# FOLEY OB AND AESTHETICS
# NEW PATIENT FORM

| **DEMOGRAPHICS** | | | |
|---|---|---|---|
| **Name:** | **DOB:** | **Race/Ethnicity:** | **Language:** |
| **SSN:** | **Marital Status:** (Circle)<br>S M W D | **Email:** | **Phone:** |
| **Address:**<br><br>**Apt/Suite #:** **City:**<br>**State:** **Zip Code:**<br><br>If the Mailing Address is different, please write the address below. | | **Occupation:**<br><br>**Employer:**<br><br>**Height:** | |
| **Emergency Contact:**<br>1. Name: _____ Relationship:_____ Phone:_____ Email:_____ | | | |
| **Preferred Communication:** (Circle)<br>Text Call Email Mail | | **Do you consent to us sending a patient portal invitation link?:** (Circle) Yes / No *(Access to ultrasound pictures, lab results and appointment reminders)* | |
| **INSURANCE CARRIER** | | | |
| **Primary Insurance Name:** | | **Insurance ID:** | |
| **Subscriber:** Self or Name: | | **DOB:**<br>Sex: M F | **SSN:**<br><br>**DOD#:** |
| **Secondary Insurance Name:** | | **Insurance ID:** | |
| **Subscriber:** Self or Name: | | **DOB:**<br>Sex: M F | **SSN:**<br><br>**DOD#:** |

**How did you hear about us?** (Circle)

Provider Referral:_____ Recommendation:_____

Google Facebook Yelp Instagram Other: _____

**What is your preferred pharmacy location?:** _____

**Are you interested in any of our Aesthetic Services?** (Circle)

Massage / Facials / Waxing / Botox/Xeomin/Jeaveau / Dermal Fillers / PDO Threads

## PREGNANCIES

| ☐ Never been pregnant | Total Pregnancies: |
|---|---|

| Full Term: | Premature: | Induced Abortion: | Miscarriage: | Ectopic: | Living: |
|---|---|---|---|---|---|

| Month/Year | Weeks | Sex | Weight | Hrs in Labor | Delivery Type | Hospital | Epidural/ Complications |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |
| 7. | | | | | | | |
| 8. | | | | | | | |

## GYNECOLOGY HISTORY

| **Last Pap Smear:**_____<br>Results: _____<br>_____ | Any **abnormal** Pap Smear results: (Circle) Yes / No<br><br>**Diagnosis:** _____ | Treatment for Abnormal Pap: |
|---|---|---|
| **Last Mammo/Breast Ultrasound:**<br>_____<br>Results: _____<br>_____ | **Last Dexa Scan (Bone Density):**<br>_____<br>Results:<br>_____<br>_____ | **Last Menstrual Period:**_____ |
| **Current Birth Control:** | **History of IUD/Implant:** (Circle) Yes / No<br>Type: (Circle) Skyla / Mirena / Paragard / Kyleena / Nexplanon / Other:<br><br>Insert Date: | |
| | **History of Dislodged IUD/Implant:** (Circle) Yes / No<br><br>Type:<br>When: | |

| **SEXUAL HISTORY** (Circle) | | |
|---|---|---|
| Sexually Active: Yes No | ____ x per week (Hetero / BI / Homosexual) | Monogamous / Polygamous |
| **Any History of:** | | |
| Herpes: Oral / Genital | STDs: Chlamydia / Gonorrhea / Syphilis / Trichomoniasis / HPV / Warts | HIV / Hep B / Hep C / Molloscum Contagiosum |

| **SOCIAL HISTORY** (Circle) | | |
|---|---|---|
| **Any Usage or Exposure:** Tobacco / Alcohol / Illicit Drugs / Caffeine / Other Stimulants | | |
| If yes, how much in a day: | Name/Dosage: | How many years: |

| **MEDICAL HISTORY** (Check Yes or No) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Yes** | **No** | | **Yes** | **No** | | **Yes** | **No** |
| Neurological | | | Thyroid Dysfunction | | | Anemia | | |
| Heart Disease | | | Cancer | | | Autoimmune | | |
| Pulmonary | | | Gastrointestinal | | | Hospitalizations | | |
| Hypertension | | | Hepatitis/Liver Disease | | | Depression | | |
| Deep Vein Thrombosis | | | Kidney Disease/UTI | | | Psychiatric Disorder | | |
| GYN Surgery | | | Diabetes Type 1 or 2 | | | Gestational Diabetes | | |
| Blood Transfusion | | | Anesthetic Complications | | | Gestational HTN | | |
| Infertility | | | Dermatology | | | Postpartum Depression | | |
| IVF | | | Hematology | | | Other: | | |

| | |
|---|---|
| **Surgical History:** Year / Type / Indication | **Current Medications:** Name / Dose / Frequency<br><br>**Allergies:** Type / Reaction |
| **Primary Care Provider:** | **Specialty Providers:** |

| **IMMEDIATE FAMILY HISTORY** (Check corresponding box) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Maternal** | **Paternal** | | **Maternal** | **Paternal** | | **Maternal** | **Paternal** |
| High Blood Pressure | | | Autoimmune Disorder | | | Cancer Type | | |
| Heart Disease | | | Genetic Disorders | | | Breast | | |
| Diabetes | | | Alcoholism | | | Ovary | | |
| High Cholesterol | | | Mental Disorders | | | Uterus | | |
| Bleeding Disorder | | | Osteoporosis | | | Colon | | |
| Clotting Disorder | | | Lung Disorders | | | Skin | | |
| **Additional Comments:** | | | | | | | | |

**Reason for today's visit**: _____

**Do you prefer a chaperone in the room for pelvic exams and procedures?:** (Circle) **Yes / No**

**Any other concerns you would like your provider to know?**

_____

_____

**Mililani**
95-720 Lanikuhana Ave Suite 220, Mililani, HI 96789
**Phone:** 808-762-0261 **Fax:** 805-856-1568
**Office Cell:** 808-364-1231

**Honolulu**
1329 Lusitana St - POB II, Suite 804, Honolulu, HI 96814
**Phone:** 808-523-9300 **Fax:** 808-523-8834
**Office Cell:** 808-465-0853

**Aesthetics**
**Phone:** 808-762-0265

**Email:** office@foleyobandaesthetics.com
**Website:** www.foleyobandaesthetics.com
**Instagram:** @foleyobandaesthetics

## HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our notice may change, if we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information (PHI) about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to use and disclosure of PHI about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance of your prior Consent. The Practice provides this form to comply with the Health Insurance and Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information (PHI) may be disclosed or used for treatment, payment, or healthcare operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
- The Practice reserves the rights to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this consent in writing at any time and all future disclosed will then cease.
- The Practice may condition treatment upon execution of this consent.

____ **INITIALS** Patient gives the office permission to forward any verified contact information and PHI to patient specialists. Office may discuss pertinent patient chart information, including PHI, with laboratory results and pharmaceuticals, and with product representatives involved in patients' cases through verified unsecured, unencrypted means (i.e. email or fax). The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose Protected Health

Informations, such as x-rays, laboratory, and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities. See 45 CFR 164.506. Any source other than your Healthcare Providers, will sign a Business Associate Agreement. Patient understands permission is not granted, USPS, is the only means of communication with those involved in patient-cases which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail, but the patient may request and pick up copies of PHI to be hand delivered.

Print Patient Name_____ DOB_____
Parent Legal Guardian(s) Name_____ Date_____
Signature of Patient or Legal Guardian_____ Date_____

## PRIVACY NOTICE ACKNOWLEDGMENT

____ **INITIALS** I acknowledge that I have had the opportunity to review a copy of Foley OB & Aesthetics Privacy Notice. I understand that I am responsible to read this Notice and notify Foley OB & Aesthetics, in writing, of any request for restrictions in the use of disclosure of my individually identifiable health information. I understand the notice included electronic access to my medication history. Foley OB & Aesthetics has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times. Foley OB & Aesthetics will provide me with a copy of its most recent Notice upon my request.

Print Patient Name_____ DOB_____
Parent Legal Guardian(s) Name_____ Date_____
Signature of Patient or Legal Guardian_____ Date_____

## FINANCIAL RESPONSIBILITY

____ **INITIALS** I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Foley OB & Aesthetics.

____ **INITIALS** I am responsible for any applicable deductible, coinsurance or co-payments prior to the provision of services.

____ **INITIALS** I assign any benefits to Foley OB & Aesthetics that I may have for reimbursement for my medical treatment received by OB/GYN Assoc. Of Hampton, which I may be entitled to from any insurance coverage, workers compensation benefits, disability benefits, and all settlements, judgements, and verdicts against liable third parties. Foley OB & Aesthetics may file a claim for payment with my insurance company as required by contractual agreement.

____ **INITIALS** I understand and acknowledge that a $25 fee may incur if I do not show up for my medical appointment and/or fail to give Foley OB & Aesthetics a 24-hour notice of cancellation prior to my scheduled appointment. (This fee will <u>not</u> be charged to the insurance, this is the patient's responsibility)

## RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

____ **INITIALS** I understand that it is my responsibility to provide Foley OB & Aesthetics with a copy of my current insurance card. If I do not have insurance, I will be considered a Private Pay (Self-Pay) patient to which I am responsible for paying a n<u>on-refundable $150 each visit.</u>

____ **INITIALS** I am financially responsible for the total amount of the services provided. I will notify Foley OB &

Aesthetics immediately upon any change in my insurance.

## RELEASE OF PRESCRIPTION HISTORY

____ **INITIALS** I authorize any physician who is treating me on behalf of Foley OB & Aesthetics to request and receive any and all information regarding my medication history, including information maintained by the Hawaii Prescription Monitoring Program.

## HIV TESTING DISCLOSURE

____ **INITIALS** Under lab, if a Foley OB & Aesthetics employee comes in contact with your blood or body fluids during your care, Foley OB & Aesthetics has the right to do a current HIV and Hepatitis B or C screening. This means that you, the Patient may be tested for HIV, Hepatitis B or C viruses without your actual consent, if this type of exposure occurs during your medical care. The law also requires that the results of these tests be released to the person who was exposed to your blood or bodily fluids without your consent.

## RESULTS NOTIFICATION

____ **INITIALS** A phone call will be made to all patients regarding abnormal results. Generally, all normal results will be posted to the patient portal, OnPatient, for patients to access at their convenience. Please allow one week for result notification. If you have not received notification of your results after one week, please contact our office.

## DISCLOSURE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

____ **INITIALS** I authorize Foley OB & Aesthetics to share my medical information and medical records to my insurance company and third party payers. I also assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare or Medicaid for payment.

____ **INITIALS** If I require medical records to be sent to another physician and/or facility, I understand a separate consent form will be provided to me to fill out. If printed hard copies are requested, I understand that there is a 0.25 cent fee per page. This fee may change at any time.

**EACH PARTY TO THIS AGREEMENT ACKNOWLEDGES THAT THEY HAVE CAREFULLY READ AND FULLY UNDERSTAND THE MEANING AND CONSEQUENCES OF EACH TERM AND PROVISION OF THIS AGREEMENT.**

Print Patient Name_____ DOB_____
Parent Legal Guardian(s) Name_____ Date_____
Signature of Patient or Legal Guardian_____ Date_____