

CINDY PARNES, MD
PATIENT REGISTRATION FORM

DATE: _____
LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____
ADDRESS: _____ **MARITAL STATUS:** _____
CITY: _____ **STATE:** _____ **ZIP CODE:** _____
HOME PHONE: _____ **CELL PHONE:** _____ **WORK PHONE:** _____
DATE OF BIRTH: _____ **AGE:** _____ **SSN#** _____
EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____ **PHONE:** _____
EMAIL: _____

PRIMARY CARE PHYSICIAN: _____
TELEPHONE NO: _____

WHOM MAY WE THANK FOR REFERRING YOU?

EMPLOYER NAME: _____
ADDRESS: _____
CITY: _____ **STATE:** _____ **ZIP CODE:** _____
POSITION: _____

SPOUSE/GUARDIAN NAME: _____
DOB: _____ **AGE:** _____ **SSN#:** _____
ADDRESS: _____
CITY: _____ **STATE:** _____ **ZIP CODE:** _____
HOME PHONE: _____ **CELL PHONE:** _____ **WORK PHONE:** _____
SPOUSE EMPLOYER: _____ **EMPLOYER'S ADDRESS:** _____
CITY: _____ **STATE:** _____ **ZIP CODE:** _____

PRIMARY INSURANCE PLAN: _____ **Self Spouse Child**
POLICY NO: _____ **GROUP NO:** _____
SECONDARY INSURANCE PLAN: _____ **Self Spouse Child**
POLICY NO: _____ **GROUP NO:** _____

TO MY INSURANCE CARRIER(S):

I authorize the release of any medical information necessary to process my insurance claim(s) to Precision Billing, LLC/NJ Women's Wellness Center. I authorize and request payment of medical benefits directly to my physician, Cindy Parnes, MD/NJ Women's Wellness Center. I agree that this authorization will cover all medical services rendered until such authorization is revoked from me. I agree that a photocopy of this form may be used in lieu of the original. I agree to pay all charges not covered by my insurance carrier(s). These charges include but are not limited to deductibles and copayments of my insurance policy. I authorize doctor to initiate a complaint to the Insurance Commissioner or my health care provider for any reason on my behalf.

Signature: _____ **Date:** _____

CINDY PARNES, MD

History Intake Form

Patient Name _____	DOB _____	Today's Date _____
Phone Number _____	Age _____	<input type="checkbox"/> New Patient <input type="checkbox"/> Established Patient

Reason for today's visit? _____

Annual pap smear and well woman exam

Problem, please describe: _____

Are there any questions you would like to discuss Yes No

Review of Systems:

1. Constitutional

- Weight loss? Yes No
- Weight gain? Yes No

2. Eyes

- Visual changes? Yes No
- Glasses/contact lenses? Yes No

3. ENT/MOUTH

- Headaches? Yes No
- Cold sores? Yes No

4. Cardiovascular

- Chest pains? Yes No
- Palpitations? Yes No
- Swelling/Edema? Yes No

5. Respiratory

- Shortness of breath? Yes No
- Coughing? Yes No
- Wheezing? Yes No

6. Gastrointestinal

- Diarrhea? Yes No
- Nausea/Vomiting? Yes No
- Constipation? Yes No

7. Genitourinary

- Pain with urination? Yes No
- Frequent urination? Yes No
- Incontinence? Yes No

8. Skin/Breast

- Rashes? Yes No
- Breast pain? Yes No
- Nipple discharge? Yes No
- Lumps in breast? Yes No

9. Endocrine

- Sugar problems/Diabetes? Yes No
- Thyroid problems? Yes No
- Hot flashes? Yes No

10. Psychiatric

- Depression? Yes No
- Anxiety? Yes No
- Mood changes? Yes No

Family History

- Diabetes: Yes No
- Heart Disease: Yes No
- Ovarian Cancer: Yes No
- Uterine Cancer: Yes No
- Cervical Cancer: Yes No
- Breast Cancer: Yes No
- Colon Cancer: Yes No
- Osteoporosis: Yes No

Social History

- Tobacco Use: Yes No
- Alcohol/Drug Use: Yes No

CINDY PARNES, MD

History Intake Form

Past History:

Do you have any medical problems? Yes No

Please list:

Have you ever had any type of surgery? Yes No

Please list:

Do you have any allergies? Yes No

Please list:

Are you on any medications: Yes No

Please list:

When was your last menstrual period? ____ / ____ / ____

How many times pregnant? _____

Period occurs every _____ days and lasts _____ days.

Number of children: _____

Heavy Yes No

Intermenstrual bleeding Yes No

Have you ever been pregnant? Yes No

X _____
Patient Signature

Date

X _____
MD Signature

Date

To be completed by the physician

Date reviewed: _____ Any Changes? Yes No _____
MD Signature

Date reviewed: _____ Any Changes? Yes No _____
MD Signature

Date reviewed: _____ Any Changes? Yes No _____
MD Signature

Date reviewed: _____ Any Changes? Yes No _____
MD Signature

CINDY PARNES, MD

FINANCIAL STATEMENT & POLICIES

Dear Patient,

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care programs.

While we are pleased to be able to provide this service to you, it is important to remember that your plan is a contract between you and your insurance company. It is your responsibility to know your insurance plan and its requirements. As such, we strongly encourage that you be familiar with your plan, what it covers, and what referral, if any, are needed. It is extremely important that you come into our office with all of the proper documentation and be fully aware of how your plan works.

To help you assure that your insurance covers your care, the following reminders and suggestions have been developed for your use:

- Always provide your insurance card to the receptionist.
- Always inform the receptionist of any changes in your insurance coverage, address, phone number, etc.
- Be aware if your plan covers well woman or sick visits only.
- Referrals, if needed, must be obtained prior to your visit and given to the receptionist.
- Maintain awareness of the type of visits you have and how many you are allowed.
- Know what your participating lab is and inform the office staff at your visit.

FINANCIAL POLICIES

- Non-covered services become the patients' responsibility.
- You will receive a receipt for all payments; cash, check or credit card. This will be your proof of payment; please retain for your records.
- All patients with managed care policies are required to pay their appropriate co-pays at the time of service. **A SERVICE FEE OF \$25.00 WILL BE BILLED TO YOUR ACCOUNT IF YOU FAIL TO MAKE PAYMENT AT THE TIME OF SERVICE.**
- All patients with non-managed care insurance (PPO, POS, BC/BS, ETC.) will be balance billed after we receive payment from your insurance company (except for your co-pay which is due at the time of your visit; and again, a \$25.00 service charge will be billed to your account if it is not paid.)
- All patients with traditional indemnity policies (non-managed care), out-of-network plans or no insurance are responsible for the balance in full at the time of service.
- Patients sent for collection or to our attorney for collection will be held responsible for any court costs, collection/attorney fees and interest.

INSURED OBSTETRICAL PATIENTS

Our office will contact your insurance company to precertify your pregnancy.

NON-INSURANCED OBSTETRICAL PATIENTS

A payment will be developed for you upon diagnosis of pregnancy.

NON-INSURED SURGICAL PATIENTS

A payment plan will be developed for you upon the decision that surgery will be performed.

If you have any questions regarding insurance issues, please feel free to discuss them with the office staff. We are available to assist you in any way that we can. With your cooperation, we can provide you with all of the medical benefits to which you are entitled.

I have read and understand the Financial Statement above and agree to accept the responsibility described.

Signature _____

Date _____

CINDY PARNES, MD

Notice of Privacy Practices and Patient Acknowledgement

To Our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients conveniences, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Ins. Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent and inappropriate use of PHI.

It is our policy to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Notice of Privacy

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule provides standards to health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment payment or health care operations.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with our HIPAA Privacy Officer. You have the right to review our entire notice of privacy policies upon request.

Patient Name: _____

Signature: _____ Date: _____

If minor, signature of parent or guardian: _____

Thank you for being one of our highly valued patients.

For office use

A "good faith effort" was made to get a signature from patient. Signature was not attained due to the following: _____
