**□ Dr. Marissa N. Largoza □ Dr. Rene Saenger □ Dr. Kelly J. Morales**

***Office Policy for Annual Visits***

**Thank you for selecting one of our physicians as your provider for your gynecological needs.**

**For clarification purposes we would like for you to read the following information regarding your annual visit to establish what an “annual visit” includes.**

**Women in Child Bearing Years an Annual Includes:**

-PAP smear, breast exam, and continuation of birth control method.

If birth control is established at annual visit this will be charged as a separate visit.

**Women in Pre-menopausal Years an Annual Includes:**

**-**If patient is 40 years and oldershe will receive a PAP smear, breast exam, continue Hormone Replacement Therapy (HRT) or Birth Control Method (BCM), mammogram order and rectal exam for fecal occult blood (checking for blood in stool).

If birth control or hormone replacement is established you will be charged a separate visit.

-If patient is 50 years and older she will receive a PAP smear, breast exam, mammogram order, rectal exam for fecal occult blood (checking for blood in stool) and bone mineral density scan order as needed.

If hormone replacement is established you will be charged a separate visit.

**ANY** problem or concern (i.e. discharge, painful intercourse, irregular bleeding, UTI’s etc.) discussed and treated at “annual visit” that is not included in the above description **WILL** be charged as a separate visit.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

**~ ~ ~ MEDICARE PATIENTS ONLY ~ ~ ~**

\_\_\_\_ Medicare **ONLY** pays for annual visits every **TWO** years. If you are seen for an annual within that two year time span **YOU** will be held responsible for payment at the time of service **UNLESS** your annual visit is covered by your secondary insurance.

By signing this form I confirm I understand the information stated above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

PATIENT INFORMATION FORM

 **Demographics (Complete in full) :**  **Today’s Date** \_\_\_\_\_\_\_\_\_\_\_\_\_

 Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HM Ph # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Ph# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Single\_ Separated\_ Married\_ Divorced\_ Wk Ph# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(necessary for appt confirmation)**

 **Employment Information:**

 Employer’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip\_\_\_\_\_\_

 Employer’s Telephone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Emergency Contact Information:

 Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_ Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_ Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **PREFERRED PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone** ( ) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 

 Reason for consultation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 List **any allergies** to medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 

#  Insurance Information:

 **Primary** Insurance Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employer’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer’s Telephone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Secondary** Insurance Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employer’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer’s Telephone ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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#  Assignment of Benefits

 I, the undersigned, understand that I am financially responsible for all charges whether or not my insurance pays.

 I hereby authorize the release of all information necessary to secure payment.

 I hereby assign all Medical/surgical benefits to **Marissa N. Largoza, M.D., P.A., Rene Saenger, M.D., P.A. and/or**

 **Kelly J. Morales, M.D., P.A.**

 I further understand a 60% fee will be added to my account in the event it is necessary for my account to be forwarded

 to a Collection Agency.

##  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***Please let us know how you prefer that we contact you (except for appointment confirmations***

 ***which will be provided to you by email):***

 **(Please mark YES, NO, OR N/A)**

1. **Please indicate where we may contact you by phone (at the numbers listed in your patient**

 **information).**

 **Home**: \_\_\_yes \_\_\_no \_\_N/A \_\_\_

 **Work**: \_\_\_ yes \_\_\_no \_\_\_N/A\_\_

 **Cell Phone**: \_\_\_yes \_\_\_no \_\_\_N/A\_\_

1. **May we leave a message regarding your medical information on an answering machine or**

 **voice mail:**

 **Home**: \_\_\_yes \_\_\_no \_\_N/A\_\_

 **Work**: \_\_\_ yes \_\_\_no \_\_\_N/A\_\_\_

 **Cell Phone**: \_\_\_yes \_\_\_no \_\_\_N/A\_\_

1. **May we leave a phone message regarding your Protected Health Information with any of the**

 **persons listed below:**

 **Home**: \_\_\_yes \_\_\_no \_\_N/A\_\_

 **Work**: \_\_\_ yes \_\_\_no \_\_\_N/A\_\_

 **Cell Phone**: \_\_\_yes \_\_\_no \_\_\_N/A\_\_\_

 ***Using the methods of communication selected above please list those person(s) to whom you***

 ***permit □Marissa N. Largoza, M.D.P.A., □Rene Saenger, M.D., P.A. and/or □Kelly J. Morales, M.D.,***

 ***P.A. to discuss or release your Protected Health Information and their contact information.***

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 I acknowledge that I have received a copy of □Marissa N. Largoza, M.D., P.A., □Rene Saenger, M.D.,

 P.A. **and/or** □Kelly J. Morales, M.D., P.A. Notice of Privacy Practices. I also acknowledge that I have

 been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient/Patient Representative Name Signature

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Relationship to Patient Date