

Far Hills OB-GYN, Inc.  
**REGISTRATION FORM**

PATIENT INFORMATION							
Last Name		First Name		Middle Name		Maiden Name	
Address				City/ State		Zip	
DOB	Age	Relation to Responsible Party		S.S. #	Home Phone	Work Phone	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Employer Name & Address			Employment Status <input type="checkbox"/> Full time <input type="checkbox"/> Retired <input type="checkbox"/> Part time <input type="checkbox"/> Not Employed		Cell Phone	
Referring Physician		Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W		Patient Student Status: <input type="checkbox"/> Part time <input type="checkbox"/> Full Time <input type="checkbox"/> Not a student			
Name of other family members coming to this practice:							

<input type="checkbox"/> SAME AS PATIENT <b>RESPONSIBLE PARTY INFORMATION (If different from patient)</b> <i>Person who accompanies child to visit</i>							
Last name		First Name		Middle Initial		Maiden Name	
Address		S.S.#		Home Phone		Cell Phone	
City, State, Zip		Relationship to patient				Employer Name	
Spouse		Spouse Employer & Address				Spouse work phone	
						Birthdate	
						Work Phone	

EMERGENCY CONTACT (spouse or nearest relative)			
Emergency Contact Name		Home phone	
Address, City, State & Zip		Work Phone	
		Other Phone	
		Relation to Patient	

PRIMARY INSURANCE INFORMATION				
Insurance Company	Group# / Plan ID	Member Number	Copay Amount	Effective Date
Subscriber Employer Name & Address		Patient Relationship <input type="checkbox"/> Self <input type="checkbox"/> Child to Insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Other		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Subscriber Name		Does your insurance require A referral to a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Subscriber DOB

SECONDARY INSURANCE INFORMATION				
Insurance Company	Group# / Plan ID	Member Number	Copay Amount	Effective Date
Subscriber Employer Name & Address		Patient Relationship <input type="checkbox"/> Self <input type="checkbox"/> Child to Insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Other		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Subscriber Name		Does your insurance require A referral to a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Subscriber DOB

The undersigned patient or guardian certifies that the above facts are correct and agrees as follows:

1. Authority is granted to Far Hills OB/GYN, Inc. to render needed treatment and/or tests for the above named patient.
2. I authorize Far Hills OB/GYN, Inc. to release any information required for payment of claims.
3. I authorize my insurance or Medicare benefits to be paid directly to Far Hills OB/GYN, Inc., realizing I am responsible to pay noncovered and unauthorized service.
4. I understand that **I am responsible** for charges incurred through Far Hills OB/GYN, Inc. not covered by my insurance. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.
5. If you are unable to keep your appointment, 24 hour cancellation notice is required. If you miss your appointment without notifying our office, you will be charged \$25.00 after the third occurrence and each time thereafter. This charge is not billable to your insurance. If you are more than ten minutes late for an appointment, you will need to reschedule. It is unfair to our other patients to make them wait when they have arrived on time.

\_\_\_\_\_

The above information is correct / Patient or Guardian Signature

\_\_\_\_\_

Date

**FAR HILLS OB/GYN, INC.**

**David W. Shie, M.D. John M. Shie, M.D. Caroline H. Kennebeck, M.D.**

**Kelly L. McCluskey, M.D., LLC Shannon N. McAfee, D.O., LLC**

**FINANCIAL POLICY**

1. All Co-Pay/Co-insurance amounts are due at each visit or procedure.
2. Charges not covered by insurance are due at the time of service.
3. Balances remaining after insurance payment are due within 30 days.
4. All charges/balances are due within 90 days of the date of service regardless of insurance.
5. Any unpaid balance after 90 days will be charged an interest rate of 1.5% per month thereafter until paid in full.
6. We accept Cash, Check, Visa, and Mastercard.
7. There is a returned check fee of \$35.00 for any check returned without payment.

**MATERNITY CARE/SURGERY**

1. Insurance benefits for maternity care and surgery will be verified through your carrier. For maternity, monthly payments will be established through the months of your prenatal care so that your out-of-pocket expenses are credited two months prior to your due date.
2. For surgery, a prepay deposit may be requested depending upon your out-of-pocket expenses your insurance carrier quotes to us.

**COLLECTION ACCOUNTS**

1. If you allow your account to go to collection, you are notifying our office that you are terminating the Doctor/Patient relationship.
2. If you have allowed your account to be sent to collection, you will be put on a cash only basis for one year. You then will be permitted to pay your co-pay/co-insurance at the time of service thereafter once your benefits are verified.
3. If your account has been sent to Collection twice and you return to our office after clearing your collection balance, you will be on a permanent cash only basis and payment will be required at each visit.
4. Accounts are sent to Collection starting at 90 days unless payment arrangements have been arranged and approved through our billing department. You will be responsible for all collection expenses charged to our office by any agency.

**I have read and understand the above financial policy and agree to the terms as stipulated by FAR HILLS OB/GYN, INC., KELLY L. McCLUSKEY, M.D., LLC, and SHANNON N. McAFEE, D.O., LLC.**

\_\_\_\_\_  
**Patient**

\_\_\_\_\_  
**Dated**

Name \_\_\_\_\_

## Health History Form

Have you or an immediate family member (mother, father, sister, brother, or grandparent) ever had any of the following conditions?

	Patient	Family	Check and detail positive findings including date and place of treatment. Precede findings by reference number.
1. Congenital anomalies . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
2. Genetic diseases . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
3. Multiple births . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
4. Diabetes mellitus . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
5. Malignancies . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
6. Ovarian cancer . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
7. Breast cancer . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
8. Hypertension . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
9. Heart attack . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
10. Stroke . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
11. Rheumatic fever . . . . .	<input type="checkbox"/>		
12. Pulmonary disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
13. GI problems . . . . .	<input type="checkbox"/>		
14. Renal disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
15. Genitourinary tract problems . . . . .	<input type="checkbox"/>		
16. Abnormal uterine bleeding . . . . .	<input type="checkbox"/>		
17. Infertility . . . . .	<input type="checkbox"/>		
18. Venereal disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
19. Blood clots - leg or lung . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
20. Phlebitis, varicosities . . . . .	<input type="checkbox"/>		
21. Emotional/psychological disorders . . . . .	<input type="checkbox"/>		
22. Neurologic disorders . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
23. Headaches/migraines . . . . .	<input type="checkbox"/>		
24. Metabol./endocrine disorders . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
25. Anemia/hemoglobinopathy . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
26. Blood disorders . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
27. Infectious diseases . . . . .	<input type="checkbox"/>		
28. Skin problems . . . . .	<input type="checkbox"/>		
29. Operations/accidents . . . . .	<input type="checkbox"/>		
30. Allergies/meds sensitivity . . . . .	<input type="checkbox"/>		
31. Blood transfusions . . . . .	<input type="checkbox"/>		
32. Other hospitalizations . . . . .	<input type="checkbox"/>		
33. Thyroid disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
34. Arthritis . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	
35. _____	<input type="checkbox"/>	<input type="checkbox"/>	
36. _____	<input type="checkbox"/>	<input type="checkbox"/>	
37. <b>No known disease/problems</b>	<input type="checkbox"/>	<input type="checkbox"/>	

Do you drink alcohol? \_\_\_\_\_ If so, how many drinks per week? \_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_ If so, what do you use? \_\_\_\_\_

How much? \_\_\_\_\_ How often? \_\_\_\_\_

Would you like to quit? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How many per day? \_\_\_\_\_ Would you like to quit? \_\_\_\_\_

# MEDICAL HISTORY

PLEASE ANSWER ALL QUESTIONS ON THIS FORM

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Who Referred You Here? \_\_\_\_\_

What Is Your Main Problem For Coming To The Doctor Today? \_\_\_\_\_

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Are You Taking Any Medicines-Including Birth Control Pills \_\_\_\_\_

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Are You Allergic To Any Medications: Which: \_\_\_\_\_

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When Did Your Last Period Start? \_\_\_\_\_

When Was Your Last PAP Smear? \_\_\_\_\_

Have You Ever Had Herpes? \_\_\_\_\_

Have You Had Previous Surgery? \_\_\_\_\_

Date & Types: 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

List All Past Pregnancies:

Date	Length of Labor (Hours)	Sex	Birth Weight	Complications
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

**Notice of Privacy Practices**

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

**Ways in Which We May Use and Disclose Your Protected Health Information:** The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

**Treatment.** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician who we have requested to be involved in your care. *For example* - we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

**Payment.** We will use and disclose your protected health information to obtain payment for the health care services we provide you. *For example* - we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

**Health Care Operations.** We will use and disclose your protected health information to support the business activities of our practice. *For example* - we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

**Other Ways We May Use and Disclose Your Protected Health Information:**

**Appointment Reminders.** We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

**Treatment Alternatives.** We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

**Others Involved in Your Care.** We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

**Research.** We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

**As Required by Law.** We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

**To Avert a Serious Threat to Public Health or Safety.** We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

**Worker's Compensation.** We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

**Inmates.** We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

(over)

**Acknowledgement of Receipt of Notice of Privacy Practices**

*\*You May Refuse to Sign This Acknowledgement\**

I, \_\_\_\_\_  
have received a copy of this office's Notice of Privacy Practices.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) \_\_\_\_\_

**Your Health Information Rights:** Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

**A Paper Copy of This Notice.** You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

**Inspect and Copy.** You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager, at 5701 Far Hills Avenue, Dayton, OH 45429. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

**Request Amendment.** You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if: 1. the information was not created by us, or the person who created it is no longer available to make the amendment; 2. the information is not part of the record which you are permitted to inspect and copy; 3. the information is not part of the designated record set kept by this practice; or 4. if it is the opinion of the health care provider that the information is accurate and complete.

**Request Restrictions.** You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. *For example* - you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

**An Accounting of Disclosures.** You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information). Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

**Request Confidential Communications.** You have the right to request how we communicate with you to preserve your privacy. *For example* - you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

**File a Complaint.** If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services.

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to 5701 Far Hills Avenue, Dayton, OH 45429. You should know that there would be no retaliation for your filing a complaint.

**Uses or Disclosures Not Covered:** Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

**For More Information:** If you have questions or would like additional information, you may contact our practice manager at 5701 Far Hills Avenue, Dayton, OH 45429.

Effective Date: 4/14/03

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