Columbus Center for Reproductive Endocrinology & Infertility

Confidential Demographic Information

Patient's Name (as it appears on insurance card): _____
(First) (M) (Last)

Date of Birth: _____ Social Security Number: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Second Phone Number: _____

Are we able to contact you at these numbers via Text or Phone messages? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Email Address: _____ May we contact you via Email? ☐ Yes ☐ No

Patient Employer: _____ Occupation: _____

Work Address: _____ Work Number: _____

Spouse's Information:

Name: _____ Date of Birth: _____

Social Security Number: _____ Phone number: _____

Spouse's Employer: _____

Insurance Information

Please update the office of new health insurance prior to being seen by the provider. This way we can verify benefits and ensure services will be covered by insurance. Thank you.

Primary:

Insurance Carrier: _____ Policy Holder: _____

Policy Number: _____ Group Number: _____

Secondary:

Insurance Carrier: _____ Policy Holder: _____

Policy Number: _____ Group Number: _____

Are you covered under a VA policy? _____Yes _____No

_____ (Initial) I hereby certify that the above information is complete and correctly stated to the best of my ability.

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Assignment of Insurance Benefits: I hereby authorize payment directly to my attending physician for services rendered. I understand that I am responsible for all charges not covered by this assignment (all non-covered services, ie. Copay, coinsurance, deductible). I also understand that my insurance benefits were verified over the phone and is not a guarantee of payment from my insurance company**. I understand that if I do not provide the correct insurance information at time of service, I may be responsible for the incurred charges of that date of service.** My signature also authorizes the release of information required by the third-party payor to process my insurance claims.

My insurance listed above is correct and below is my authorization to use or disclose my information.

Signature: _____ Date: _____

Referring Doctor

Reason for Referral: _____

Referring Doctor: _____ Phone Number: _____

Address: _____

Release of Information

Would you like us to give out any information about your medical treatment being performed in this office to anyone beside yourself (i.e. husband, parent, sibling, friend)? Please understand that by checking "yes," you are giving the office the right to disclose personal information regarding your treatment to the person(s) listed below.

☐ No ☐ Yes, Name: _____ Phone Number: _____

Additional Testing

I, (Patient's Name) _____ understand that Dr. Thiruppathi may order laboratory, x-ray, and our ultrasound tests which may or may not be performed in office.

The laboratory tests may include, but are NOT limited to: hormone levels, RPR, Hepatitis, ABO/RH, and any screening lab work.

The x-ray and ultrasound tests may include but are NOT limited to: vaginal ultrasound, DEXA scan, mammogram, CT scan and MRI.

I, the patient, take full responsibility for payment of these procedures, whether performed in this office or off site, after correspondence with insurance has been completed. I also understand that if for any reason I do not wish any of these procedures to be performed I must inform Dr. Prakash Thiruppathi.

Signature: _____ Date: _____

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Notice of Privacy and Office Policies

Notice of Privacy

_____ Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. This includes disclosure for the purpose of diagnosing or providing treatment to you, obtaining payment for your healthcare bills, or to conduct healthcare operations.

By initialing, you are acknowledging that you have been informed of the privacy notice in our office and consenting to use of medical information or disclosure as outlined above. You are also acknowledging that you have received a full copy of our Notice of Privacy Practices.

No Show Policy

_____ If you are unable to keep your scheduled appointment, we ask that you call and cancel at least 24 hours prior to the appointment. If notice of cancellation is not received, there will be a fee billed to the patient's account. This fee is not reimbursable by insurance.

Regular office visits or lab visits: $25.00
Procedures (to include ultrasounds, hysteroscopy, pellets, etc.): $100.00

Recurrent missed appointments could result in being discharged from our practice due to noncompliance.

Televisit and Phone Policy

_____ If treatment is rendered through telephone evaluation and management, you will be billed for services rendered. These calls could be in reference to medical advice and/or treatment given over the phone. The fee for this service can range from $20 to $45. The fee for televisit is reimbursable by insurance and you would be responsible for any copay, coinsurance, or deductible.

Routine Testing Policy and Procedure

_____ The Physician and/or Nurse Practitioner will make age appropriate recommendations regarding routine screenings for prevention and early detection. This is to include routine screening for colon, cervical, breast, and prostate cancer. Routine screenings may also include diagnostic tests, lab work, and exams performed outside the treatment of this practice. Patients are encouraged and expected to notify Dr. Thiruppathi if these screenings have not been performed. If you prefer not to have the recommended screenings, please discuss this with Dr. Thirupppathi or Mrs. Haley Seifert F.N.P.

Referral

_____ If you have an HMO, POS, or Tricare Prime Insurance, you will need a referral authorization from your primary care physician or your OB/GYN to obtain services from our providers. It is your responsibility to obtain the referral for this visit. Please make sure your referrals do not expire during or prior to treatment.

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Notice of Privacy and Office Policies

Narcotic Medication Policy

_____ By initialing, you acknowledge our Narcotic Medication Policy:

1. Narcotic medications will not be called into the pharmacy and will require a written prescription.
2. Refills will not be given because of lost or stollen prescriptions.

E-Prescribing Consent

_____ E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. E-Prescribing greatly reduces medication errors and enhances patient safety. By initialing, you are agreeing and authorizing that Columbus Center for Reproductive Endocrinology and Infertility, LLC can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

_____ _____

Printed Name of Person Completing Form Date

_____

Signature

Columbus Center for Reproductive Endocrinology & Infertility

Review of Systems

Name: _____ Age: _____ Date of Birth: _____
Race: _____ Height: _____ Weight: _____

Current Medications

_____

_____

Social History

Do you Smoke? _____ Previously Smoked? _____ For How Long? _____
Caffeine Usage: _____ How Many Cups per Day? _____
Alcohol Usage: _____ Average Weekly Drinks: _____

Menstrual History

Age of First Cycle: _____ Last Menstrual Cycle: _____
How Many Days? _____ Cramps? _____
Amount of Flow: _____ Spotting or Bleeding Before or After Cycle: _____
Pain With Cycle: _____ Ovulation Pain: _____
Can you tell when your period is approaching? _____ How far in advance? _____
What are the symptoms it is approaching? _____
Breast Pain: _____ Vaginal Discharge: _____ Color: _____

Sexual/Pregnancy History

Sexual Intercourse per Month: _____ Difficulties: _____
Pain or Discomfort with Intercourse: _____ Contraception: _____
Number of Children: _____ Number of Pregnancies: _____ Number of Miscarriages: _____

Family History

Have there been any of the following diseases in your family?

___ Diabetes
___ Hypertension
___ Tuberculosis
___ Cancer
___ Blindness
___ Deafness
___ Mental Retardation
___ Congenital Anomalies
___ Spina Bifida
___ Kidney Disease
___ Cleft Lip or Palate
___ Down Syndrome
___ Cystic Fibrosis
___ Infertility
___ Heart Disease
___ Muscular Dystrophy
___ Limb Deformities
___ Menstrual Problems
___ Recurrent Miscarriages
___ Birth Defects
___ Early Deaths
___ Abnormal Genitalia
___ Sickle Cell Disease
___ Depression

Explain Relationship:

_____

_____

_____

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Review of Systems

Please select if you have any of the following.

Urinary

Frequent Urination	No	Yes
Burning or painful urination	No	Yes
Blood in Urine	No	Yes
Incontinence or Dribbling	No	Yes

Reproductive

Irregular Periods	No	Yes
Vaginal Discharge	No	Yes
On Birth Control	No	Yes
Past Vaginal Infection	No	Yes
History of Abnormal PAP	No	Yes
Breast Pain	No	Yes
Breast Exams	No	Yes
Breast Lump	No	Yes
Breast Discharge	No	Yes

Gastrointestinal

Loss of Appetite	No	Yes
Change in Bowl Movements	No	Yes
Nausea or Vomiting	No	Yes
Frequent Diarrhea	No	Yes
Constipation	No	Yes
Stomach Pain	No	Yes
Blood in Stool	No	Yes

Psychiatric

Nervousness	No	Yes
Depression	No	Yes
Sleep Problems	No	Yes

Skin

Rash or itching	No	Yes

Eyes

Glasses/Contacts	No	Yes

ENT

Sinus Problems	No	Yes
Sore Throat or Voice Change	No	Yes
Swollen Glands in Neck	No	Yes

Cardiovascular

Heart Trouble	No	Yes
Chest Pains	No	Yes
Sudden Heart Beat changes	No	Yes
Swelling in Hands, Feet & Ankles	No	Yes

Respiratory

Frequent Cough	No	Yes
Shortness of Breath	No	Yes
Asthma or Wheezing	No	Yes

Endocrine

Excessive Thirst or Urination	No	Yes
Heat or Cold Intolerance	No	Yes
Dry Skin	No	Yes

Musculoskeletal

Joint Pain	No	Yes
Back Pain	No	Yes
Muscle Pain or Cramps	No	Yes

Neurological

Headaches	No	Yes
Light Headed or Dizzy	No	Yes
Numbness or Tingling	No	Yes

Hematologic/Lymphatic

Easily Bleed or Bruise	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past Transfusion	No	Yes

Other: _____

_____

_____

Patient's Signature Date

Physician's Signature Date