prescription, Over the Counter, Vitamins, Herbs, etc.) Please bring medication bottles with you to your appointment.

Drug Name and Dose	Frequency	Drug Name and Dose	Frequency

OB History:

Delivery Date	Vaginal/ C-Section	Baby's Sex & Weight	Place of Birth	Complications	Current Health of Child

Medical History:

Please indicate if you have had problems with (**Past**), current (**Current**), or never (**Never**) any of the following:

	P	**C**	**N**		**P**	**C**	**N**		**P**	**C**	**N**		**P**	**C**	**N**
AIDS/HIV				Deep Vein Thrombosis				Hemorrhoids				Sexual Transmitted Disease			
Asthma				Eating Disorder				Hepatitis				Suicide Attempt			
Anemia				Epilepsy				High Blood Pressure				Thyroid Problems			
Anxiety				Depression				Kidney Disease				Cancer			
Bipolar Disorder				Drug Abuse				Liver Disease				Other:			
Bleeding Disorder				Heart Disease				Osteoporosis							
Bruising Easily				Heart Murmur				Pacemaker							
Diabetes															

Surgeries and Hospitalizations	**Date**

Breast History:

Have you ever had an abnormal mammogram? ☐ YES ☐ NO

If yes, when_____

Family History:

Has any member of your family (including parents, grandparents and siblings) ever had the following?

Illness	Which Family Member	Approximate Age When Diagnosed	Living or Deceased
Cancer (describe type)			
Diabetes			
Drug or Alcohol Addiction			
Heart Disease			
Hyperlipidemia			
Hypertension (high blood pressure)			
Mental Disease (anxiety, depression, etc.)			
Stroke			
Other:			

Social History: Please indicate if you have in the (**Past**), current (**Current**), or never (**Never**) any of the following:

	P	C	N	
Do you smoke?				If past or current, how many packs per day? How many years?
Do you drink alcoholic beverages?				If past or current, how much per week?
Caffeine usage?				If past or current, how many cups per day?

Birth Control History:

What birth control method do you currently use?					
	Condoms		IUD		Sterilization
	Pills		Implant		Vasectomy
	Patch		Ring		None
	Depo-Provera		Rhythm		Other:

Are you interested in switching to any of the following?					
	Condoms		IUD		Sterilization
	Pills		Implant		Vasectomy
	Patch		Ring		None
	Depo-Provera		Rhythm		Other:

Sexual History	Yes	No	
Are you sexually active?			If no, when was the last time?
Have you ever engaged in any activity that has put you at risk of getting a sexually transmitted disease?			If yes, explain:
Do you wish to be tested for a sexually transmitted disease?			
Have you ever had a sexually transmitted infection?			If so, which one?
Are past/current partners men?			
Are past/current partners women?			

Menstrual History:

Age of first period _____

How long does your menstrual cycle last? _____

How frequent? ☐ Regular (28-40 days) ☐ Irregular (<21 days or >41 days)

Do you have any associated symptoms?

SYMPTOMS	Yes	No
Bloating		
Nausea		
Mood Swings		
Heavy Bleeding		
Hot flashes/Night Sweats		

Pap History

Have you ever had any abnormal pap smear? ☐ YES ☐ NO

If yes, what was the diagnosis? _____

Prevention	Yes	No	
Do you wear seat belts?			If no, why not?
Do you wear a bike helmet?			
If there is a gun in your home, do you keep it unloaded and out of children's reach?			
Do you feel safe at home?			
Do you have smoke/carbon monoxide detectors in your home?			

Review of Medical Symptoms:

Please indicate if you have had problems with (**P**ast), current within the past 30 days (**C**urrent), or never (**Never**) any of the following:

	P	C	N		P	C	N		P	C	N		P	C	N
Unexpected Weight Change				Chest pain				Heat Intolerance				Pain with Urination			
Fatigue				Leg Swelling				Cold Intolerance				Seizures			
Change in appetite				Abdominal Pain				Vaginal Discharge/Odor				Weakness			
Change in vision				Constipation				Vaginal Irritation				Anxiety			
Headaches				Diarrhea				Vaginal Bleeding				Depression			
Shortness of Breath				Vomiting				Urinating Often				Problems Sleeping			
Cough				Nausea				Pelvic Pain				Mood Swings			
Wheezing				Blood in Stool				Blood in Urine				Other:			

I CERTIFY THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY DOCTOR OR ANY MEMBERS OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

Patient Signature _____ Date _____

Review By _____ Date _____

Virtua Health

ACKNOWLEDGEMENT OF RECEIPT FORM

Health Insurance Portability and Accountability Act, [HIPAA]

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name_____**Date of Birth:** _____
(Please Print)

By signing below, I acknowledge receipt of or the opportunity to review the Notice of Privacy Practices of Virtua Medical Group. In addition, by signing below, I authorize Virtua Medical Group to disclose my health information in conformance with the provisions of the Notice of Privacy Practices.

Signature:_____**Date:** _____

Phone Authorization

____Yes, you have my permission to leave medical information on my answering machine. Please let us know which daytime telephone number is best to do so.

( )_____**.**

_____No, you do not have my permission to leave medical information on my answering machine.

To whom, other than yourself, may we speak regarding your medical condition?

Name_____**Relationship** _____

Phone# _____

Name_____**Relationship** _____

Phone# _____

I have the right to withdraw or revise my permission at any time in writing.

Signature:_____**Date:** _____

For Office Use Only:

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, indicate the reason why the acknowledgement was not obtained.

_____Individual refused to sign.

_____An emergency situation prevented us from obtaining the acknowledgement.

Signature of Virtua Representative: _____

Virtua Medical Group

PATIENT CONSENT

Name: _____ **Date of Birth:** _____

I am either the patient who is seeking treatment or I am the person who is authorized to seek treatment for the patient. I consent to medical treatment and diagnostic procedures as provided by Virtua, its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination at Virtua

MEDICARE

I request that payment of authorized Medicare benefits be made to either me or on my behalf to Virtua Health for any services furnished to me by their physicians. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I assign to Virtua, and/or a Virtua based healthcare professional, all of my right, title and interest to medical and/or automobile insurance benefits and all other rights and benefits otherwise payable to me for those services provided at Virtua and/or by a Virtua based healthcare professional. I understand that Virtua may not be obligated to accept this assignment as payment in full. If my insuring company or agency refuses to pay any charges on the bill for whatever reason, I agree to be responsible for payment of fees, charges and costs associated with this Virtua service to the extent allowed by Law. If my insurer refuses to make payment to Virtua who provides care to me, I give my consent to Virtua who provided care to me to appeal the denial of payment. I give consent to access all of my electronic medication information in connection with providing a list of current medications.

GENERAL

RELEASE OF INFORMATION

Virtua may disclose any or all parts of my clinical records to any insurance company or companies, or in the case of Worker's Comp claims, to my past or present employer(s), for purposes of satisfying charges billed by Virtua Health. I agree, in order for Virtua to service my account to collect any amounts owed, Virtua and its affiliates, may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Virtua and its affiliates, may also contact me by sending text messages or e-mails, using any email address you provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I give consent to access all of my electronic medication information in connection with providing a list of current medications. I give consent to access all of my electronic immunization information in connection with providing my complete list of vaccinations.

GUARANTEE OF ACCOUNT

For and in consideration of services rendered by Virtua Health to the below and named patient, the undersigned (jointly and several if more than one) guarantee payment of all charges incurred by all said patient in accordance with the policy of payment of such bills.

PATIENT BILL OF RIGHTS

- The patient Bill of Rights has been made available for me to review.
- The Health Information Exchange brochure has been made available for my review.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS

_____	_____	_____
Patient Signature	**Patients Agents Representative/Guarantor Signature**	**Date**

ACKNOWLEGEMENT OF FINANCIAL RESPONSIBILITY

PATIENT NAME _____ DATE _____

REGISTRATION # _____ MEDICAL RECORD # _____

Welcome to Virtua Health. You are here to receive outpatient services requested by your physician. Depending upon the type of health insurance coverage you have and the requirements of your insurance plan, you may have a personal responsibility for all, part, or none of the cost of these outpatient services.

Most insurance plans (HMO's, managed care plans, indemnity plans, etc.) require you to obtain and present to us BEFORE services are rendered, a pre-authorization or referral form. If that is the case and you do not present this information to us, your insurance plan may not pay some of all of the cost of the services it would ordinarily pay on your behalf and it will be your personal responsibility to pay these costs. IT IS YOUR RESPONSIBILITY TO KNOW WHETHER YOUR INSURANCE PLAN REQUIRES YOU TO PROVIDE US WITH A PRE-AUTHORIZATION OR REFERRAL FORM OR CAPITATED SITE REQUIREMENTS.

Check all that apply	Patient Initials	
☐	_____	Virtua Health is not a participating provider for _____
☐	_____	Services have not been authorized
☐	_____	Release of medical information has not been signed
☐	_____	Medical necessity has not been determined
☐	_____	No Primary Care Physician referral
☐	_____	Patient requesting insurance billed for denial
☐	_____	Other (CAPITATED LAB / RADIOLOGY SITE FORMS) _____

If you cannot reach your physician's office to obtain the required pre-authorization or referral form or for any other reason, you have the following choices:

1. You may reschedule your appointment until such time as the required information is obtained; or
2. You may choose to receive the services at this time and attempt to have the required information delivered to us as soon as possible, but not later than three (3) business days from today.

PLEASE BE AWARE THAT IF YOU SELECT OPTION #2, YOUR INSURANCE PLAN MAY DECLINE TO PAY ALL OR PART OF THE COSTS IT WOULD HAVE PAID IF YOU HAD SELECTED OPTION #1. YOU WILL BE PERSONALLY RESPONSIBLE FOR THESE COSTS.

PLEASE INDICATE IF YOU SELECT OPTION #1 OR OPTION #2 BY CIRCLING YOUR CHOICE AND SIGNING YOUR NAME BELOW:

_____ _____

Signature of Patient / Legal Representative Virtua Health Representative

Virtua Health

Authorization to Release Health Information

1. Patient Information

Patient's Full Name _____ Date of Birth _____

Patient's Address _____ Patient's Home Phone Number _____

City, State _____ Zip Code _____ Patient's Work Phone Number _____

2. Health Information Release Instructions

Information to be released **FROM**:

Practice / Physician's Name _____

Address _____

City, State _____ Zip _____ Telephone _____

Information to be sent **TO**:

Name (Patient / Practice / Company) _____

Address _____

City, State _____ Zip _____ Telephone _____

3. Authorization

I, _____, do hereby authorize _____ to release my "Health Information", as defined below: (check one)

1) _____ Routine: 2 years of progress notes, 1 year of other records including testing results

2) _____ Only Medical Records pertaining to _____
List conditions, treatments or type of medical records

3) _____ All Medical Records, Or All Medical Records from _____ (Date) through _____ (Date)

4) _____ All Medical Records **EXCEPT** _____
List Exceptions

NOTICE: Unless excluded above, this Authorization is for FULL DISCLOSURE of ALL RECORDS. I acknowledge that such information may include the testing, diagnosis and /or treatment of HIV, AIDS, sexually transmitted diseases, mental health/psychiatric care, genetic information and/or substance abuse.

4. Purpose of Information Release

Insurance Change	Moving; transferring	Other _____
Disability Determination	Workers Compensation	Personal Injury

5. Health Information

This Authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this Authorization. Unless otherwise revoked, this Authorization will expire ninety (90) days from the date signed below. This Authorization is fully understood and is made voluntarily on my part. I acknowledge that once my health information has been released, it may be subject to re-release by the recipient and no longer protected. Virtua may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure, except in certain circumstances. For example, if the purpose of a test or exam is to produce a record for my employment, I may be required to complete this authorization form before the test or exam is performed

SIGNATURE: ☐ **Patient** ☐ **Parent** ☐ **Other** _____ **Date** _____ **Witness** _____ **Date** _____

If **OTHER** is checked above, state relationship: _____

Copy Charge Notification*:* There may be a charge for copying medical records as most offices utilize an outside copy service. Please contact the office you are requesting records from for details.

Medium Source: ☐ Paper ☐ Electronic (if left blank, paper copies will be released)

☐ **I am also requesting records from another VMG Practice** _____

ANNUAL GYN VISIT

Dear Patient

You are scheduled for your annual Women's Wellness Exam with one of our provider's.

This annual exam (termed Preventative Medical Service) is conducted for a patient that presents with no symptoms or problems.

If an abnormality is encountered, or a pre-existing problem is addressed in the process of performing this preventative medical evaluation and medical services are provided, an additional office visit procedure code 99201-99215 will also be reported to your insurance carrier. This would be reported in addition to the appropriate preventative medical service.

If an additional procedure code is used, you may be responsible for an additional co-payment or deductible. Our office will help in making a determination regarding co-pays and deductibles at the end of your encounter and collect any applicable payment. However, our billing department may not know how your insurer deals with additional coding until after an explanation of benefits is produced and our office has a chance to review it. You may eventually get an additional bill.

An insignificant or trivial problem or abnormality which does not require additional work will not be reported as a separate charge to you or your insurance carrier. However, for instance if a problem is encountered that involves additional services (including minor surgical procedure) and you elect to just have the problem addressed at this visit, we would be happy to reschedule your annual women's wellness exam to a later date.

We apologize for any inconvenience this may cause.

By signing this notification, I verify that I have read the above, and any questions have been answered to my satisfaction. I understand that payment may be due prior to my departure from this office.

_____ _____

Patient Signature Date

_____ _____

Review by Date