

**M**etropolitan OB/GYN  
**Patient Information Form**

Today's Date: \_\_\_\_\_ Age at **TODAY'S** Visit \_\_\_\_\_ Years  
Patient's Name (First): \_\_\_\_\_ (Last): \_\_\_\_\_ (Middle): \_\_\_\_\_  
Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone:(\_\_\_\_\_) \_\_\_\_\_ Cell Phone:(\_\_\_\_\_) \_\_\_\_\_  
SSN #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex (circle): F M  
Marital Status (circle): Married Single Divorced Widowed Other  
Employment Status (circle): Employed Self-Employed Unemployed Retired  
Full Time Student Part time Student  
Employer Name: \_\_\_\_\_ Work Phone:(\_\_\_\_\_) \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Who referred you to our Practice? \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone Number(\_\_\_\_\_) \_\_\_\_\_

**Spouse/Partner Information**

Name (First): \_\_\_\_\_ (Last) \_\_\_\_\_ (Middle) \_\_\_\_\_  
Work Phone:(\_\_\_\_\_) \_\_\_\_\_ Cell Phone:(\_\_\_\_\_) \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex (circle): F M Occupation: \_\_\_\_\_  
Emergency Contact (not at same address): \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone:(\_\_\_\_\_) \_\_\_\_\_ Work:(\_\_\_\_\_) \_\_\_\_\_ Cell:(\_\_\_\_\_) \_\_\_\_\_

**Responsible Party and Primary Insurance Information**

Responsible Party Name (First): \_\_\_\_\_ (Last) \_\_\_\_\_ (MI) \_\_\_\_\_  
Address: \_\_\_\_\_ Apt.#: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone:(\_\_\_\_\_) \_\_\_\_\_ Cell Phone:(\_\_\_\_\_) \_\_\_\_\_  
SSN #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex (circle): F M  
Employer Name: \_\_\_\_\_ Work Phone:(\_\_\_\_\_) \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Insurance Name: \_\_\_\_\_  
Customer Service Phone:(\_\_\_\_\_) \_\_\_\_\_  
Subscriber ID: \_\_\_\_\_ Group ID: \_\_\_\_\_ Copay \$ \_\_\_\_\_  
Effective Date \_\_\_\_\_ Termination Date: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Secondary Insurance Information**

Insurance Name: \_\_\_\_\_ Customer Service Phone:(\_\_\_\_\_) \_\_\_\_\_  
Subscriber ID: \_\_\_\_\_ Group ID: \_\_\_\_\_ Copay \$ \_\_\_\_\_  
Effective Date \_\_\_\_\_ Termination Date: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Do you have a living will or a durable power of attorney? (circle one) YES NO

\*\*If yes please provide the office a copy\*\*

I the undersigned authorize Metropolitan OB/GYN to leave (circle one): Detailed General  
voice mail messages regarding future appointments, test results and personal information on the  
number I specify: Phone Number:(\_\_\_\_\_) \_\_\_\_\_

I acknowledge that I have been given the **Notice of Privacy Practices** by **Metropolitan OB/GYN**.  
I understand that if I have questions or complaints that I should contact the Privacy Official.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**M**etropolitan OB/GYN  
HealthOne Clinic Services

**Financial Policy:**

In order to reduce confusion and misunderstanding between our patients and the practice we have adopted the following financial policy. If you have any questions please discuss them with our billing staff. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Unless other arrangements have been made in advance by yourself or your health coverage carrier, full payment for office services are due at the time of service. For your convenience we will accept VISA, MasterCard, Discover, and American Express, as well as cash, check or money order.

**About Health Insurance:**

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.

**About Participating Health Plans:**

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-payment **at the time of service**.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.

For all service rendered to minor patients we will look to the adult accompanying the patient and parent or guardian with custody for payment.

It is your responsibility to verify that this office participated with your insurance. If we do not participate with your insurance, you will likely be responsible for all charges out of pocket.

**By signing below, I acknowledge that I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed name if signed on behalf of patient**

\_\_\_\_\_  
**Relationship to Patient**

**M**etropolitan OB/GYN  
HealthOne Clinic Services  
Patient Consent Form

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand **M**etropolitan OB/GYN may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that **M**etropolitan OB/GYN will use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

**Medicare Patients:** I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services at **M**etropolitan OB/GYN.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents

\_\_\_\_\_  
**Patient (or Responsible Party) Signature    Date**

\_\_\_\_\_  
**Patients Printed Name**

**M**etropolitan OB/GYN  
HealthOne Clinic Services  
HPV & Pap Smears

In the past ten years our understanding of abnormal tissue growth on the cervix cause by HPV (Human Papillomavirus) has grown exponentially. We now realize that significant cervical abnormalities and cancers of the cervix are caused by the High Risk strains of HPV. We are also aware that 50-75% of women will clear/suppress an HPV infection within 18 months and that it takes several years for an initial HPV infection to progress into significant precancerous or cancerous abnormalities. Based on these new scientific understandings our professional organizations have made the following recommendations:

1. **Adolescents (age 20 and under)** who become sexually active should be seen by an OB-GYN or other practitioner for a pelvic exam and screening for sexually transmitted diseases such as Gonorrhea and Chlamydia. However, a pap smear should not be performed until 3 years after initiation of sexual contact – since the vast majority of High Risk HPV infections will be cleared/suppressed spontaneously by the woman.
2. For women **age 21-29**, an HPV test is performed if the Pap test reveals cells that are “atypical”
3. For **women 30 and over**, the combined use of the Pap smear and an HPV test can markedly increase the sensitivity of the test looking for significant precancerous cervical changes. A Pap test alone can miss 20-30% of precancerous cervical changes whereas a combined Pap/HPV test will miss only 1 in 1000 significant precancerous changes. If a woman has a normal Pap test and a normal HPV test, she will still need to be seen yearly for a pelvic and breast exam, but may not need a Pap test for 3 years. If a woman tests persistently positive for High Risk HPV (even with normal cervical cells), she needs to be evaluated just as if the cells had been abnormal – looking at the cells with a special microscope (colposcopy).

Like so many things in medicine, our new understandings must initiate new protocols for their diagnosis and management. **Regardless of your pap and/or HPV status, women must be seen annually (pelvic exam, breast exam, etc).**

While the HPV test is covered by most insurance plans, you may receive a bill due to the following: 1. You have not yet met your annual deductible, 2. Your insurance plan has a co-share (i.e. Plan pays 80%, Patient pays 20%), 3. You have a Lab deductible, 4. Your employer has decided to “carve out” or not pay for specific screening tests.

Please call the following number to determine your specific payment responsibility:

1-866-895-1HPV (1-866-895-1478)

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents

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**Patient (or Responsible Party) Signature      Date**

**M**etropolitan OB/GYN  
HealthOne Clinic Services  
Authorization to Disclose Personal Health Information

I \_\_\_\_\_ authorize the disclosure of my personal health information to the following person/people.

\_\_\_\_\_ Relationship \_\_\_\_\_  
Name

\_\_\_\_\_ Relationship \_\_\_\_\_  
Name

\_\_\_\_\_ Relationship \_\_\_\_\_  
Name

\_\_\_\_\_ Relationship \_\_\_\_\_  
Name

\_\_\_\_\_ Relationship \_\_\_\_\_  
Name

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents

\_\_\_\_\_  
**Signature** **Date**

## **Insurance Billing For Pregnancy**

We at **M**etropolitan OB/GYN try our best to inform you of our billing policies. Each insurance policy is different regarding what is a paid benefit. It is your responsibility as the policy holder to know your insurance benefits. Please call your insurance company any time you have questions regarding your benefits.

Frequently asked questions:

### **How is my insurance billed?**

Your first visit to our office is a diagnostic visit. Your insurance will be billed immediately for these services. The diagnosis is “Amenorrhea” (no menses, not pregnancy, we will establish pregnancy at this visit).

Your next visit is the beginning of your “**prenatal care**” all routine prenatal visits, delivery and routine postpartum visits are a **Global** fee billing. These services will be billed to you insurance company after you deliver.

### **Do I have a co-payment with each visit?**

This differs by each insurance company: some policies require one co-payment for the diagnostic visit and one for prenatal care. Some insurance companies require a co-payment for the diagnostic visit and for each prenatal visit. A Co-payment is **NEVER** required for a postpartum visit. It is **YOUR** responsibility to call your insurance carrier and find out how **YOUR** policy is written. Insurance companies change some rules on January 1<sup>st</sup> every year, so be sure to check each year. What was done during another pregnancy may no longer apply.

### **What is NOT in the Global fee?**

Pap Smears, the laboratory that processes your pap will bill your insurance company for these services. You will also be required to pay a co-payment for these services in our office.

Blood Work, the laboratory that processes your blood work will bill your insurance company for these services.

Ultrasounds, as a part of your standard care your will have an anatomy scan at 20 weeks. We will bill your insurance company on the date of service. If you have had ultrasounds at another facility, for genetic screening or care at the hospital, they will also bill your insurance company on the date of service.

**WARNING:** Some insurance companies only allow one ultrasound per pregnancy, regardless of where it was performed.

Non-stress test, if done in our office, we will bill your insurance company on the date of service. If you go to the hospital they will bill your insurance company on the date of service.

Non-routine prenatal visits, if you come in for a problem during pregnancy we will bill your insurance on the date of service. You will also be required to pay a co-payment for these services.

High risk pregnancy, if you are considered high risk you may require additional visits. Most insurances will cover your high risk pregnancy at the Global fee, although some charges may be considered non-routine, requiring a co-payment.

### **How much do I owe?**

This depends on the type of coverage you have with your insurance company. Some people have a traditional 80%/20%. This means the insurance pays 80% of the bills and you are responsible for 20% of the bills. Some have a 90%/10% or even a 70%/30%. Some insurance companies have a large co-payment for the patient to make, then they are responsible for the rest. Some policies also have a deductible that must be paid by the patient before the insurance will pay any of the bills. It is **YOUR** responsibility to check on your policy so you know what to expect.

### **What if I change insurance companies during my pregnancy?**

It is very important that you tell our office immediately about your change of insurance. We will need to precertify your anticipated delivery with your new insurance company and bill your old insurance for visits you already had. ***Any delays can cost you: If not notified in a timely matter, the insurance company can deny payment, making you responsible.***

We have **ONLY** discussed the charges for the doctor. You may have responsibility for the hospital bills as well. **PLEASE** contact your insurance company to get the details on your benefits.

If you would like to contact Rose Medical Center to verify their billing process and to get estimated charges, please call:

Rose Financial Services: 303-320-2626

I acknowledge that I have read and understand the insurance billing process for my pregnancy. Metropolitan Ob/Gyn will bill my insurance on behalf of me, and I will be responsible for the amount they do not pay.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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