

FINANCIAL RESPONSIBILITY FORM

At Village Obstetrics, we strive to give you the best possible care. In order to serve this purpose, it is important that you understand the mechanisms of reimbursement. Please read this Financial Responsibility Form and sign at the bottom to acknowledge that you understand your accountability.

INSURANCE COVERAGE

It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is obtained by contacting your insurance carrier.

We attempt to verify that your coverage is valid at the time of the visit. However, if your coverage is not in effect at the time of the visit, the financial responsibility for payment is yours.

If you have had any changes in your insurance coverage – even if there is only a small change in the co-payment amount or a change in the expiration date of the policy – you must notify us. Even a small discrepancy on the claim form can lead to a claim denial.

CO-PAYMENTS, CO-INSURANCES AND DEDUCTIBLES

Co-payments and co-insurances are your responsibility. Your insurance company expects us to collect them from you at the time of service. Understand that you will be expected to pay your co-payment for each and every date of service.

You are also responsible for your deductibles. The deductible is determined by your individual contract with your insurance carrier. We do not have information about each person's deductible amount, and how much of that has been met. You will be responsible for finding out all information about your deductible prior to your appointment with our office.

REFERRALS AND/OR AUTHORIZATIONS

Many insurance carriers require pre-authorization and/or a referral for each visit with us. You are responsible for obtaining these referrals or authorizations. You may need to work with your primary care provider or your Ob/Gyn doctor in order to obtain this. Contact your insurance carrier if you have any questions regarding what type of services require pre-certification.

INSURANCE PAYMENTS SENT TO YOU

If insurance payments are sent to you erroneously, you are responsible for forwarding them to our office.

NON-COVERED SERVICES

All patients are responsible if their insurance carrier denies payment for services rendered because they were "non-covered services." These non-covered services may include certain treatment types, bloodwork, supplies or equipment, etc. To avoid this, please check with your insurance carrier prior to receiving any treatment.

I have read and fully understand this Financial Responsibility Form. I acknowledge my personal financial responsibility and I consent to continue with treatment.

Signature

_____/_____/_____
Date

Patient Demographics/Insurance

How Did You Hear About Village Obstetrics? _____

Demographics	Name: _____ S.S. #: _____		Date of Birth: _____ Age: _____ Marital Status: _____	
	Maiden Name: _____		Phones: Home: _____ Work: _____	
	Address: _____		Cell: _____ E-mail: _____	
	City: _____ State/Zip: _____		Emergency Contact: _____	
		Emergency Phone: _____ Relationship: _____		
Financial Insurance	Policy Holder: _____ name relationship		Secondary Insurance Policy Holder: _____ name relationship	
	Employer: _____		Employer: _____	
	Insurance: _____ company contract #		Insurance: _____ company contract #	
	Group #: _____ Policy Holder DOB: _____		Policy Holder DOB: _____	
RX	Pharmacy: _____		Location (Street/City): _____	
	Reminder: Please remember your insurance card at the time of your visit so that we may obtain a copy.			
Authorization Signature	I authorize Village Obstetrics to release information to the above insurance carriers regarding my medical care, and I hereby assign to Village Obstetrics all payments for services rendered to me. I understand that I am responsible for any amount not covered by insurance.			
	Photo release: I understand that by emailing photographs of myself and my family to Village Obstetrics I am giving my permission to display these photographs in the practice office and website. I may revoke this permission at any time by asking that the photo be removed.			
	I have read the notice of privacy posted on the village obstetrics website, villageobstetrics.com.			
	Signature: _____		Date: _____	

Patient Medical History-1

Demographics	Name: _____ S.S. #: _____ Date of Birth: _____ Age: _____				
Obstetrical History	Total Number of Pregnancies: _____		Total Number of Living Children: _____		Miscarriages: _____
	Name of Child	(sex)	Health	Year Born & Weight	M.D./CNM
		()			
		()			
		()			
		()			
Menstrual History	Last Period: _____		Cycle Length? _____	Days	Flow: Regular/Irregular
	Cramps?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amount of Flow: <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Clots		
	Pain Meds?	<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of medication _____	When? Before / During / After bleed		
Cancer Screen	Self Breast Exam: _____		Last Pap Date: _____	Last Mammogram Date: _____	
	Illness/Surgery Excluding Childhood	Year:	Type of Illness or Surgery:	Hospital	M.D.
Allergies	Known Drug Allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes, if so, which ones				
	Known Latex Allergy? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know				
Medications O-T-C Drugs Special Health Foods	Name	Dose/Frequency		Reason	
	_____	_____		_____	
	_____	_____		_____	
	_____	_____		_____	
	_____	_____		_____	

Signature: _____

Date: _____

Patient Medical History-2

Dr/NP/PA Review	Date: _____ By: _____ Comment: _____ _____ _____ _____																		
Family History	<p style="text-align: center;"> → Mother, Father, Grandparents, Brothers/Sisters, Children → Such as diabetes, heart condition, cancer, high blood pressure, ect </p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Who</th> <th style="width: 50%;">Disease</th> <th style="width: 25%;">Status</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>			Who	Disease	Status	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	
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_____	_____	_____																	
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Social History	Marital Status: _____ Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No Packs/day _____ # yrs _____ Type of Work Done: _____ Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks/Day _____ week _____ Use Seat Belt <input type="checkbox"/> Yes <input type="checkbox"/> No Street Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____ Regular Exercise <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency: _____																		
Review of Systems	<p style="text-align: center;">Have you had any of these problems? Answer each item with a Yes (Y) or a No (N)</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 25%; vertical-align: top;"> Constitutional Y N Fatigue Y N Weight Change Y N Fever/Chills Other: _____ </td> <td style="width: 25%; vertical-align: top;"> Neurological Y N Tremors Y N Dizziness Y N Numbness/Tingling Other: _____ </td> <td style="width: 25%; vertical-align: top;"> Hematologic/Lymphatic Y N Swollen Glands Y N Bleeding Problems Y N Anemia Other: _____ </td> <td style="width: 25%; vertical-align: top;"> Eyes Y N Blurred Vision Y N Pain Other: _____ </td> </tr> <tr> <td style="vertical-align: top;"> Ears, Nose, Throat, Mouth Y N Ear Infection Y N Hearing Problem Y N Sinus Y N Sore Throat Other: _____ </td> <td style="vertical-align: top;"> Psychiatric Y N Anxiety Y N Depression Y N Considered Suicide Y N Eating Disorder Other: _____ </td> <td style="vertical-align: top;"> Endocrine Y N Appetite Change Y N Excessive Thirst Y N Fatigue/Sluggish Y N Too Hot/Cold Other: _____ </td> <td style="vertical-align: top;"> Integumentary Y N Rash/Itch Y N Change in Mole/Lesion Y N Breast lump/discharge Y N Breast Pain Other: _____ </td> </tr> <tr> <td style="vertical-align: top;"> Cardiovascular Y N Chest Pain Y N Varicose Veins Y N Shortness of Breath Y N High Blood Pressure Other: _____ </td> <td style="vertical-align: top;"> Respiratory Y N Wheezing Y N Coughing Y N Shortness of Breath Other: _____ </td> <td style="vertical-align: top;"> Allergies/Immunizations Y N Hay Fever Y N Drug Allergies Y N Latex Allergies Other: _____ </td> <td style="vertical-align: top;"> Gastrointestinal Y N Abdominal Pain Y N Nausea/Vomiting Y N Indigestion/Heartburn Y N Blood/Change in Stool Other: _____ </td> </tr> <tr> <td style="vertical-align: top;"> Musculoskeletal Y N Joint Pain Y N Neck Pain Y N Back Pain Y N Osteoporosis Other: _____ </td> <td style="vertical-align: top;"> Genitourinary Y N Painful Urination Y N Urinary Frequency Y N Urinary Incontinence Y N Prolapse Bladder Other: _____ </td> <td style="vertical-align: top;"> Sexual Problems Y N Abuse Y N Sex Drive Y N History of STD's Other: _____ </td> <td style="vertical-align: top;"> Except for the problems circled Y, all other systems are negative Dr/NP/PA _____ </td> </tr> </table>			Constitutional Y N Fatigue Y N Weight Change Y N Fever/Chills Other: _____	Neurological Y N Tremors Y N Dizziness Y N Numbness/Tingling Other: _____	Hematologic/Lymphatic Y N Swollen Glands Y N Bleeding Problems Y N Anemia Other: _____	Eyes Y N Blurred Vision Y N Pain Other: _____	Ears, Nose, Throat, Mouth Y N Ear Infection Y N Hearing Problem Y N Sinus Y N Sore Throat Other: _____	Psychiatric Y N Anxiety Y N Depression Y N Considered Suicide Y N Eating Disorder Other: _____	Endocrine Y N Appetite Change Y N Excessive Thirst Y N Fatigue/Sluggish Y N Too Hot/Cold Other: _____	Integumentary Y N Rash/Itch Y N Change in Mole/Lesion Y N Breast lump/discharge Y N Breast Pain Other: _____	Cardiovascular Y N Chest Pain Y N Varicose Veins Y N Shortness of Breath Y N High Blood Pressure Other: _____	Respiratory Y N Wheezing Y N Coughing Y N Shortness of Breath Other: _____	Allergies/Immunizations Y N Hay Fever Y N Drug Allergies Y N Latex Allergies Other: _____	Gastrointestinal Y N Abdominal Pain Y N Nausea/Vomiting Y N Indigestion/Heartburn Y N Blood/Change in Stool Other: _____	Musculoskeletal Y N Joint Pain Y N Neck Pain Y N Back Pain Y N Osteoporosis Other: _____	Genitourinary Y N Painful Urination Y N Urinary Frequency Y N Urinary Incontinence Y N Prolapse Bladder Other: _____	Sexual Problems Y N Abuse Y N Sex Drive Y N History of STD's Other: _____	Except for the problems circled Y, all other systems are negative Dr/NP/PA _____
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Sign	I authorize Village Obstetrics to release information to my insurance carriers regarding my medical care. Signature _____ Date _____																		