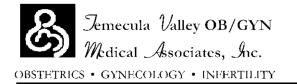
Demceula Valley OB/GYN Midical , Asociates, Inc.

OBSTETRICS • GYNECOLOGY • INFERTILITY

PATIENT REGISTRATION FORM

Medical Center Drive, Suite 100 Murrieta, CA 92562 (951) 677-4748 FAX (951) 677-6529

NEW PATIENT UPDATE Doctor:	Account:	Date:	
PATIENT INFORMATION			
Patient Name	Age	DOB Sex	
Address	City	Zip	
Please indicate, in the boxes below, which order	· []	, 2 nd and 3 rd choice) Alternate Phone #	
Social Security Verified _	Marita	I Status	
Patient's Employer			
Local Friend or Relative Name	Home Phone	Work Phone	
This information MUST be supplied.		work Phone	
Emergency contact other than spouse	ne Relatio		
Would you like access to our patient portal? (To view you			
If <u>YES</u> please provide your email address			
Please confirm your email (print clearly)			
	JRANCE INFORMATION		
Insurance Co Name			
Subscriber Name	_ DOB	Relationship to PT	
Identification No	Group No		
Effective Date	_ Social Security #		
Insured Employer	Work Phone		
SECONDARY IN	SURANCE INFORMATION		
Secondary Insurance Co Name			
Subscriber Name	DOB	Relationship to PT	
Identification No	Group No		
Effective Date	Social Security #		
Insured Employer	Work Phone		
DEMOGRAPHIC QUESTIONS (FEDE	RALLY MANDATED THAT W	/E ASK BY LAW)	
What do you consider your race to be?American Indian or Alaska African AmericanNative Hawaiian/Pacific IslanderOthe Marital Status:SingleMarriedDivorcedWidow	r	_CaucasianHispanic/Latina	
What is your preferred Language?			
Preferred Method of contact:CellHomeMail Only	Decline to specify the abov	3	
AUTHORIZATION TO RELEASE INFO	ORMATION AND ASSIGNMENT OF	BENEFITS	
I hereby authorize Temecula Valley OB/GYN Medical Associates, Inc. to examine and treat the above patient and will assume full responsibility for payment of all services. In the event of default, I also agree to pay for collection costs and attorney's fees that may be required to effect collection of the amount. The undersigned hereby authorizes Temecula Valley OB/GYN Medical Associates, Inc. to furnish necessary information to the involved insurance company, and further authorizes and assigns payment and surgical benefits due under the insurance policy.			
Responsible Party Signature	Date		
Relationship to Patient			



Account # _____

Acknowledgement of Having Read the HIPAA Privacy Notice Notebook

Our HIPAA Privacy Notice Notebook is in each exam room. As you are waiting for the Doctor, please read it. After you have finished, hand this signed sheet to the nurse and she will place it in your chart. Thank you.

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have read the HIPAA Privacy Notice Notebook for the medical practice of Temecula Valley OB/GYN Medical Associates, Inc. I am aware that if I would like a copy of the Privacy Notice, I can request it at the front desk.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative (Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient

"21 Practice Specializing in Women's Health Care"



PATIENT RIGHTS AND RESPONSIBILITIES

To comply with new federal regulations (HIPAA), this office has established procedures to make your identity and medical records secure. Our only use of your personal information is for billing purposes and for proper medical treatment. We must have on record, a signed acknowledgement that you have read your rights and responsibilities as patients and that you understand them. Pleas

Please contact the office staff if you have any questions.		
PATIENT RIGHTS	Le Co	PATIENT RESPONSIBILITIES
To receive service within a reasonable period of time.		Having appropriate identification, insurance membership cards, coverage stickers. etc., at the time of the appointment.
To receive medically necessary services.		
To be treated with respect and courtesy.		Neeping appointments or contacting this office in advance to cancel an appointment.
To receive all available information about your care and treatment, including risks and options.		Fulfilling financial obligations at the time of service such as deductible or Co-pay fees.
To have all medical and personal records treated as confidential.		Providing complete and accurate information.
To participate in treatment decisions		Following the health plan you and the physician agree on.
To refuse treatment.		Being considerate of others.
To receive impartial access to treatment.		Providing legal documentation of guardianship of a minor being treated.
To receive a second opinion regarding any treatment plan.		Providing a list of persons who may receive medical information about
To review or to receive a copy of your medical records subject to legal restrictions and reasonable copying charges.		ff it becomes necessary to contact you by phone, do we have your
To request review of your medical records by the physician, and to request corrections if necessary.		permission to leave messages regarging tab results and/or appointments on your answering device, or with another person who answers the phone?
To be given information on how to file a complaint/grievance.	[What is the best time of day to reach you?
Please sign and return this form to the front desk		you prefer to receiv
Patienťs Name		□ Home □ Work □ Cell
Data		

In order for us to notify you in an expedient manner, we would like to notify you by phone with any questions, appointment confirmation calls, and any normal results that we may have.

I give Temecula Valley OB/GYN Medical Associates permission to leave a CONFIDENTIAL voice message on the telephone number below.

()	-	
Signed:	Date S	Signed: /
Printed:	Date o	of Birth: / /
Witness Signature:	Date:	/

Joseph Glaser, MD Debra Lebo, DO Charles Yang, MD Tammy Hayton, MD Kendra Jones, MD Emily Thomson, D.O. Elizabeth Locascio, DO Nancy Ferrell, RNP Robin Robbins, RNP

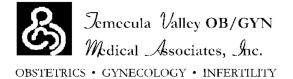
"A Practice Specializing in Women's Health Care"



25460 Medical Center Dr, 100 Murrieta, CA 92562 (951)677-4748 fax (951)677-6529

THIRD PARTY RELEASE OF INFORMATION

PATIENT NAME (PRINT)		ACCOUNT NUMBER
I, medical/billing/and personal information inc		
(Example Spouse, parent, guardian, agency, or insur	ance)	
NAME	PHONE	<u></u>
NAME	PHONE	<u> </u>
NAME	PHONE	
COMPANY NAME	PHONE	
I may be contacted at PLEASE CHECK BOX AND SIGN BELC PROVIDE PERMISSION TO RELEASE A	W IF YOU ARE DECLINING T	0]
Social Security Number		Date of Birth
Patient Signature		Today's Date
		Today's Date
	Joseph Glaser, MD Charles Yang, MD	
Debra Lebo, DO	Charles Yang, MD	Tammy Hayton, MD
Kendra Jones,MD	Elizabeth Locascio, DO	Emily Thomson, DO



Please read the following financial policies of this office:

NOTE: YOU WILL RECEIVE A SEPARATE BILL FROM THE LABORATORY FOR ANY LABORATORY SERVICES ORDERED (I.E., PAP SMEAR, URINALYSIS, BIOPSIES, CULTURES, BLOOD WORK, ETC.). **THESE CHARGES ARE NOT INCLUDED IN OUR BILL**. IF YOUR INSURANCE COMPANY IS CONTRACTED WITH A SPECIFIC LABORATORY FOR PAP SMEARS, BLOOD WORK, ETC., YOU MUST NOTIFY US AT THE TIME OF SERVICE. YOU ARE RESPONSIBLE FOR INFORMING THE NURSE BEFORE THE END OF YOUR APPOINTMENT.

PRIVATE INSURANCE: As a courtesy, we will bill your insurance company. We will, however, collect all percentages and/or deductibles at the time of your visit. If your insurance company requires their insurance claim form be utilized, rather than the universal HCFA 1500, it will be the patient's responsibility for providing the form prior to their office visit. If such a form is unavailable, then we will collect all charges and then you will be responsible for billing your insurance company.

MEDICARE: This office will bill for all of your charges. Please show your Medicare card at the window. We ask that you pay any Medicare deductible that has not been met and your 20% Medicare co-payment at the time of your visit. You will receive an itemized bill which, when attached to the Explanation of Medicare Benefits, will provide your secondary insurance with sufficient information to process your claim. If your secondary insurance does not respond to our billing, we will transfer the remainder of the charge to you. If you find yourself having to bill your secondary again, at your request, we will assist you with any information you need.

SURGERY: The office will bill for all surgery charges. Please assign authorization of payment directly to the physician. Prior to your surgery, please make arrangements for payment of any deductibles and/or co-payments. If you are not covered by insurance, payment in full will be expected on the day of your pre-operative appointment. Please be aware that there may be an assistant fee, anesthesiologist fee, laboratory fee, and radiologist fee, etc.

PREFERRED PROVIDER ORGANIZATIONS (PPO or HMO): If you are covered by an insurance company that we are contracted with, please present your membership card at the front desk. We will bill your insurance company. Any co-payment will be expected at the time of your visit. Please be aware that a prior authorization may be necessary for your visit and must be obtained prior to your visit. Prior authorization is a requirement of many HMO's and their procedures and policies MUST be followed.

SECONDARY INSURANCE: Our office will bill your secondary insurance as long as the secondary allowable is greater than the primary allowable. Our office will bill your secondary insurance as a courtesy to you one time. If your secondary insurance does not respond to our billing, we will transfer the remainder of the charge to you. At your request, we will assist you with any information you may need to bill your secondary again.

CASH: If you do not have insurance, you will be expected to make payment at the time of service. Please stop at the front desk after each Gynecological or Obstetrical visit.

ALL OBSTETRICAL PATIENTS: An account will be established on your first visit. If you have pregnancy health insurance coverage it will not be billed until you have delivered. However, any additional fees not included in your obstetrical care, such as ultrasounds, are due and payable at the time of service. You will also be responsible for all co-payments and deductibles to be paid in full by your 30th week of pregnancy. Payment arrangements should be arranged on your first visit. If you are a member of a PPO or HMO, your co-payments will be expected at each visit, if applicable. An obstetrical contract will be generated and explained to you at check out.

If you have any questions, please feel free to stop at the front desk. We are here to help you in any way possible.

I have read the above information and understand my financial obligation to Temecula Valley OB/GYN Medical Associates, Inc.

Patient / Guardian Signature

Date

Consent for Testing Blood

To Detect Antibodies to the

Human Immunodeficiency Virus (HIV)

I have been informed that my blood will be tested for antibodies to the Human Immunodeficiency Virus (HIV), the probable agent of AIDS. I have been informed about the limitations and implications of the test. I have had a chance to ask questions which were answered to my satisfaction. I understand that the test's accuracy and reliability are not 100 percent certain.

I have been informed that the test is performed by withdrawing blood from my arm and testing the blood specimen.

By my signature below, I acknowledge that I have been given information concerning the benefits and risks, and that I either accept or decline to have my blood tested for antibodies to the HIV.

Patient Name (Please Print)

Date

Accept: ____

Patient/Guardian Signature

Decline: _____

Patient/Guardian Signature

Relationship to Patient

". | Practice Specializing in Women's Health Care"

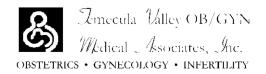


GENETIC QUESTIONAIRE

PATIENT NAME:	PHYSICIAN:	
DATE:	ACCOUNT:	

These questions will help in the care of your pregnancy. Your answers may indicate whether certain tests would be helpful in evaluating the health of your unborn baby. Have you, the father of the baby, or anyone in either of your families ever had any of the following? Please specify for each "yes" (\checkmark) answer, the problem and the relationship of the affected person to you or the baby's father.

YES	NO	FACTOR	EXPLANATION	RELA	TIONSHIP
		Will you be 35 years or older when the baby is due?			
		Mental retardation		YourselfYour:	Baby's FatherBaby's Father's:
		Down Syndrome or any other chromosome abnormality		YourselfYour:	 Baby's Father Baby's Father's:
		Birth defects (i.e., cleft lip or palate, limb defects)		YourselfYour:	 Baby's Father Baby's Father's:
		Spina Bifida (open spine), anencephaly, neural tube defect		YourselfYour:	 Baby's Father Baby's Father's:
		Hydrocephalus (water on the brain)		YourselfYour:	 Baby's Pather Baby's Father's:
		Congenital blindness or deafness		YourselfYour:	 Baby's Father Baby's Father's:
		Blood disorders (anemia)		YourselfYour:	 Baby's Father Baby's Father's:
		Cystic Fibrosis		YourselfYour:	 Baby's Father Baby's Father's:
		Epilepsy or seizures		YourselfYour:	 Baby's Father Baby's Father's:
		Heart defects		YourselfYour:	Baby's FatherBaby's Father's:
		Hemophilia (bleeding)		YourselfYour:	 Baby's Father Baby's Father's:
		Huntington's Chorea		YourselfYour:	 Baby's Father Baby's Father's:
		Kidney problems		YourselfYour:	Baby's FatherBaby's Father's:
		Mental illness (schizophrenia or manic depression)		YourselfYour:	 Baby's Father Baby's Father's:
		Muscular Dystrophy		YourselfYour:	Baby's FatherBaby's Father's:
		Neurofibromatosis		YourselfYour:	Baby's FatherBaby's Father's:
		Stillbirth		YourselfYour:	Baby's Father's:
		3 or more miscarriages		YourselfYour:	Baby's Father's:
		Birth defects or inherited disorders not listed above		YourselfYour:	Baby's FatherBaby's Father's:



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GENETIC QUESTIONAIRE (continued)

PATIENT NAME: ACCOUNT:	
1. What countiries are your ancestors from originally? Please be specific (i.e., England, Africa, Vietnam	h)
Mother of baby: Father of baby:	
2. Certain genetic diseases are more common in certain ethnic groups.	
a. Are either you or the father of the baby of Jewish or French Canadian ancestry?	🗆 Yes 🗖 No
If yes, have you ever been tested for Tay Sach's disease? Please indicate by whom and the result:	🗆 Yes 🗆 No
b. Are either you or the father of the baby of African American ancestry?	🗆 Yes 🗖 No
If yes, have you been tested for sickle cell trait? Please indicate by whom and the result:	🗆 Yes 🗆 No
c. Are either you or the father of the baby of African American, Asian, Middle Eastern,	
East Indian or Mediterranean (Greek, Italian, etc.) ancestry?	□ Yes □ No
If yes, have you been evaluated for thalassemia trait? Please indicate by whom and the result:	🗆 Yes 🔲 No
3. Are you and the baby's father related, such as first or second cousins?	🗆 Yes 🗖 No
4. Are you an insulin dependent diabetic?	🗆 Yes 🗖 No
 Have you had any occurrences in this pregnancy, such as bleeding, spotting, fever or illness? If yes, please specify:	🗆 Yes 🔲 No
6. Have you been exposed to any X-rays during your pregnancy?	🗆 Yes 🔲 No
If yes, please indicate the type of X-ray, how many and whether or not you were shielded:	
7. Excluding prenatal vitamins, have you taken any medications or recreational drugs since your last menstrual period?	🗆 Yes 🔲 No
If yes, please include medication/drug name, dosage/amount and approximate time and duration taken:	
8. Do you smoke eigarettes? Yes No If yes, how many per day?	
9. Have you used alcohol since your last mentrual period?	🗆 Yes 🗆 No
If yes, please include amount and approximate time and duration used:	

If there has been alcohol usage, drug or teratogen exposure during the pregnancy, the UCSD Teratogen Registry is available to evaluate the potential risk to the fetus. They may be contacted at (619) 294-6084.