DEMOGRAPHIC & INSURANCE INFORMATION
PLEASE PRINT
(Blue or Black Ink only)

☐ANNUAL UPDATE ☐INFORMATION CHANGE ☐NEW PATIENT

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

Marital Status: ☐Single ☐Married ☐Divorced ☐Other:_____

Address: _____

Apt/Space/Unit#:_____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____)_____

SS#: _____Employer: _____ Occupation: _____ Address: _____

THE FOLLOWING INSURANCE INFORMATION IS REQURIED

Primary Insurance Co: _____Policy#: _____ Group#: _____

Primary Policy Holder Name: _____ **SS#:** _____

Primary Policy Holder Birthday: _____ **Employer:** _____

Primary Policy Holder Address: _____

Secondary Insurance Co: _____Policy#:_____ Group#: _____

Secondary Policy Holder Name: _____**SS#:** _____

Secondary Policy Holder Birthday: _____ **Secondary Policy Holder Employer:** _____

Secondary Policy Holder Address: _____

Name of person to Notify in Case of Emergency **(NOT LIVING WITH PATIENT):**

_____ Phone #: (_____) _____ Relationship to Patient: _____

Pharmacy Name and Cross Streets: _____

Personal Email: _____

You will receive a link to access the patient portal website. You can see results, request refills, make appointments, send messages and pay any outstanding balance(s). Billing statements are sent via the Patient portal, unless opt out of the patient portal.

****ALL UNPAID BALANCES WILL INCUR A $5 MONTHLY FEE ****

***NOTE:** *We do not give your email or personal information to any third parties.*

TO AVOID A $50 CANCELLATION FEE, APPOINTMENTS MUST BE RESCHEDULED OR CANCELLED 72 HOURS PRIOR TO YOUR SCHEDULED VISIT.

UNCANCELLED APPOINTMENTS FOR PROCEDURES OR SURGERIES WILL INCUR A $100 FEE

My signature below indicates that the above information is accurate & that I agree to the above update.

Signature: _____ Date: _____

You may confidentially fax this information back to Dr. Maria Keller, MD office at 702-252-3000.

OFFICE & FINANCIAL POLICY

Welcome to the office of *Dr. Maria Keller, MD*. In an effort to protect your confidential information, all of your records are computerized via an Electronic Medical Record. This ensures the safety of your records and allows us to immediately identify you when you call the office. **Prescriptions are faxed to the pharmacy of your choice, unless you request a printed copy**. All forms and documents are scanned into the computer system and are then destroyed. It is our policy to protect all of your private financial and health information in compliance with the HIPPA laws.

Payment for services provided is required at the time of service, unless prior arrangements have been made. **Co-pays, co-insurance, deductibles, and/or non- covered services are due at the time of service, no exceptions are allowed.** If we are contracted with your insurance company, we will bill your insurance company as a courtesy to you. Understand that it is ultimately your responsibility as the patient to know your insurance coverage. We encourage every patient to know their medical benefits, if you need further clarification contact your insurance company directly. ***The office will check your medical benefits with your insurance company, however the benefits quoted to the office of Maria Keller, MD is not a guarantee of benefits and/or payment per your insurance company***. Co-Insurance and allowable information given is only an estimate and further payment may be required after your claim has been paid. Exact payment is not determined until your claim is processed by your insurance company. If we over collect, you are entitled to a refund, please contact the billing office if you feel you are owed a refund.

Please Initial _____

The office of Maria Keller, MD. Prohibits discrimination against and harassment of any patient because of race, color, national or ethnic origin, age, religion, disability, sex, sexual orientation, gender identity and expression, veteran status or any other characteristic protected under applicable federal or state law.

Please Initial _____

Services provided by outside laboratories such as the reading of Pap smear and/or biopsies will be **billed directly to you by the outside laboratory, not by the office of Maria Keller, MD.** If you need to be referred to a specific laboratory or cytology lab, it is your responsibility to communicate this information to the front office staff and/or your medical assistant.

Please Initial _____

If *Maria Keller MD, PC* is **not contracted** with your insurance company and you need a major medical service (such as needing surgery), we will provide you with information regarding the estimate of the cost of your medical services. A financial agreement form will be completed, which will include the cost of the surgery, any deductible due, an estimate of your insurance payment out of network rates and an estimate of the amount that you will need to pay for the service. Financial arrangements will be discussed in advance so that a specific payment plan can be arranged, if necessary. All fees are required to be paid in full prior to surgery.

Please Initial _____

You will receive a statement showing in detail charges incurred during the statement period and the amount due. **Any uncollected fees are payable within 15 days of receiving the statement**. You are responsible for complete payment of any charges that you incur, whether covered by your insurance or not covered by your insurance. A finance charge of 1.5% per month or 18% annually may be incurred 30 days following the date your services were provided if your account is not paid in a timely fashion. **If your account becomes delinquent and referred to a collection agency, you will be responsible for the costs of collection and/or legal fees.** All accounts that are 90 days past due will automatically be assigned to a collection agency, regardless of insurance coverage. Accounts assigned to collections will include a **35%** collection and processing fee.

Please Initial _____

You have a 10-minute grace period to arrive for your appointment with completed paperwork, along with your photo ID and health Insurance card. If you are later than 10 minutes/or no paperwork completed, along with your photo ID and health Insurance card you will need to be rescheduled. There will be a $50.00 cancellation fee for all appointments not canceled within 72 hours of the appointment. This fee must be paid A fee of $100.00 for all surgical or procedure appointments not canceled within 72 hours of appointment. A $100.00 fee will be charges for all re-deposited, returned checks or stop payments on checks written to the office of Dr. Maria Keller.

Please Initial _____

I authorize *Maria Keller, M.D., P.C.* to release to my insurance carrier and its agents any information needed to determine the benefits payable under their coverage. I further authorize my insurance company and its carriers to disclose any information requested regarding claims for medical benefits to *Maria Keller, M.D. P.C.* A copy of this authorization may be used in place of the original.
Please Initial _____

I request that payment of authorized medical benefits be made on my behalf to *Maria Keller, M.D., P.C.* for services furnished to me, any physician covering for the care of her patients, or her staff unless I have paid for the services and will be billing the insurance company directly.

Please Initial _____

Release of information:
○ I authorize Gynecare to release my medical and/or billing information to the following individual: _____ Relation to Patient:_____

○ I do not authorize release of any of my medical and/or billing information to anyone.

Your signature below indicates that you understand and agree to this financial policy. You also are acknowledging that you have read the ***NOTICE OF PRIVACY PRACTICES.*** (You may ask for a copy.)

Printed Patient Name:_____

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Guardian: _____

GYNECOLOGY HISTORY

(Please Print)

Name:_____DOB:_____Date:_____

☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed

Reason for visit: ☐ Annual/Well Woman Exam ☐Other: _____

_____

Medical History

☐Alcohol abuse	☐Diabetes	☐Kidney stones	☐Anemia
☐Drug and substance abuse	☐Lupus/Autoimmune	☐Anesthetic reaction	☐Eating disorder
☐Migraine Headaches	☐Anxiety Disorder	☐Heart disease	☐ Mitral valve prolapse
☐Asthma	☐Hepatitis/Jaundice	☐Seizure Disorder	☐Bleeding Disorder/Blood Clots
☐High blood pressure	☐Stomach Ulcers	☐Cancer: _____	☐High cholesterol
☐Stroke	☐Chronic lung condition	☐Hypothyroidism	☐Transfusion reaction
☐Depression	☐Irritable bowel syndrome	☐Tuberculosis	☐Other: _____

☐Superficial Venous Thrombosis ☐Deep Vein Thrombosis (DVT) ☐Pulmonary Embolism ☐Urinary Incontinence

List all medications you are currently taking, including over-the-counter medications, vitamins and herbal remedies:

Name:	Dose/Frequency:	Reason for using/medical condition:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any allergies to medications: ☐ None (list name(s) of medication & side effect, i.e. nausea, rash, etc.)

_____

_____

Surgical History ❑ None

List all surgeries you have had with dates, i.e. Hysterectomy, ablation, tubal ligation, cesarean:

_____

_____

Obstetrical History:

❑ Check here if you have never been pregnant

❑ Check here if you have adopted children and number adopted/inherited in a marriage, etc: _____

List total number of pregnancies: _____ How many Vaginal deliveries: _____ How many cesareans: _____

How many miscarriages: _____ How many abortions: _____ How many ectopic (tubal): _____

How many premature births: _____ Have you had twins: _____ Total # living children: _____

Have any of your children died? (Please explain):_____

Gyn History

Last Menstrual Cycle (date):_____ Periods as:❑ Regular Flow is ☐ Light

☐ Irregular ☐ Light to moderate

☐ Painful ☐ Moderate to heavy

☐ Not bothersome ☐ Very Heavy

Menopausal: ☐ Yes ☐No ☐ Age of menopause: _____

Are you sexually active? ☐ Yes ☐ No ☐Virginal

Are you experiencing a loss of interest in Sex (decreased libido)? ☐ Yes ☐No

STD Screening: Would you like to have testing today? ☐ Chlamydia & Gonorrhea ☐ HIV testing ☐ Herpes Screen ☐Syphilis

***Method of Birth Control*:** ☐ condoms ☐ Nuvaring ☐ Mirena IUD, date placed: _____ ☐ pills ☐ tubal/Essure ☐ Copper IUD, date placed:_____ ☐ patch ☐ vasectomy ☐ natural family planning ☐ none ☐ other:_____

Date of last pap smear: _____ ☐Normal ☐Abnormal ☐Never had
Date of last mammogram: _____ ☐Normal ☐Abnormal ☐Never had
Date of last Bone density: _____ ☐Normal ☐Osteopenia/Osteoporosis ☐Never had
Date of last colonoscopy: _____ ☐Normal ☐Abnormal ☐Never had

Family History: Please list any close relative with a history of the following:

	Relative	**Age at Diagnosis**
Breast Cancer		
Ovarian Cancer		
Uterine Cancer		
Colon Cancer		
Bleeding Disorder		

Social History:

Alcohol Use	☐Yes	☐No	If yes, _____ drink(s) per day/week/month
Tobacco Use	☐Yes	☐No	If yes, _____ pack(s) per day for ____ years
Street drug Use	☐Yes	☐No	Type and frequency_____
Sexual Abuse	☐Yes	☐No	If yes, Are you safe now? Yes No Counseling? Yes No
Physical Abuse	☐Yes	☐No	If yes, Are you safe now? Yes No Counseling? Yes No Emotional
Abuse	☐Yes	☐No	If yes, Are you safe now? Yes No Counseling? Yes No

Review of systems: Do you currently have any of the following (**Circle only those that apply**)

N	Y	Generally Healthy	N	Y	Frequent urination
N	Y	Recent weight gain or loss of 25 lbs.	N	Y	Burning with urination
N	Y	Fever	N	Y	Incontinence of urine
N	Y	Vision problems (excluding glasses)	N	Y	Urgency with urination
N	Y	Sinus Problems	N	Y	Bladder infections
N	Y	Hearing loss	N	Y	Stomach Pains
N	Y	Chest Pains	N	Y	Joint/muscle pain
N	Y	Varicose Veins	N	Y	Depression/ Anxiety
N	Y	Shortness of breath	N	Y	Cold Intolerance (always cold)
N	Y	Diarrhea	N	Y	Heat Intolerance (always hot)
N	Y	Constipation	N	Y	Irregular Vaginal Bleeding
N	Y	Blood in stools	N	Y	Stress that is overwhelming
N	Y	Heartburn/reflux			

Thank you for your understanding with our updating your medical history. If you have issues outside of the annual visit, they may or may not able to be addressed, depending on the complexity of your problems. Some insurance companies do not allow more than a well visit or a sick visit. If personal/gynecologic issues are deemed more important that the well visit, your pap/physical will be scheduled at a later date. Dr. Keller encourages all women to check their breast monthly. All women 40+ years need a mammogram every year, unless if you have a family history of breast cancer or have genetic risk factor, then earlier screening may be required. Mahalo.

_____

Patient Signature Date