Patient Demographics

PATIENT NAME____Birth Date:___/___/_______
(Last) (First) (Middle)

AGE:____________SOCIAL SECURITY NUMBER:______________________________ MARITAL STATUS (pls. circle):

PHYSICAL ADDRESS:____ Married Single Divorced

CITY:________________________STATE:________________ ZIP:__________ Separated Significant Other

MAILING ADDRESS:____________________________________ CITY:________________ STATE:_________ ZIP:__________

HOME PHONE: ________________________ CELL PHONE:__________________ WORK PHONE: ________________________

PATIENT'S EMPLOYER:____ OCCUPATION:________________________________

WHOM MAY WE THANK FOR REFERRING YOU?____

E- Mail Address ____

May we contact you regarding lab results via e-mail Yes_______ No_________

SPOUSE/RESPONSIBLE PARTY INFORMATION:

Person responsible for payment:__________________________________ Birth Date:___/___/_______

Social Security Number:_________________________ Relationship to patient:____________________________________

Employer:___________________________________ Work Phone: __________________ Home Phone:___________

INSURANCE INFORMATION:

Primary Insurance:_____________________________ Policy ID#:_____________________Group #:______________________

Policyholder's Name:__________________________Relationship to Patient:___________ SSN:________________________

Secondary Insurance:__________________________ Policy ID#:_____________________ Group #:______________________

Policyholder's Name:__________________________Relationship to Patient:___________ SSN:________________________

Last Known Menstrual Period:_____________________ Passport Provider (Medicaid Only)______________________________

EMERGENCY CONTACT:

Name:_____________________________________ Phone #:_______________ Relationship:__________________

I acknowledge that Jeanne Hebl may release to third party payers requested medical and/or other information necessary to process my claim(s). I hereby assign to Jeanne Hebl all benefits which are or shall become payable from any third party payer who is responsible for payment of my Jeanne Hebl expenses. I authorize and direct all third party payers to pay all benefits directly to Jeanne Hebl.

Patient and/or person legally and financially responsible for patient's medical bills agree to pay patient's account regardless of the existence of insurance or other third party liability. Full payment will be made promptly unless other credit arrangements are made. Jeanne Hebl is free to declare the entire balance to be due and payable if any scheduled payments are missed. The undersigned agrees to pay all costs of collection, including reasonable attorney's fees, if the account is not paid in a timely manner.

I authorize treatment of the person named above and agree to pay all fees and charges for any services.

PATIENT'S SIGNATURE:____ DATE:________________

LEGAL GUARDIAN SIGNATURE:____ DATE:________________

Patient Name: **DOB:**

Patient Compliance Policy

Please Initial All Sections Below:

_______1. We expect payment on the day of service. This reduces our billing costs and allows us to keep costs down for you. We require full payment of expected patient responsibility at the time of service based on your insurance coverage.

_______2. By accepting Medicaid and private insurance we are mandated by law and the terms of the contracts we have signed with Medicaid and private insurance to collect your co-pay at the time of service. If you are unable to make the co-payment that is due at the time of your appointment we will need to reschedule your appointment until such time as you are able to make the payment.

_______3. We will submit charges to your insurance carrier when complete information has been received. If Insurance payment is delayed over 60 days you will be expected to pay the balance. If non-payment from your carrier is due to documentation needed to support service we will make all efforts to supply the needed information. We will not fraudulently change diagnoses from the supporting documentation in order for a better outcome from your insurance company. We do supply some services that insurance carriers do not consider a covered benefit of contracts such as infertility testing and IUD devices. For any non-covered services we will require payment in full on the day of services. Any payments received from your insurance carrier after you have paid on your balance will be refunded to you within 30 days of receipt of overpayment.

_______ 4. We will bill secondary insurance. Carrying primary and secondary policies does not alleviate all patient responsibilities; deductibles, co-pays and patient co-insurances still apply. After receipt of insurance payments, the amount that is remaining as patient responsibility is due in full within 30 days. We recommend that you review your insurance carrier explanation of benefits (EOB's). It is your responsibility to know what you owe on your accounts.

_______ 5. If arrangements for payment are needed, an agreement will be completed and signed with our office staff. A confidential meeting will allow for questions and explanation of our policies. You will receive copies of all signed financial agreements.

_______ 6. We require 24 hour notice for cancellations on scheduled appointments. Failure to comply with this policy can result in additional fees and dismissal from our practice. In addition, if you miss three appointments without providing our office with notice of cancellation, or by rescheduling an appointment, you will be imposed a $75.00 fee and possible dismissal from our practice.

_______7. In the event we are unable to collect payment directly from you, your account will be sent to a collection agency. You acknowledge and agree you will be responsible for any and all collection agency fees and reasonable attorneys fees and costs which may be incurred as a result of your non-payment. These charges are the sole responsibility of the patient and will not be billed to any insurance carrier.

Patient Responsibility:

_______ 8. I have been offered the Notice of Privacy Practices document and received a copy of the philosophy and mission statement.

_______ 9. I understand failure to comply with any of the above policies can result in dismissal from care at this facility.

_______ 10. There will be a 1% interest charge per month on all accounts over sixty days.

________________________________   __________________________   _____________
Print Patient Name   Relationship to Patient   Date

____
Signature of Patient or Responsible Party

Patient Name: **DOB:**

NOTICE OF PRIVACY PRACTICES

Jeanne Hebl, CNM, PLLC dba The Birth Center

THIS NOTICE IS REQUIRED BY LAS (FEDERAL REGULATION 45 CFR PARTS 160&164) AND DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS NOTICE IS IN EFFECT ON AND AFTER FEBRUARY 3, 2009. PLEASE REVIEW IT CAREFULLY.

USAGE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

We use health information about you for treatment (diagnostic testing, medical prescription, referral, etc.), to obtain payment (submit claims to and/or encounters with billing services and/or clearinghouses, and/or collection agencies, etc.), for healthcare operations (reporting, utilization management, etc.) and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for other purposes such as auditing and research studies when the research has been approved by an institutional review board. As required by law, we may disclose your health information to public health or legal authorities charged with prevention or controlling disease, injury, or disability.

YOUR HEALTH INFORMATION RIGHTS

- You have the right to inspect and obtain a copy of your health record with a signed authorization as provided in 45 CFR 164.524
- You have the right to request in writing that we restrict and/or not use of disclose your protected health information as provided in 45 CFR 164.522 *but we do not have to agree to accept your restrictions.*
- You have the right to request in writing that your physician amend your protected health information as provided in 45 CFR 164..528
- You have the right to request in writing to receive confidential communications from us by alternative means or at an alternative location as provided in 45 CFR 164.522
- You have the right to obtain a list of instances (accounting of disclosures) where we have disclosed your protected health information for purposes other than treatment, payment or health care operations as provided in 45 CFR 165.528
- You have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken as provided in 45 CFR 164.508

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy of your health information.
- We are required by law to provide you with this notice about our privacy practices
- We are required by law to follow the privacy practices that are described in this notice; however, we reserve the right to change or modify our practices and to make the new provisions effective for all protected health information (PHI) we maintain. Should our information practices change, we will post the revised privacy notice.

QUESTIONS/COMPLAINTS

If you have questions or if you are concerned that we have violated your privacy rights, you may contact the privacy officer. You may also file a complaint with the US Secretary of Health and Human Services. There will be no retaliation against you for filing a complaint.

Privacy Officer: Jeanne Hebl (406) 541-7115

Mailing Address: 2404 39th Street, Missoula, MT 59803

Patient Name: **DOB:**

Personal Medical History

DATE:____________ NAME:_______________________Date of Birth____________ Age:_______

Marital Status: S M D W Other: _________________________Years Together: _________

Husband/Partner: ____ Age:_______

Allergies: ____

Date Last Menstrual Period: ____________ Normal: Y N Flow: Norm Heavy Light

Are your periods regular?____________________ Medications Taken?_________________

Birth Control:______________________________ How long?______________________________

Date of last Pap:___________________________ Normal or Abnormal:_________________

Explain treatment & list dates:____

PREGNANCY HISTORY: Total including live, abortions, & miscarriages:__________________

Live:__________________ Dates:___________ Premature_____________ Dates:___________

Miscarriage(s):__________ Dates:___________ Abortion(s):___________ Dates:___________

Stillbirths: ______________ Dates:___________ C-Section:_____________ Dates:___________

PAST MEDICAL HISTORY – Check Yes/NO (If yes, give date of occurrence)

ISSUE	Y	N	COMMENT	ISSUE	Y	N	COMMENT	ISSUE	Y	N	COMMENT
Breast Lumps				HIV				Asthma			
Kidney/Bladder Infections				Migraines							
Blood Clots				Bleeding Disorders							
Diabetes				Heart Problems							
Ovarian Cysts				Pelvic Inflammatory Disease							
Seizures				Uterine Fibroids							
Genital Herpes				High Cholesterol							
High Blood Pressure				Sexually Transmitted Disease							

PERSONAL HISTORY:

Do you perform monthly self breast exams?_____Have you had a Mammogram?___________Date:_________

If Mammogram was not routine, please list reason: ____

Do you exercise, what type, how, what type, how often:____

Do you wear seat belts?_______Date of last dental exam: ___________ Date of last cholesterol test: _________

Do you experience loss of urine when you cough or sneeze? Y N Constipation? Y N Diarrhea? Y N

Any concerns about intercourse?____

Patient Name: **DOB:**

Do you Smoke? Y N How much per day?___________ Alcohol Y N How much per day?________________

Caffeinated Beverages or Energy Drinks? Y N How much per day?______________________________

Would you describe yourself as happy? ______________ Depressed? _____________ Anxious?___________

Have you experienced physical, sexual or emotional abuse? Y N ______________________________

Have you ever had an eating disorder?______________ Have you had the gardasil vaccine? ______________

MEDICATIONS: Please list all medications including vitamins, herbs, and pain pills; please include dose

____

Please list any serious illnesses, hospitalizations or surgeries:

____

Family History: Please check the following:

	Mother	Father	Brother	Sister	Mother's Mother	Mother's Father	Father's Mother	Father's Father	Other
Currently alive?									
Deceased?									
Asthma									
Arthritis									
Bleeding Disorder									
Breast Cancer									
Colitis									
Diabetes									
High Blood Pressure									
Depression									
High Cholesterol									
Heart Attack									
Kidney Disease									
Migraines									
Stroke									
Suicide									
Thyroid Disease									

Reason for Today's Visit: ____

Signature: ____Date: _______________

Provider's Signature: _____________________________________Date: _______________

Patient Name: **DOB:**

MEDICAL INFORMATION PREFERENCES

Patient: ____ DOB:_______________

As our patient, we may need to communicate with you when you are not in the practice office. To assure your privacy we would like you to indicate your preferred method for us to communicate medical information to you and/or to others involved in your care.

Please Indicate Your Preferences

_______I give permission to leave a message with medical information pertaining to me at the numbers listed below:

Method	**Yes**	**No**	**Area Code/Number**
Home			
Work			
Cell			
Other			

Without specific permission we will not release your medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify below those individuals and their relationship to you (i.e. spouse/partner, parent etc.)

____

____

Patient Name: **DOB:**

PATIENT NAME:________________________________ DOB: _________________

DEMOGRAPHICS (The following information helps us understand your support system and environmental exposures.)

Number of people in household/children:____

Pets in the house:____

Ethnicity/Race:_______________________Tribe (If Native American): __________________

Years of education:____

Hobbies/special interests:____

Do you have family or friends who will be helping you with chores, meals etc., following the birth of your baby? YES________NO_________ Where do they live:_________________________

DESCRIPTION OF EMOTIONAL/SOCIAL STATUS:

Are you in a safe relationship with your current partner? (This means that you are not in a physically, emotionally, or sexually abusive relationship). YES______NO______________

On a scale of 0-10 being depressed/stressed, 0 being completely stress free and happy; how do you rate yourself?____

Was your pregnancy planned? YES____________NO______________

How do you feel about being pregnant?____

____

How does your partner feel about being involved in the pregnancy?

____

EXERCISE

Intensity, frequency and duration of activity:____

Type of activities:____

Attitude, belief or knowledge about exercise during pregnancy:__________________________

Patient Name: **DOB:**

PATIENT NAME:___________________________________ DOB: ___________________

GENERAL ENVIRONMENTAL INFORMATION:

Was your house built before 1970? YES_________ NO_________

Have you had your Radon checked? YES________ NO_________

Do you have cats in the house? YES______ NO_________

Do you filter your drinking water? YES___________ NO_________

Are you exposed to harmful chemicals through your work or home? YES_______ NO_________

If your drinking water source is a well, do you have it tested yearly? YES_______ NO_________

NUTRITION

How many times a week do you eat fast food?____

How many servings of vegetables do you eat a day?_____________________________________

What types of vegetables?____

What type of bread do you eat?____

How many glasses of water do you drink during the day?_________________________________

Do you drink milk? YES NO How many glasses per day?_____________________

How much soda do you drink?____

Do you drink coffee or tea?____

Do you have a special diet that you follow? YES_______________ NO______________________

Vegetarian? YES NO

What are your favorite foods? ____

____

STD/HIV RISK ASSESSMENT:

Client of partner with history of IV drug use: YES NO

Previous sexual partners of client or partner with history of IV drug use: YES NO

Client, partner, or previous sexual partner with history of homosexual partners? YES NO

Client/partner with history of blood transfusions between 1974 & 1985? YES NO

Client/partner, with history of multiple sexual partners since 1978? YES NO

Client/partner who resided in an area where AIDS is endemic (Africa, Haiti, India)? YES NO

Client works in health care, emergency worker or other occupational exposure risk? YES NO

Permission to Publish

I hereby give my permission for The Birth Center to display and publish my name and photograph and my baby's name and photograph, in any promotional materials or publications, in electronic format or otherwise, and including but not limited to: in The Birth Center's Office, on its website, in e-mail newsletters, social media sites and all other promotional publications. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to The Birth Center.

__________________________ _________

Signature Date

Patient Name: **DOB:**