

**Seton Medical Management
REGISTRATION FORM
WELCOME TO OUR OFFICE**

(Please Print)

Date:		Physician:		
PATIENT INFORMATION				
Patient's Last Name:		First:	Middle:	
Street address:		City:	State:	Zip:
P.O. Box:	Birth date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital status: Circle	Social Security:
City: Zip:	/ /		S / M / D / W	
Home Phone: ()	Cell Phone: ()	E-mail Address: (Patient or Guarantor)		
Occupation:	Employer:	Work Phone: ()		
Referred to clinic by (please check one box): <input type="checkbox"/> Physician Referral <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family Member				
<input type="checkbox"/> Friend <input type="checkbox"/> Close to Home/Work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____				
Name of Spouse, Parent or Guarantor:			Cell Phone:	Employer Phone:
Patient's Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____				
Patient Vision Impaired: <input type="checkbox"/> Yes <input type="checkbox"/> No		Hearing Impaired: <input type="checkbox"/> Yes <input type="checkbox"/> No		
INSURANCE INFORMATION AS PRINTED ON INSURANCE CARD(S)				
Primary Insurance:				
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
Subscriber's name:	Birth date:	Group no.:	Policy no.:	Co-payment:
	/ /			\$
Secondary Insurance:				
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
Subscriber's name:	Birth date:	Group no.:	Policy no.:	Co-payment:
	/ /			\$
EMERGENCY CONTACT				
Name of local relative or friend, not living at same address:		Relationship to Patient:	Work:	
			Home:	
			Cell:	

RELEASE OF MEDICAL INFORMATION

I, the undersigned as the patient or his/her authorized representative, do hereby authorize Seton Medical Management, (SMM) to release to my insurance company(ies) or other appropriate agency(ies) that information which is necessary to validate this claim. SMM is also hereby authorized to release to my physicians(s), either as an individual(s) or as a professional association, who perform services for me, the patient, on a fee for service basis such information as is necessary for filling purposes.

ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY

I do hereby authorize payment of all insurance benefits, basic and major medical for these services, to be made directly to SMM. For and in consideration of services rendered. I hereby agree to pay SMM for all charges not covered by insurance payments. I agree to pay all costs of collecting, securing, or attempting to collect or secure, including reasonable attorney fees or Collection Agency fees not exceeding 15% of the unpaid debt, whether suit be necessary or otherwise.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDE PHYSICIANS AND PATIENT

I request that payment of authorized Medicare benefits be made wither to me on my behalf for any service furnished me by or in SMM, including physicians services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

MEDICAID PATIENT SIGNATURE

I authorize any holder of medical or other information about me to release any information needed for this or any related Medicaid claim to the Medical fiscal intermediary, the Medical Services Administration and/or parties who may be liable for any of my Medicaid expenses.

AUTHORIZATION TO RELEASE MEDICAL REPORTS (INFORMATION TO CONSULTING PHYSICIANS

I hereby authorize SMM to release any medical information to physicians other than original referring physicians, who may be involved in my or my child's health care treatment, when requested by these physicians.

By signing this consent, information will be given to requesting physician without further signed authorization.

CONSENT FOR MEDICAL SERVICES

Permission is hereby granted to the authorities of SMM for such medical procedures as may be deemed necessary by my attending physician, or whomsoever he or she my designate.

RESPONSIBILITY FOR PERSONAL PROPERTY

I understand that SMM does not assume RESPONSIBILITY FOR PERSONAL PROPERTY.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of SMM/PHS's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information. Further, I permit a copy of this authorization to be used in place of the original when deemed necessary.

Restrictions: _____

_____	_____	_____
DATE	SIGNATURE OF PATIENT	SIGNATURE OF SPOUSE
_____	_____	_____
DATE	SIGNATURE OF AUTHORIZED REPRESENTATIVE	RELATIONSHIP
_____	_____	
DATE	WITNESS	

GYN Oncology at the Cancer Center

PRIVACY POLICY

1. **OUR OBJECTIVE.** The personal health information you provide to GYN Oncology at The Cancer Center is important to the doctor and staff, and is vital in enabling us to serve your medical needs. We are committed to the responsible collection, management and use of such information. This Privacy Policy guides us in achieving that commitment and applies to all of our employees and representatives.
2. **PROTECTED HEALTH INFORMATION COVERED BY PRIVACY POLICY.** By "Protected Health Information," we mean information we possess that identifies you personally and is not otherwise available to the public. This information includes general personal information (such as name, address, telephone number, birth date, and social security number), personal health information, and financial information such as major medical insurance and other payment information.
3. **COLLECTION OF PERSONAL INFORMATION.** We may obtain Protected Health Information from you or a third party. We may collect such information from personal information sheets or other forms submitted by you, from transactions with us or other healthcare entities who work with us, or from other sources (this may include pathology materials from current and/or prior surgical procedures).
4. **OUR USE OF PERSONAL PROTECTED HEALTH INFORMATION.** We limit our use of personal protected health information to information we need to help us serve you as our patient. We share such information with certain employees and representatives in order to enable them to assist with your care and treat your disease or illness, as well as assisting your insurance carrier to pay claims and benefits on your behalf.
5. **SHARING OF PROTECTED HEALTH INFORMATION WITH OTHER HEALTHCARE PROFESSIONALS.** We may share Personal Protected Health Information relating to your experience with us with hospitals, other doctors and healthcare facilities who are directly involved with your care.
6. **SHARING OF PROTECTED HEALTH INFORMATION WITH NON-AFFILIATED PERSONNEL AND ENTITIES.** We may also share personal protected health information with unaffiliated third parties, including billing agents, insurance companies and administrators who assist us in performing our business functions, and as otherwise permitted by law.
7. **SHARING PROTECTED HEALTH INFORMATION WITH GOVERNMENT ENTITIES.** We are required Alabama law to report certain cancer diagnosis to the Alabama Cancer Registry in Montgomery within six months after the date of initial diagnosis. This information includes personal patient information and medical information specifically related to the diagnosis of certain types of cancer. This information is made available only to the Alabama State Department of Public Health, which has assured us it maintains such information in complete confidentiality to assure the identities of patients are not revealed. However, the Alabama Department of Public Health had advised us it may contact patients whose information is reported according to law as part of their ongoing investigations into the causes of cancer.

8. **ACCOMMODATIONS FOR RESEARCH.** GYN Oncology at The Cancer Center is a member of the Gynecological Oncology Group, a National Center Institute-funded project dedicated to cancer research. We will not disclose your Personal Protected Health Information to the Gynecological Oncology Group or anyone else for the purpose unless you authorize us to do so in writing. Even when you authorize us to use such information for research purposes, we will use every effort to identifiers from improper use or disclosure, and will destroy the identifiers at the earliest opportunity, unless retention of identifiers is required by law or justified by research or other issues.
9. **MAINTAINING THE SECURITY OF YOUR INFORMATION.** We have implemented security procedures, which use reasonable measures to ensure the security, confidentiality and integrity of Personal Protected Health Information in our possession and guard against unauthorized access or use. We also identify data that is to be protected health information only to those individuals who need to use it in performing their job-related duties. Employees or representatives who violate our security procedures will be subject to disciplinary action, which may include termination.
10. **TREATMENT OF PERSONAL PROTECTED HEALTH INFORMATION OF FORMER PATIENTS.** We will continue to follow our Privacy Policy even when you are no longer a patient of GYN Oncology at The Cancer Center.
11. **CHANGES TO OUR PRIVACY POLICY.** The Privacy Policy set forth herein are subject to updates and other changes from time to time, and this Privacy Policy is subject to change at any time. In the event of any such changes, we will notify all patients of such changes in the manner and to the extent required by law.
12. **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY.**

I, _____, hereby acknowledge receipt of the GYN Oncology at The Cancer Center Privacy Policy.

Signature

Date

NAME: _____

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D.O.B.: _____

Date of Visit: _____

MEDICAL HISTORY

Who referred you? _____ His/Her Specialty: _____

Referring Dr.'s Address: _____ Phone: _____

Are there any other physicians (e.g. Primary Care) with whom you would like your consultation discussed?

Dr's Name & Address: _____ His/Her Specialty: _____

_____ Phone #: () _____

For what reasons were you referred?

Please list any X-rays, Ultrasounds, CT Scans, MRIs, Biopsies, or blood test related to this conditions that have already been done:

Please list any other related medical problems or conditions for which you have been treated in the past:

NAME: _____

PAST MEDICAL HISTORY

PLEASE CHECK ANY MEDICAL PROBLEMS WITH WHICH YOU HAVE EVER BEEN DIAGNOSED:

- | | |
|--|--|
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Bleeding disorders (Hemophilia, etc.) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood clots? Phlebitis |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Angina or Coronary artery disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Arrhythmia (Irregular heart beat) | |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Kidney / Bladder problems: |
| <input type="checkbox"/> Hepatitis: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | _____ |
| <input type="checkbox"/> Gall Bladder attacks | |
| <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hypothyroidism (Low thyroid) |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Hyperthyroidism (Overactive) |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Cancer: Type _____ |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Received Radiation |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Received Chemotherapy |

Other: _____

Have you ever had a flexible sigmoidoscopy or colonoscope (screening for colon cancer)? _____ When? _____

Any other medical problems or hospitalizations? _____

List all the Medications you take including the dose and frequency: _____

Any Allergies to medication? _____ Which drugs? _____

What type of reaction? _____

List all of the Surgeries you've had and the dates: _____

NAME: _____

Obstetric and Gynecologic History

Your age at first menstrual period? _____ Are they (or were they) regular or irregular? _____

Date of your last period? _____ How long are they? _____ How many days between periods? _____

Number of pregnancies: _____ Number of births: _____ Number of Abortions/miscarriages: _____

Vaginal deliveries: _____ Cesarean Sections: _____ Reason for C-Section? _____

Any problems with pregnancy? (Explain) _____

When was your last Pap smear? _____ How often? _____ Any abnormal Paps? _____

When was your last Mammogram? _____ How often? _____ Any abnormal studies? _____

Did you ever take birth control pills? _____ For how many years total? _____

Ever take hormone replacement therapy (Estrogen and/or progesterone) _____ How long? _____

Type of hormone therapy and how taken: _____

Are you currently sexually active? _____ Vaginal intercourse? _____ Problems (e.g. pain)? _____

Have you or do you use birth control? _____ What Method? (e.g. condoms, pills, IUD, etc.) _____

Have you had any gynecologic problems in the past? _____ (Check all that apply)

_____ Fibroids _____ Ovarian cysts _____ Endometriosis _____ Infertility

_____ Sexually transmitted diseases or Pelvic inflammatory disease _____

_____ Heavy bleeding requiring medication or surgery _____ Pelvic prolapse or urinary problems

Family History

Has any one in your family had cancer? _____ Any gynecologic or breast cancer? _____

Type of cancer and relationship of affected family member to you _____

Any other serious medical problems run in your family? (Explain) _____

Social History

_____ Single _____ Married-how long? _____ _____ Domestic partnered _____ Divorced _____ Widowed

Education level achieved? _____ Do you work outside the home? _____ What type of work? _____

Who would you consider your primary support person? _____ Relationship: _____

Do you smoke? _____ Did you use to smoke? _____ How many packs per day? _____ How long? _____

How much alcohol do you consume typically? _____ None _____ Minimal _____ Moderate _____ Heavy

Any other information you think may be helpful? (Explain) _____

Office Policy

During your initial visit we will ask you about your medical history and your symptoms. A complete physical exam focusing on your gynecologic cancer or other problem will then be made by the doctor.

It is your responsibility to give the physician accurate and complete information about your illness, medical history, diagnostic tests, and medications. After reviewing your medical history and diagnostic tests, you will be presented with treatment options. We will inform you of the risks and benefits of these options and will assist you in making your final decision concerning these options.

Office Hours

Office hours are from 9:00 a.m. to 5:00 p.m. Monday through Friday. Patients are seen on Wednesday and Thursday. The Doctor performs surgery on Monday and Tuesday.

Requests for prescription renewals are processed Monday through Friday from 8:30 a.m. to 3:30 p.m. Please allow 48 hours for a prescription to be called into your pharmacy.

Making Appointments

In order to keep a meaningful time schedule, we require that appointments be made for each clinic visit. To make an appointment, please call (251) 631-3490.

If you are unable to keep your appointment, or are going to be late please call our office as soon as possible. This courtesy allows us to reschedule you and serve other patients who had urgent problems. We understand you may forget an appointment, but if you do not show for your appointment twice we will charge your account \$50.00. These fees are not covered by insurance. After the third no show we will ask that you find another doctor to take over your care.

Telephone Calls

We will work to maintain communication with you regarding your care. Telephone calls are for your convenience and frequently require as much time as an office visit. Most of our patients appreciate this effort and do not abuse it. A large number of telephone messages are handled each and every day. We return our calls as time permits, or as the situation demands. Office personnel will relay results of tests and answer questions as per the doctor's instructions. Our telephones are answered 24 hours a day including weekends and holidays. If you call after our scheduled office hours, the telephone will be answered by an answering service which will relay all emergency messages to the doctor. If you feel you must go to the emergency room, notify the doctor immediately. By discussing your concern with the doctor, another option may be found, and a long wait in the emergency room may be avoided. All non-emergency calls, such as prescription refills, should always be made during our regular business hours when your records are readily accessible.

BILLING POLICIES

WE FIND THAT COMMUNICATION WITH OUR PATIENTS REGARDING FINANCIAL POLICY ASSISTS US IN PROVIDING THE BEST SERVICE TO YOU. WE, THEREFORE, HAVE TAKEN THE TIME TO ANSWER SOME OF THE MOST COMMONLY ASKED QUESTIONS.

IF YOU HAVE COMMERCIAL INSURANCE:

AS A COURTESY TO OUR PATIENTS, WE WILL BILL YOUR INSURANCE COMPANY. IF YOUR INSURANCE COMPANY HAS FAILED TO PAY THE BALANCE WITHIN A 60-DAY PERIOD, WE WILL EXPECT YOU TO PAY AT LEAST 20% EACH MONTH UNTIL THE BALANCE IS PAID. TWENTY PERCENT OF THE ESTIMATED SURGICAL FEES WILL BE DUE TO YOUR OPERATION.

IF YOU HAVE MEDICARE:

WE DO ACCEPT ASSIGNMENT ON MEDICARE CLAIMS. WE MUST BILL MEDICARE FOR ALL SERVICES RENDERED. WE WILL BILL SECONDARY INSURANCE IF WE HAVE INSURANCE INFORMATION.

IF YOU HAVE AN HMO/PPO/UNITED HEALTHCARE/AETNA/BCBS:

AS A MEMBER OF AN HMO/PPO, YOUR INDIVIDUAL FINANCIAL RESPONSIBILITY IS LIMITED, BUT WE DEPEND UPON YOU TO KNOW YOUR POLICY AND HELP US OBTAIN THE NECESSARY REFERRALS AND AUTHORIZATIONS. PAYMENT OF YOUR CO-PAY IS REQUIRED AT THE TIME SERVICES ARE RENDERED. WE WILL WORK WITH YOU TO OBTAIN THE PROPER REFERRALS/AUTHORIZATIONS, BUT SOME POLICIES REQUIRE THAT YOU OBTAIN THE APPROVAL FROM YOUR PRIMARY CARE DOCTOR; YOU MUST HAVE AN AUTHORIZATION FOR EACH VISIT UNLESS OTHERWISE INSTRUCTED.

LAB FEES:

THIS IS ANOTHER AREA WHERE WE NEED TO WORK TOGETHER. ANY LAB WORK SHOULD BE DONE AT A "PARTICIPATING " FACILITY. SOME TESTS SUCH AS CT SCANS MUST BE PRE-AUTHORIZED AS WELL. PLEASE NOTIFY THE OFFICE IF YOU HAVE A PARTICIPATING LAB SO THAT WE MAY SEND OUT ANY SPECIMENS TO THE APPROPRIATE LAB. YOU DON'T WANT TO RECEIVE "DENIED" CHARGES.

SPECIAL NEEDS:

WE UNDERSTAND SPECIAL NEEDS. IT MAY BE NECESSARY TO SET UP A PAYMENT PLAN FOR THE PATIENT REQUIRING EXTENSIVE TREATMENT. IF THIS SITUATION IS NECESSARY FOR YOU, PLEASE CONTACT THE OFFICE MANAGER AT YOUR APPOINTMENT.

ADDRESS AND INSURANCE CHANGE:

PLEASE ADVISE US IF YOU CHANGE YOUR ADDRESS, TELEPHONE NUMBER, PLACE OF EMPLOYMENT, OR YOUR INSURANCE COMPANY.

THANK YOU FOR TAKING THE TIME TO READ THIS POLICY STATEMENT. WE HOPE THAT IT ANSWERS ANY QUESTIONS YOU MAY HAVE. IF YOU HAVE MORE QUESTIONS TO ASK, PLEASE DO SO.

Billing and Insurance

Our physician is a provider for many major insurers including HMO's and PPO's. Please contact your insurance company to ask if we participate in your plan. We will bill your insurance as a courtesy to you; however it is your responsibility to make sure we have the correct insurance card and billing information. It will also be your responsibility in helping the billing office to collect all payments from your insurance company if needed. All co-payments will be collected at the time of appointment check-in. It is our policy that we do not bill for co-payments since patients are expected to be aware of and prepared to pay them. If, after receiving your insurer's explanation of benefits (EOB) statement, there remains an amount for which you are responsible beyond what you already paid, we will bill you for this amount and require that it be paid in full. You are responsible for the bill in full if the insurance company does not pay. If after a reasonable amount of time the balance has not been paid on your account either by your insurance company or you, the responsible party, we may send your account to collections. If this occurs you will then be responsible for the bill and all collections fees.

PLEASE READ AND SIGN THE FOLLOWING:

I understand that I have a financial responsibility for payment of medical services provided by GYN Oncology at The Cancer Center, and hereby assume and guarantee payment of all expenses incurred during my office visits and surgeries. Should legal action be required to secure payment of this account, I agree to pay the legal and or collections fees.

I have read and understand this policy and agree to accept responsibility as described.

SIGNATURE _____

DATE _____