Initial GYN Visit Packet

- **Patient copies of post-op instructions are on top of the packet.**
- **If more than one page, staple them together and place one patient label on the first page only.**
- **No need to hole punch patient copies of post-op instructions. Just place instructions inside the chart.**

Pelosi Medical Center

PATIENT INFORMATION UPDATE

(Please Print) Date: ____ /___/___

Last Name: First Name: MI:

Preferred: Maiden: Miss/Ms/Mrs/Mr

Birthdate: / / Social Security #: - - Race:

Marital Status: ___Divorced ___Married ___Single ___Widowed ___Separated

Driver's License #:

Primary Language: Religion:

Address:

City: State: Zip code:

Phone Home: ( ) - Primary Work: ( ) - Cell: ( ) -

Employer Name: Employer Address:

Occupation:

Email Address:

Preferred method in which we may contact you: ☐ Email ☐ Voicemail ☐ Text Message

Preferred Pharmacy: Address: Tel #:

Do you have an Advance Directive? ☐ Yes ☐ No If yes, do you have a Proxy Directive? ☐ Yes ☐ No

If yes, name of Proxy (Healthcare Representative): _____

Do you have an Instruction Directive? ☐ Yes ☐ No

VISIT INFORMATION

Why have you come to the office today?

GYNECOLOGIC: ☐ Annual exam ☐ Problem visit If you are here for a problem visit, please explain:

_____

COSMETIC: ☐ Cosmetic Consultation ☐ Cosmetic Procedure

PELOSI MEDICAL CENTER

PATIENT FINANCIAL AGREEMENT

Attachment 17.43(a)

I understand that, for services rendered by Dr. Pelosi II/III or the Staff of Pelosi Medical Center, my insurance carrier will be billed initially; however, I am responsible for the balance of the charges, or in the event that the insurance does not cover these charges, the total balance. If I am covered by an HMO or insurance plan in which Dr. Pelosi II/III is a participating provider, the insurance company's payment shall be regarded as payment in full, assuming all deductibles and co-payments have been met.

I understand that these charges are for services rendered by Dr. Pelosi II/III or his staff only and do not include the charges of other physicians, such as anesthesia, surgical assistants or consultants that may be necessary for my proper care. Nor does this include hospital charges. In addition, it is possible that at the time of surgery, additional procedures may be found necessary, and I may be charged for these services.

Additionally, I understand that many insurance companies require preauthorization and/or referrals for the hospital and that Dr. Pelosi II/III and their staff will fulfill their obligation to obtain these referrals and preauthorization. I may need to go to my primary care physician's office to pick up these referral forms and bring them to Pelosi Medical Center. I agree to cooperate in providing any necessary information and completing any forms which the insurance company requires for the successful processing of the insurance claim.

I understand that if I do not complete a necessary form or respond to an inquiry by the insurance company regarding the processing of this claim that such action may result in the non-payment of the claim by the insurance company. Under these circumstances responsibility for payment of this claim will be placed solely upon me.

I understand that if forwarding of this debt to a collection attorney becomes necessary for the collection of this debt, all reasonable legal and collection fees may be added to my bill and become my responsibility. This fee may be 35% or more of the outstanding medical bill. In addition, interest may begin to accrue on the outstanding bill.

Release of Information: **Init _____**

I hereby authorize the supplier to release any information required to process this claim.

Assignment of Benefits: **Init** _____

I acknowledge receipt of medical services and authorize the release of any medical information necessary to process this claim for health care payment only. I authorize payment directly to the provider.

PRINT NAME: _____

SIGNATURE: _____ DATE: ___/____/____

Patient ID

Pelosi Medical Center

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Policy Attachment 06.09(a)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA'), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Pelosi Medical Center has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the Center at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____ Signature: _____ Date: _____

Family members or others you authorize us to discuss your protected health information with:

Last Name: _____ First Name: _____

Tel #: _____ ☐ Spouse ☐ Son/Daughter ☐ Parent ☐ Other, specify _____

Last Name: _____ First Name: _____

Tel #: _____ ☐ Spouse ☐ Son/Daughter ☐ Parent ☐ Other, specify _____

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices but was unable to do so as documented below:

Reason:

_____

_____

Date: _____ Initials:_____

Pelosi Medical Center

PATIENT HISTORY

TODAY'S DATE: ___/___/___

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

PAST MEDICAL HISTORY

MAJOR ILLNESS	YES (DATE)	NO	NOT SURE
AIDS			
ANEMIA			
ANXIETY			
ARTHRITIS			
ASTHMA			
AUTOIMMUNE DISEASE (LUPUS)			
BLEEDING DISORDERS			
BLOOD CLOTS IN LUNGS OR LEGS			
BLOOD TRANSFUSIONS			
BOWEL PROBLEMS			
BROKEN BONES			
CANCER			
CATARACTS			
CHICKENPOX			
CONVULSIONS / SEIZURES / EPILEPSY			
DES EXPOSURE			
DIABETES			
EATING DISORDERS			
FIBROIDS			

MAJOR ILLNESS	YES (DATE)	NO	NOT SURE
GALL BLADDER DISEASE			
GLAUCOMA			
HEADACHES			
HEART DISEASE			
HEPATITIS			
HIATAL HERNIA / REFLUX			
HIGH BLOOD PRESSURE			
INFERTILITY			
KIDNEY INFECTIONS			
KIDNEY STONES			
LIVER DISEASE			
LUNG DISEASE			
PNEUMONIA			
SEXUALLY TRANSMITTED DISEASE			
STROKE			
THYROID DISEASE			
TUBERCULOSIS			
ULCER			
OTHER			

PAST SURGERIES (INCLUDING COSMETIC SURGERY)

NAME OF OPERATION	DATE

NAME OF OPERATION	DATE

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, and nonprescription medications)

DRUG NAME & DOSE	WHO PRESCRIBED

DRUG NAME & DOSE	WHO PRESCRIBED

ALLERGIES & SENSITIVITIES (FOOD, MEDICATION, & ENVIRONMENTAL)

ALLERGY/SENSITIVITY	TYPE OF REACTION
☐ NO KNOWN ALLERGIES OR SENSITIVITIES	

Pelosi Medical Center

PATIENT HISTORY

FAMILY HISTORY

ILLNESS	YES	WHICH RELATIVE(S) (mother, father, grandmother, grandfather, sister, or brother)	AGE OF ONSET
ALCOHOL PROBLEMS			
ALZHEIMER'S DISEASE			
BIRTH DEFECTS			
BLOOD CLOTS IN LUNGS OR LEGS			
CANCER TYPE: _____			
DIABETES			
DRUG PROBLEMS			
HEART DISEASE			
HEPATITIS			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
HIV/AIDS			
MENTAL ILLNESS/DEPRESSION			
OSTEOPOROSIS (WEAK BONES)			
STROKE			
TUBERCULOSIS			
OTHER			

MENSTRUAL HISTORY

AGE PERIODS BEGAN:
CYCLE INTERVAL: DAYS
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING): DAYS
FLOW: ____ LIGHT _____ MEDIUM _____ HEAVY
LAST NORMAL PERIOD (FIRST DAY): / /
HOME PREGNANCY TEST: ____ POSITIVE ____ NEGATIVE _____ TEST NOT DONE
MENOPAUSE STATUS: ____ PRE MENOPAUSAL ____ PERI MENOPAUSAL ___ POST MENOPAUSAL
AGE OF MENOPAUSE: YEARS
PRESENT METHOD OF BIRTH CONTROL:
DO YOU HAVE BREAKTHROUGH BLEEDING?
ARE YOU TAKING HORMONAL REPLACEMENT MEDICATIONS?

PREGNANCY HISTORY

TOTAL PREGNANCIES:	
TOTAL LIVE BIRTHS (Full Term):	
TOTAL MISCARRIAGES (Ab Spontaneous):	MISCARRIAGES OCCURRED IN ____1ST ____2ND ____3RD TRIMESTER
TOTAL TERMINATION OF PREGNANCIES:	

Pelosi Medical Center

PATIENT HISTORY

SOCIAL HISTORY

	NEVER	CURRENT	FORMER	AGE STARTED	AGE STOPPED	AMOUNT USED/DAY
SUBSTANCE USE						
ALCOHOL						
CAFFEINE						
COCAINE						
INHALANTS						
IV DRUG ABUSE						
MARIJUANA						
NARCOTICS						
OTHER SUBSTANCE ABUSE						
STIMULANTS						
TOBACCO						

OCCUPATION
☐ DESK JOB, MOSTLY
☐ HEALTH CARE PROFESSIONAL
☐ PHYSICAL JOB, MOSTLY

INFECTION RISK		
	EXPOSED TO	**POSSIBLY EXPOSED TO:**
GENITAL HERPES		
GONORRHEA		
HEPATITIS B		
HIV		
SYPHILIS		
TUBERCULOSIS		

INFECTION RISK		
	YES	**NO**
HISTORY OF BLOOD TRANSFUSION:		
HAVE YOU EVER HAD SEXUAL RELATIONS		
HISTORY OF SEXUALLY TRANSMITTED DISEASE:		
MULTIPLE SEXUAL PARTNERS:		
NEW SEXUAL PARTNER:		
NO KNOWN INFECTION RISK		

EXERCISE
☐ ACTIVE BUT NO FORMAL EXERCISE
☐ MINIMAL AMOUNT OF EXERCISE (ONCE PER WEEK OR LESS)
☐ MODERATE AMOUNT OF EXERCISE (1 - 3 TIMES PER WEEK)
☐ HEAVY AMOUNT OF EXERCISE (4 OR MORE TIMES PER WEEK)
☐ SEDENTARY

DOMESTIC VIOLENCE
☐ HISTORY OF EMOTIONAL ABUSE BY SPOUSE/PARTNER
☐ HISTORY OF PHYSICAL ABUSE BY SPOUSE/PARTNER
☐ REPORTED ABUSE TO LOCAL AUTHORITIES
☐ TRAUMA SECONDARY TO ABUSE
☐ TRAUMA SECONDARY TO ABUSE, WITH HOSPITALIZATION
☐ TRAUMA SECONDARY TO ABUSE, WITH SURGERY

Pelosi Medical Center

PATIENT HISTORY

REVIEW OF SYSTEMS

Please check (x) if any of the following symptoms apply to you now or since adulthood

	NOW	PAST
1. CONSTITUTIONAL		
CHANGE IN HEIGHT		
FATIGUE		
FEVER		
WEIGHT GAIN		
WEIGHT LOSS		
2. EYES		
DOUBLE VISION		
SPOTS BEFORE EYES		
VISION CHANGES		
GLASSES/CONTACTS		
3. EAR, NOSE, & THROAT		
EAR ACHES		
RINGING IN EARS		
HEARING PROBLEMS		
SINUS PROBLEMS		
SORE THROAT		
MOUTH SORES		
DENTAL PROBLEMS		
4. CARDIOVASCULAR		
CHEST PAIN OR PRESSURE		
DIFFICULTY BREATHING ON EXERTION		
SWELLING OF LEGS		
RAPID OR IRREGULAR HEARTBEAT		
5. RESPIRATORY		
PAINFUL BREATHING		
WHEEZING		
SPITTING UP BLOOD		
SHORTNESS OF BREATH		
CHRONIC COUGH		
5. GASTROINTESTINAL		
FREQUENT DIARRHEA		
BLOODY STOOL		
NAUSEA/VOMITING/INDIGESTION		
CONSTIPATION		
INVOLUNTARY LOSS OF GAS OR STOOL		
7. GENITOURINARY		
BLOOD IN URINE		
PAIN WITH URINATION		
STRONG URGENCY TO URINATE		
FREQUENT URINATION		
INCOMPLETE EMPTYING		
INVOLUNTARY/UNINTENDED URINE LOSS		
URINE LOSS WHEN COUGHING OR LIFTING		
ABNORMAL BLEEDING		

	NOW	PAST
FEMALES:		
PAINFUL PERIODS (females)		
PREMENSTRUAL SYNDROME (PMS)		
PAINFUL INTERCOURSE		
ABNORMAL VAGINAL DISCHARGE		
8. MUSCULOSKELETAL		
MUSCLE WEAKNESS		
JOINT PAIN		
MUSCLE PAIN		
9. SKIN		
RASH		
SORES		
DRY SKIN		
MOLES (GROWTH OR CHANGES)		
10. BREASTS (Females)		
PAIN/TENDERNESS IN BREAST		
NIPPLE DISCHARGE		
LUMPS		
ABNORMAL CHANGE IN BREAST SIZE		
11. NEUROLOGIC		
DIZZINESS		
SEIZURES		
NUMBNESS OR TINGLING		
TROUBLE WALKING		
MEMORY PROBLEMS		
FREQUENT HEADACHES		
12. PSYCHIATRIC		
DEPRESSION OR FREQUENT CRYING		
ANXIETY		
13. ENDOCRINE		
HAIR LOSS		
HEAT INTOLERANCE		
COLD INTOLERANCE		
ABNORMAL THIRST		
HOT FLASHES		
14. HEMATOLOGIC		
FREQUENT BRUISES		
EASY BLEEDING		
ENLARGED LYMPH NODES (GLANDS)		
15. ALLERGIC/IMMUNOLOGIC		
SINUS ALLERGY SYMPTOMS		
ALLERGIC DERMATITIS		

FORM COMPLETED BY: ☐ PATIENT ☐ OFFICE MED ASST ☐ OTHER

PATIENT SIGNATURE: _____

Pelosi Medical Center

Female Health Assessment Questionnaire

NAME: _____

TODAY'S DATE: ___/___/___ **PHONE:** _____ **EMAIL:** _____

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sleep Problems (difficulty falling asleep or sleeping through the night)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	☐	☐	☐	☐	☐
Decline in drive or interest (loss of "zest for life," feeling down or sad)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐	☐	☐
Vaginal dryness or difficulty with sexual intercourse	☐	☐	☐	☐	☐
Sexual Problems (change in desire, activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hot Flashes (burst that starts in chest and lasts for short duration)	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feeling cold all the time, having cold hands or feet	☐	☐	☐	☐	☐
Headaches or migraines (increase in frequency or intensity)	☐	☐	☐	☐	☐
Weight (difficulty losing weight despite diet/exercise)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐

Other symptoms or unique health circumstances to take into consideration:

Pelosi Medical Center

PATIENT RIGHTS & RESPONSIBILITIES

As a patient, you have the right to:

- Receive an understandable explanation from your physician of your complete medical condition including recommended treatment, expected results, risks and reasonable alternatives. If your physician believes that some of this information would be detrimental to your health or beyond your ability to understand, the explanation must be given to your next of kin or guardian.
- Give informed written consent prior to the start of specified, nonemergency medical procedures or treatments only after your physician has explained—in terms you can understand—specific details about the recommended procedure or treatment, the risks, time to recover and reasonable medical alternatives.
- Be informed of the Center's written policies and procedures regarding life-saving methods and the use or withdrawal of life-support.
- Refuse medication and treatment to the extent permitted by law and to be informed of the medical consequences of refusal.
- Be included in experimental research only when you have given informed consent to participate.
- Receive appropriate assessment and treatment for pain.
- Be transferred to another facility only if the current facility is unable to provide the level of appropriate medical care or if the transfer is requested by you or your next of kin or guardian.
- Receive from a physician in advance an explanation of the reasons for transfer including alternatives, verification of acceptance from the receiving facility, and assurance that the move will not worsen your medical condition.
- Be treated with courtesy, consideration and respect for your dignity and individuality.
- Know the names and functions of all physicians and other health care professionals directly caring for you.
- Expeditiously receive the services of a translator or interpreter, if needed, to communicate with the staff.
- Be informed of the names, titles, and duties of other health care professionals and educational institutions that participate in your treatment. You have the right to refuse to allow their participation.
- Be advised in writing of the Center's rules regarding the conduct of patients and visitors.
- Receive a summary of your rights as a patient, including the name(s) and phone number(s) of the staff to whom to direct questions or complaints about possible violations of your rights.
- Have prompt access to your medical records. If your physician feels that this access is detrimental to your health, your next of kin or guardian has a right to see your records.
- Obtain a copy of your medical records for a reasonable fee within 30 days after submitting a written request to the Center.
- Receive a copy of the Center charges, an itemized bill, if requested, and an explanation.
- Appeal any charges and receive an explanation of the appeals process.
- Obtain the Center's help in securing public assistance and private health care benefits to which you may be entitled.
- Receive sufficient time before discharge to arrange for follow-up care.
- Be provided with physical privacy during medical treatment and personal hygiene functions, unless you need assistance.
- Be assured confidentiality about your patient stay. Your medical & financial records shall not be released to anyone outside the Center without your approval, unless you are transferred to another facility that requires the information, or release of the information is required & permitted by law.
- Have access to individual storage space for your private use and to safeguard your property if unable to assume that responsibility.
- Be free from physical and mental abuse.
- Be free from restraints unless authorized by a physician for a limited period of time to protect your safety or the safety of others.
- Receive treatment and medical services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay or source of payment.
- Exercise your constitutional, civil and legal rights.

As a patient, you have the responsibility to:

- Provide, to the best of your knowledge, accurate & complete information about present complaints, past illnesses, hospitalizations, medications, & other matters relating to your health. You have the responsibility to report unexpected changes in your condition to the responsible practitioner. As a patient you are responsible for reporting whether you understand a contemplated course of medical action and what is expected of you.
- Report dissatisfaction with the quality of care or service provided.
- Follow the treatment plan recommended by the practitioner primarily responsible for your care. This may include: following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care, implement the responsible practitioner's orders, and enforce the applicable facility rules and regulations.
- Keep appointments and, when you are unable to do so for any reason, notify the responsible practitioner.
- Be accountable for your actions if you refuse treatment or do not follow the practitioner's instructions.
- Follow rules and regulations affecting patient care and conduct.
- Be considerate of the rights of other patients and personnel. Either you or your decision maker has the responsibility for being respectful of the property of other persons and of the Center. Verbally abusive language and verbally disruptive conduct are not acceptable, and if it continues after a request to stop, you or your visitor(s) will be asked to leave the grounds or be escorted from the premises by Law Enforcement.

Questions and Complaints/Grievances

- If you have concerns about the care you received at this center, you may contact the facility Director, Marco Pelosi II, MD at 201-858-1800.
- You have the right to report any safety concerns to the **NJ State Department of Health** at 800-792-9770 or PO Box 367, Trenton, NJ 08625.
- You have the right to report any safety concerns to the **Accreditation Association for Ambulatory Health Care** at: 5250 Old Orchard Road, Suite 200, Skokie, IL 60077. Tel: 847.853.6060. Email: info@aaahc.org
- For information concerning **Medicare coverage**, call 800-MEDICARE (800-633-4227) or contact: Centers for Medicare and Medicaid Services, 7500 Security Blvd, Baltimore, MD 21244.
- For information regarding **Medicaid coverage**, the State's Health Benefits Coordinator for **Medicaid** and/or **NJ** FamilyCare can be reached toll free at 1-800-701-0710. Hearing impaired members can **call** the TDD / TTY number at 1-800-701-0720.

Patient Signature _____ Date _____

Print Name _____