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Physicians Board Certified by
American College of
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Downtown
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105 W. 8th Ave, Ste 6060
Spokane, WA 99204
Phone (509) 838-4211
Fax (509) 838-6432

Valley
Valley Mission Professional Center
12509 E. Mission Ave, Ste 201
Spokane Valley, WA 99216
Phone (509) 928-2866
Fax (509) 838-6432

www.spokaneobgyn.com

Welcome to Spokane OBGYN

Thank you for choosing Spokane OB/GYN for your health care. Visit our website at www.spokaneobgyn.com to read about each of our providers and the services we offer our patients, and for directions to each location. Our mission is to provide complete care in a compassionate and individual manner.

Enclosed is the paperwork you will need to complete prior to your visit. Please check in with your completed paperwork 15 minutes early, which will allow us time to enter the information into your chart. If another physician has referred you, we will need your records before your scheduled appointment. Contact your referring provider to have your records faxed to our office.

IMPORTANT:

- Please bring both your insurance card and picture I.D. which will be scanned into your chart.
- Co-pay is due at the time of service.
- Preventative care: At times, patients request additional services which fall outside of the preventative visit (pap, pelvic, breast exam) and additional charges including co-pays and deductibles may apply.

Please check in at: ______________________________

Your appointment is scheduled on: ________________

Spokane OBGYN

Patient Information

Date: ___________________

Patient's Name: ____ Maiden Name: ______________________
First MI Last

If Child, Parent's Name: ____

Date of Birth: ___________________________ Age: _________ SSN: ____________________________________

Address: ____ Apt # __________________________

City: ______________________________ State: _________________ Zip: _____________________________

Home #: _______________________ Cell #: ____________________________ Work #:______________________

Can we leave a message on your phone? Home: Detailed or Brief Cell: Detailed or Brief

E-mail address: ____

Would you like emailed appointment reminders and access to your records via our patient portal? ___Yes ___No

What is your primary language: ____

Do you have any special needs? __ Language __ Mobility __ Other, please list ____________________________

Race: __ American Indian or Alaska Native __ Asian __ Native Hawaiian or Other Pacific Islander

__ White/Caucasian __ Black or African American __ Multiracial __ Other:__________________________

Ethnicity: __ Hispanic __Non-Hispanic __ Refuse to report

Check appropriate box: ___Minor ___Single ___Married

What pharmacy do you use most often? Name: ______________________________ Location:_______________

Are you a student? __ Yes __ No __ Full time __ Part time

Your Occupation: ________________________________ Employer: _____________________________________

Whom may we thank for referring you? ____

Please give name of your Primary Care Physician: ____

- -

Do you have medical insurance? ___Yes ___No

Name of insured: ____________________________ Relationship to Patient: ______________ DOB: _____________

Insurance Company: ____ Effective Date: _________________________

Subscriber Number: _________________________________Group Number: ___________________________________

- -

Do you have additional insurance? ___Yes ___No

Name of insured: ____________________________ Relationship to Patient: ______________ DOB: _____________

Insurance Company: ____ Effective Date: _________________________

Subscriber Number: _________________________________Group Number: ___________________________________

- -

Spouse/Partner's name: ______________________________ DOB: ______________ SSN: _____________________

Spouse/Partner's Occupation: ____________________ Employer: __________________ Phone: ________________

Who may we contact in case of an emergency? Name __________________________ Phone: ________________

Signature of patient or parent of minor: ____ Date: _______________

HIPAA Notice of Privacy Practices

Spokane Obstetrics & Gynecology, PS

Effective Date: September 23, 2013

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give this Notice of our legal duties and privacy practices with respect to health information about you
- Follow the terms of the Notice that is currently in effect
- Notify you if we become aware of a breach

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- Business Associates
- Notification of family and others
- As required by law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law Enforcement
- Research
- Coroners, Health Examiners, Correctional Institutions and Funeral Directors
- National Security and Intelligence activities
- Protective Services for the President and others

Your rights regarding Health Information about you:

- Right to Inspect and copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to cancel or revoke prior authorization
- Right to a Paper copy of the Notice (full Notice is available upon request)

Changes to this Notice: We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the current effective date.

Complaints: If you believe that your privacy rights have been violated, you may file a complaint with us. All complains must be in writing. Please contact Patty Kollenborn, Practice Manager to file a complaint.

Acknowledgement of Receipt of this Notice: We will request that you sign this form acknowledging you have received a copy of this Notice. This acknowledgement will become part of your records.

Signature:____ **Date:**______________________

Patient Information

First Name: ________________________________ Middle Initial: _______ Last Name: _____________________________
Date of Birth: _______/_______/__________ Age: ________ Cell Phone: __________________________________
Email Address: ____
Pharmacy: _______________________________________
Name of Primary Care Physician: ____

Reason for Visit: ____

Health Maintenance History

- Current Contraceptive Method:____________________________ Vasectomy:_____ Other:_______________
- Last Pap smear:____
- Last Menstrual Period:____
- Last Mammogram:____
- Last Bone Scan:____

Medications

Please list all medications or treatments you are currently taking. Include over-the-counter or herbal drugs.

Medication	Dosage	Frequency	Reason

Past Medical History

Please answer yes/no to the following questions. Please specify below with further details.

1. ____
2. ____

Condition	Yes	No	Condition	Yes	No
Thyroid Disease			**Kidney/Bladder Disease** (stones)		
Heart Disease			**Diabetes**		
Hypertension			**Gallbladder Disease**		
Lung Disease (asthma, COPD)			**Cancer** (type)		
Anemia			**Psychological** (depression)		
Blood Transfusions			**Liver Disease** (hepatitis)		
Blood clots, phlebitis			**Gastrointestinal** (ulcer, colitis)		
Migraine Headaches			**Rectal** (constipation, diarrhea)		
Urinary (involuntary loss of urine)			**Neurological** (stroke, epilepsy)		
Autoimmune (lupus, diabetes)			**Musculoskeletal** (MS, fibromyalgia)		

Allergies

- Medications? ____Yes ____No Specify:______________________________
- Iodine or Seafood? ____Yes ____No ____________________________________
- Latex? ____Yes ____No ____________________________________
- Peanut? ____Yes ____No ____________________________________

Past Surgical History

Please list all major surgeries or hospitalizations in the table below.

	Month/Year	Procedure	Reason
1			
2			
3			
4			
5			

PLEASE SEE REVERSE SIDE

Gynecologic History

Condition	Yes	No	Condition	Yes	No
Yeast Infection			Colposcopy (procedure of cervix)		
Bacterial Infection			Cone Biopsy of cervix (LEEP)		
Chlamydia			Endometriosis		
Gonorrhea			Ovarian Cysts		
Syphilis			Uterine/Ovarian Cancer		
HSV (Herpes)			Hysterectomy		
HPV (genital warts)			Tubal Ligation		
Abnormal Pap Smear			Vasectomy		

Obstetrical History

PLEASE LIST ALL PREGNANCIES INCLUDING MISCARRIAGES AND TERMINATIONS

	Date	Gest Weeks	Length of Labor	Type of Delivery	Sex M/F	Birth Weight	Place of Delivery	Preterm Y/N	Complications
1									
2									
3									
4									

Family Medical History

Are there any genetic diseases that run in your family? ___Yes ___No Please specify below with further details.

1.____

2.____

Medical Problems	You	Parents		Siblings		Maternal		Paternal		Child
		Mth	Fth	Sister	Broth	GF	GM	GF	GM	
Heart Disease										
Diabetes										
Hypertension										
High Cholesterol										
Stroke										
Neurologic Disorder (Seizure/Alzheimer's, Huntington's)										
Bleeding Disorders (Factor V Leiden)										
Cancer:										
• Breast										
• Uterine										
• Ovarian										
• Cervical										
• Colon										
Thyroid Disease										
Kidney Disease										
Liver Disease										
Endocrine (adrenal, thyroid, parathyroid)										
Birth Defects (cleft lip)										
Psychological Disorders (bipolar, schizophrenia)										
Other Genetic Disorders (Tay-Sachs, cystic fibrosis, sickle cell anemia, PKU, Canavan disease, Down's)										
Autoimmune Disorders (Lupus)										

Social History

	Never	Yes	List amount/type and frequency
Alcohol			
Tobacco			
Drug Use			
Exercise			

- **Occupation:** ____
- **Marital Status:** _____ Single _____Married _____Divorced _____Widowed

Spokane OBGYN

Financial Policy and Agreement

To help you understand our financial terms, we ask that you carefully read and sign this policy and agreement. A copy will be provided for your needs. Our office hours are Monday-Friday 8:00 am to 5:00 pm to answer any questions you may have.

Patient Information: At each visit, please provide us any changes to your name, address, phone number or insurance coverage.

Insurance: We will bill your services to your insurance company. We file claims to most major insurance companies if you provide us with your insurance identification card. While every effort is made to collect from the insurance company, patients are responsible for denied charges, non-covered services and charges denied due to inaccurate or lack of current information. Please contact your insurance company for verification of coverage, preferred provider information, co-pay and referral information. Co-pays are due at the time of service. Balances after insurance are due and payable; if payment cannot be made in full, please call our bookkeeping department at 838-4211 for the Downtown office or 928-2866 for the Valley office to discuss other payment options. If your account becomes delinquent, you may be discharged from the practice until account is paid in full. Special circumstances will be reviewed and every effort will be made to help you settle your account in a timely matter.

Private Pay: If you have no insurance you will be required to pay in full at the time of service. If you are not able to pay in full please speak to our bookkeeping department to discuss other options. We accept Visa and Master Card. You may also pay over the phone with a statement.

Returned Check: A fee of $25.00 will be charged for any returned checks.

Lab fees: We use PAML or InCyte, if your labs need to go to a different lab please let our staff know. For billing questions on lab work, pap smears, or pathology please call the appropriate facility.

Surgery: We will review your insurance benefits and coverage. Your portion of the procedure is due at the pre-op appointment.

Elective Services: All elective services including infertility, elective surgical procedures and other services not covered by insurance are due at the pre-op or time of service.

Obstetric Services: Your routine OB visits, labor and delivery and post partum care (global maternity) is billed at the time of delivery unless there is a change in service or insurance coverage. You will be billed at the time of service for problem visits, non-stress tests, ultrasounds, and labs. A staff member will go over your benefits at the beginning of your pregnancy. Your responsibility is due by the 8th month of pregnancy. If you have an HSA or FLEX Spending account please contact the bookkeeping department.

Refunds: If you receive a refund from our office the check needs to be cashed within 90 days or it will be voided and sent to the State for unclaimed property.

Insurance Assignment Authorization: I request payment of authorized insurance benefits be made on my behalf to Spokane OBGYN for medical services I receive. I authorize Spokane OBGYN and its agents to release my personal medical information to my insurance company and its agents for determination of benefits payable for related services.

I have read and understand the Financial Policy and Agreement

____

Patient Signature   Date

____

Print Patient Name   Date of Birth

Authorizations to verbally release health care information

I,_____________________________________, ____________________ authorize the Providers and Staff of
Name DOB
Spokane OBGYN to verbally release/discuss my health and medical information to:

Name	DOB	Relationship	Phone #
Name	DOB	Relationship	Phone #
Name	DOB	Relationship	Phone #
Name	DOB	Relationship	Phone #
Name	DOB	Relationship	Phone #

I **DO NOT** AUTHORIZE THE FOLLOWING INFORMATION TO BE SHARED:
__________ Drug and/or alcohol abuse treatment
__________ HIV (AIDS) testing/treatment
__________ Psychiatric
__________ Sexually transmitted disease

I choose to have this authorization expire:
__________ No expiration date __________ 1 year __________ Following event or condition

Specify: ______________________________

I understand that I can revoke, update or change this form at any time in writing. The termination of this authorization to release Protected Health Information is effective on the date that the physician office receives it. It does not apply to any information released prior to the date of receipt of the written termination.

Signature ______________________________ Date ______________