

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 REQUIRED

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: _____

New Patient History Questionnaire

(PLEASE PRINT)

I. Identifying Information:

Name: _____ DOB: _____ Date: _____

Reason for visit; choose one: Annual/Well Woman Exam Problem: _____

Age: _____ Marital Status: _____ Occupation: _____

Spouse/Partner's name: _____ Occupation: _____

Who referred you? _____

Name of internist or family doctor: _____

List any other physicians or health care providers you see: _____

II. Medical History

None

- | | | |
|--|---|--|
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug and substance abuse | <input type="checkbox"/> Lupus/Autoimmune |
| <input type="checkbox"/> Anesthetic reaction | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Bleeding Disorder/Blood Clots | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic lung condition | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Transfusion reaction |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Superficial Venous Thrombosis | <input type="checkbox"/> Deep Vein Thrombosis (DVT) | <input type="checkbox"/> Pulmonary Embolism (PE) |
| <input type="checkbox"/> Urinary Incontinence | | |

Please list any medical problems that you have that are not listed above:

III. Surgical History

None

List all surgeries you have had including breast biopsies, breast augmentation, tonsillectomy, appendectomy, tubal ligation, LEEP.

Date

Operation

Diagnosis

Excluding any surgeries listed above, have you had any other hospitalization, injuries, or fractures motor vehicle accidents? None

IV. Medications/Allergies

List all medications that you take with the dose and timing (including birth control pills):

None

Drug	Dose	Frequency	Reason for medication
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List all non-prescription medications that you take regularly including vitamins, herbs and anti-inflammatory medications. Please list type, dose and timing: None

Allergies: List all adverse reactions or allergies you have to medications: None

Medication Name	Reaction (examples: hives, shortness of breath, rash, upset stomach)
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IV. General Health

How much alcohol do you drink? None Avg. less than 1/day Avg. 1/day Avg. more _____
Do you smoke? No Yes: Amount/day _____ How many years? _____

Are you interested in help with quitting? Yes No If you quit, when did you stop? _____
Do you use illicit drugs such as marijuana or cocaine? No Yes: _____

V. Gynecologic History

Date of last Pap smear: None _____ Date of last mammogram: None _____

When was the **FIRST** day of your last menstrual period: _____

Length of cycle from first day to first day each month: _____

Regular Irregular Average length of each period: _____ Heavy Moderate
 Light Menopausal Hysterectomy

What do you use to keep from getting pregnant? Nothing Birth Control Pills/Patch Tubal ligation Vasectomy Condoms Rhythm/Natural Family Planning/Withdrawal IUD: date placed; _____ Diaphragm Abstinence

Do you perform monthly self-breast examinations? Yes No **(If your answer is no, this is essential to the early detection of breast cancer. If you don't know how, please ask us so that we may teach you how to perform a breast exam on yourself.)**

Please check if you have had any of the following gynecologic conditions:

- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Very Painful Periods |
| <input type="checkbox"/> Laser/freezing of cervix | <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Condyloma (warts) | <input type="checkbox"/> HPV | <input type="checkbox"/> Recent changes in periods |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Recurrent vaginal infections |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Uterine Fibroids |

STD Screening: Would you like to have testing today? Please check any of the following test(s) that you are interested in having performed today: Chlamydia & Gonorrhoea HIV Testing
 Herpes Screen Syphilis

Urologic History: (Complete only if you have symptoms) None

- Do you lose urine against your will? No, if no skip this section Yes
 Does your incontinence occur after coughing, exercising, sneezing, or lifting? Yes No
 Do you have a strong sense of urgency to void just prior to losing your urine? Yes No
 Do you wear a pad to protect against urine loss? Yes No

Sexual history: None

Number of sexual partners in the last year: _____ In last 10 years (1-3) _____ (4-7) _____ 8 or more _____

Are you experiencing any problems with your libido (sex drive)? Yes No

Is there violence in any of your current relationships? No Yes, _____

Pregnancy history: None

Total number of times pregnant _____ Full term births _____ Premature births _____ Abortions: _____
 _____ Miscarriages _____ Ectopic pregnancies: _____ Adopted or step children _____ Twins _____

Total number of normal vaginal deliveries: _____ Total Cesarean deliveries: _____

VI. FAMILY HISTORY: None Adopted

Which of your 1st degree family members have any of the following?

	<u>Relative</u>	<u>Age at Diagnosis</u>
Breast Cancer		
Ovarian Cancer		
Uterine Cancer		
Colon Cancer		
Bleeding Disorder		

VII. Review of systems: Have you recently had any of the following symptoms? Only check if you have symptoms.

- | | | |
|-----------------------------|----------------------------|--------------------------------|
| _____ Constipation | _____ Chest pain | _____ Weakness/Numbness |
| _____ Diarrhea | _____ Abnormal hair growth | _____ Suicidal thoughts |
| _____ Soiling pants with BM | _____ Headaches | _____ Breast lumps |
| _____ Blood in stool | _____ Change in vision | _____ Difficulty breathing |
| _____ Vomiting blood | _____ Change in hearing | _____ Coughing up blood |
| _____ Appetite change | _____ Difficulty sleeping | _____ Chest palpitations |
| _____ Sudden weight change | _____ Heartburn | _____ Heat or cold intolerance |
| _____ Depression | _____ Bloating | |

Patient Signature

Date