

Bay Point Maternity & Women's Health
Martin Schwartz, MD
1029 Nichols Road, Ste E Osage Beach, Mo 65065
573-302-4884 (p) 573-302-4434 (f)

PATIENT REGISTRATION FORM

Name: _____ SS# _____ - _____ - _____ Date of Birth: _____
(Print) First MI Last

Address: _____
City State Zip

Home (____) _____ - _____ Cell (____) _____ - _____ Work (____) _____ - _____ May we contact you

Marital Status (circle one): Single – Married – Engaged – Divorced – Separated – Widowed via email? Y - N

Language _____ Race _____ Ethnicity _____ Email _____

Employer _____ Occupation _____

Family Physician _____ Referring Physician _____ Pharmacy _____

Spouse Name _____ Best contact # (____) _____ - _____
(Print) First MI Last

Spouse Employer _____ Social Security # _____

Emergency Contact _____ Best Contact # (____) _____ - _____
(Print) First MI Last

Relationship to Patient _____

Name of family member(s) other(s) authorized to discuss you medical care/future appointments:

Relationship _____

If you do not have an *active* insurance policy, payment in FULL is due at the time of your visit. In most cases your insurance company has already informed us of your financial responsibility. Copays, deductibles, and coinsurance are collected prior to your visit. Any other patient balance due after claim has been submitted to your insurance is DUE IN FULL upon receipt of your *first* statement.

Policy holder/guarantor must supply below information in order for us to bill to the insurance you have presented and sign the assignment of benefits form following this page.

Primary Insurance _____ Policy # _____

Policy Holder Name _____ Social Security Number _____ - _____ - _____ Date of Birth _____

Policy Holder signature _____ Policy Holder contact # (____) _____ - _____

Complete the following section only if patient is under 18 years of age

Mother's Name: _____ SS# _____ - _____ - _____ Date of Birth: _____
(Print) First MI Last

Mother's home phone # (____) _____ - _____ Cell(____) _____ - _____ Work (____) _____ - _____

Father's Name: _____ SS# _____ - _____ - _____ Date of Birth: _____
(Print) First MI Last

Father's home phone # (____) _____ - _____ Cell(____) _____ - _____ Work(____) _____ - _____

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Financial And Insurance Agreement

Assignment of Benefits: CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

I authorize my physician to release any medical information concerning my care, including copies of medical records and/or billing information pertaining to my medical care to individuals or representatives of agencies or organizations for the purposes of **treatment**, various activities associated with **payment** and **health care operations**.

Insurance coverage is considered by Bay Point Maternity & Women's Health as an agreement between the patient, the insurance company and the employer when applicable. I understand that I am responsible for all services pertaining to my care, and that I am responsible to notify Bay Point Maternity & Women's Health of insurance changes or requirements. I hereby transfer payment of benefits for medical and/or surgical services rendered by Bay Point Maternity & Women's Health. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information. You have the right to revoke your consent by giving written notice to our Privacy Officer. Revocation will not affect actions that were already taken in reliance upon this consent. If consent is revoked we may decline to treat you.

I understand that if my insurance company fails to pay all or any portion of these charges for any reason, I will be responsible for all sums due and owing (Ex: referral required, pre-certification, non-covered charges, pre-existing). I understand that I will be responsible for payment of all non-covered Medicaid and Medicare services and supplies

If patient applies for Missouri Medicaid assistance we must be informed IMMEDIATELY! We bill insurance that is current at the time services are provided. **We DO NOT back bill for "back-dated" insurance policies including Missouri Medicaid.**

COLLECTION FEES NOTICE AGREEMENT:

A \$30 fee will be charged on all returned checks. A 2% surcharge will be added on all unpaid guarantor balances per month. I understand that if my account goes unpaid, Bay Point Maternity & Women's Health may be forced to turn the account over to an outside collection agency. Any payments made after accounts have been transferred will be forwarded to the collection agency. Responsible party (guarantor) shall be liable for any and all costs incurred (including late fees) in connection with any legal or collection action brought by Bay Point Maternity & Women's Health to enforce the terms of this **agreement** including but not limited to reasonable fees or charges by attorney, investigators, collection agency, and court costs. By signing below I am stating that I understand and agree to the terms of this contract.

****Patient Signature**

Printed Name

Date

****If patient is under 18 years of age and/or if another person is financially responsible for you, we must have their signature also. Person must be the policyholder or financial guarantor of the patient.**

Guarantor / Cardholder Signature

Printed Name

Date

Guarantor SS# _____ - _____ - _____

Guarantor Date of Birth _____

I will be paying by: Cash Check MasterCard Visa American Express CareCredit

The policy of Bay Point Maternity & Women's Health is to provide an environment that provides equal opportunity to all patients of this facility. In accordance with federal and state law, Bay Point Maternity prohibits unlawful discrimination on the basis of race, color, religion, sex, national origin, age, disability, citizenship, and veteran status. Discrimination on the basis of sexual orientation is also prohibited pursuant to Bay Point Maternity policy.

Bay Point Maternity & Women's Health L.L.C.

ACKNOWLEDGEMENT OF RECEIPT OF BAY POINT MATERNITY
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with Bay Point Maternity & Women's Health Notice of Privacy Practices.

Patient Signature: _____

Legal Representative Signature: _____

Relationship to Patient: _____

Date: _____

I hereby authorize the below listed individuals access to my health information including future appointment date and time:

<u>Individual</u>	<u>Relationship</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient or legal representative was unwilling/unable to sign acknowledgement.

Reason: _____

Staff Signature: _____

Date: _____

Bay Point Maternity & Women's Health
Personal Medical History and Review of Symptoms

Name: _____ Date of Birth: _____ Today's Date: _____

If you have a problem now, or if you have had a problem with any of the following body systems in the past, please check and explain in notes at the bottom right of this page. Leave blank if no symptoms. Thank you

Cardiovascular/Respiratory

- Shortness of Breath
- Palpitations
- Chest pains/discomfort
- Wheezing
- Cough
- Breathing Problems/Asthma

Dermatologic

- Itching
- Skin/rashes, moles, ulcers

Gastroenterological

- Abdomen pain
- Constipation
- Nausea/Vomiting
- Loss of Appetite
- Weight Loss
- Diarrhea
- Jaundice
- Heartburn
- Ulcers

Eyes, Ears, Nose, Throat

- Blurred Vision/Disturbance
- Hearing Loss
- Sore Throat
- Nose Bleeds
- Nasal Obstruction
- Bleeding gums

Breasts Lump Pain Nipple discharge

Genitourinary

- Hematuria
- Urine Frequency
- Urinary Urgency
- Incomplete emptying of bladder
- Incontinence/Loss of Control
- Dysuria
- Pain w/ urination
- Painful Intercourse
- Vaginal discharge
- Blood in bowel movement

Musculoskeletal

- Joint pain
- Weakness/Tires easily
- Muscle/Bone Ache or Pain
- Chills/Fever

Neurological

- Headache/Migraines
- Loss of sensation/strength
- Difficulties in speech
- Memory loss
- Dizziness/Lightheaded/fainting
- Loss of Coordination
- Seizures

Hematologic

- Blood transfusions
- Bruising
- Anemia
- Nosebleeds

Endocrine

- Diabetes
- Thyroid

Psychiatric

- Insomnia
- Anxiety
- Depression
- Decreased sexual drive
- Irritable

NOTES:

I am having none of these symptoms _____ Initials