

Patient Information

Please print clearly

Patient Name: _____ Date of Birth: ___/___/___ Age _____

Address: _____ City _____ State _____ Zip _____

Phone (____) _____ Cell (____) _____ Marital Status _____

Employer _____ Address _____

City _____ State _____ Zip _____ Occupation _____

Work Phone (____) _____ Ext _____ Social Security _____

Spouse/Parent Name _____ Phone (____) _____

Address: _____ City _____ State _____ Zip _____

Primary Care Physician (full name) _____

Phone: _____

How were you referred? _____

Reason for today's visit? _____

Primary Insurance _____ Name on Policy _____

Policy Holder Date of Birth ___/___/___ Policy Holders Employer _____

Relationship to patient _____ ID# _____ Group# _____

Claims address _____ City _____ State _____ Zip _____

Insurance Phone # _____ Do you have a copay? Yes No Amount _____

Secondary Insurance _____ Name of Policy Holder _____

Policy Holder Date of Birth ___/___/___ Policy Holders Employer _____

Relationship to patient _____ ID# _____ Group# _____

Claims address _____ City _____ State _____ Zip _____

Insurance Phone # _____ Do you have a copay? Yes No Amount _____

Authorization to pay insurance benefits to physician: I hereby authorize payment directly to Barry M. Littlejohn, M.D., S.C.; OR TO RELEASE INFORMATION: I hereby authorize Barry M. Littlejohn, M.D.,S.C. to release all medical information needed to process my insurance claim. I agree that his office may release records pertaining to my treatments to my insurance company or third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I hereby agree to pay for services rendered to the above mentioned patient as and when charges are incurred. In the event of default, I agree to pay any collection agency fees and/or attorney fees as may be required to collect for service rendered by this office.

SIGNATURE OF PATIENT _____ Date: _____
(or responsible party)

Barry M. Littlejohn, M.D., S.C. Financial Policy

Thank you for choosing Dr. Barry M. Littlejohn as your woman's health care provider. Please carefully read and initial by each statement and sign below. This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care to our patients. It is important that we work together to ensure that payment for services is as simple and straightforward as possible.

1. _____ I understand that if I do not have my insurance card or co pay, that my appointment may be rescheduled until such time that I can provide the required documents or payments.
2. _____ I understand that if my account is not paid in full within 90 days, a \$25.00 collection processing fee will be added to the outstanding balance and will be turned over to our collection agency for processing, No additional appointments will be made for delinquent amounts until they're brought current.
3. _____ I understand a \$25.00 service fee will be added for any checks returned for any reason. I will be responsible for payments of this fee and the amount of the return check. NSF checks must be paid with certified funds (money order, Visa, Mastercard or cash.)
4. _____ I understand that if I am unable to make a scheduled appointment I need to contact Dr. Barry Littlejohn's office at least 24 hours before my scheduled appointment. This helps us in scheduling appropriately others in need of urgent care in a timely fashion. **A \$25.00 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST A 24 HOUR ADVANCED NOTICE.**
5. _____ It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is my responsibility to notify Dr. Barry Littlejohn's office if there is a change in my insurance coverage, residence or phone number, **ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.**
6. _____ I have read and I understand the above Financial Policy and I agree by its terms.

Patient Name: _____
(Please print)

Responsible Party Signature: _____

Date: _____

BARRY M. LITTLEJOHN, M.D.

Name _____ Date _____

Date of Birth _____ Age _____

Please complete the patient and family history. Pertinent family members include mother, father, sisters, brothers, grandparents, aunts and uncles.

Please circle **YES** if you or a family member has been treated for:

	PATIENT	FAMILY
Cancer.....	YES	YES
Anxiety or depression.....	YES	YES
Problems with sleep.....	YES	YES
Weight loss or gain more than 20lbs.....	YES	YES
Seizures.....	YES	YES
Tuberculosis.....	YES	YES
Asthma.....	YES	YES
Thyroid problems.....	YES	YES
Blood clot.....	YES	YES
Anemia.....	YES	YES
Migraines.....	YES	YES
High Blood Pressure.....	YES	YES
High Cholesterol.....	YES	YES
Hepatitis.....	YES	YES
Gallbladder disease.....	YES	YES
Bowel disorder.....	YES	YES
Kidney disease.....	YES	YES
Frequent urinary tract infections.....	YES	YES
Vaginal infections.....	YES	YES
Urinary incontinence.....	YES	YES
Breast disease.....	YES	YES
Liver disease.....	YES	YES
Osteoporosis.....	YES	YES
Blood transfusion.....	YES	YES

If you answered yes to any of the above, please explain.

Please list any other medical condition you have been treated for or diagnosed with that was not listed on the previous page: _____

Do you have any allergies to medications? _____ If so, what medications? _____

List **all** medications and dosages you are currently taking including birth control, hormones over the counter medications and vitamins: _____

List all surgical operations you have had: _____

Who is your primary care physician? _____

Menstrual History: Age at 1st period _____ First date of your last period _____

Days between 1st day of period and next period _____ Duration of period _____ days

Have you had a hysterectomy? _____

How many times have you been pregnant? _____ Live births _____ miscarriages _____

ectopic pregnancies _____

Last pap smear _____ Were the results normal? _____

Last mammogram _____ Were the results normal? _____

Do you smoke? _____ If so, how many per day? _____

Do you drink alcohol? _____ How often? _____

Do you drink caffeine? _____ How much per day? _____

Please list any additional concerns you would like to discuss at your visit today:

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my *Protected Health Information (PHI)*. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given an opportunity to receive and read a copy of this office's *Notice of Privacy Practices*, I understand that this that this office's *Notice of Privacy Practices* contains a more complete description of the uses and disclosure's of my *Protected Health Information (PHI)*. I understand this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address listed above to obtain a copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand this office is not required to agree to my requested restrictions, but if they do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____