

MICHELE L. ASHTON, M.D.  
SANDRA R. BROWN, M.D.  
TRACY S. BYRNE, M.D.  
UTHMAN CAVALLO, M.D.  
LEN R. FERGUSON, M.D.  
JOSEPH P. HARMON, M.D.  
MARK G. LEWIS, D.O.  
CARLTON L. LYONS, M.D.  
KELLY W. MCGUIRE, M.D.  
GREGORY P. WOLFE, M.D.



610 NORTH MICHIGAN STREET  
SUITE 200  
SOUTH BEND, IN 46601  
(574) 232-1471  
(574) 234-9050  
FAX (574) 289-3372  
FAX (574) 232-0741  
www.obgynni.com

## Welcome to OBGYN Associates.

We are happy you have chosen our practice for your specific medical needs. Please fill out the enclosed forms and bring them with you to your appointment. *We do ask that you please arrive at our office at least twenty minutes before your scheduled appointment time, this enables us to complete our registration process.*

The charge for your initial appointment will be approximately \$237 to \$316, any additional services will be charged accordingly. Fees are to be paid at the time of service. We accept cash, personal check, Visa, MasterCard and Discover for payment. If you have one of the following insurance carriers we will file this charge with your insurance company on your behalf. If you do not have your current insurance card with you at your appointment you will need to pay at the time of service and file for reimbursement.

Advantage HMO	Community Health Alliance
Sagamore	Cigna PPO
Medicare	United HealthCare
Blue Cross/Blue Shield/Anthem	Aetna PPO
Select Health Network	Humana ChoiceCare
Private HealthCare Systems (PHCS)	M-Plan
Medicaid MHS or MDWise (Indiana Only)	

**WE DO NOT ACCEPT MICHIGAN MEDICAID**

Many insurance companies are now requiring their members to use a preferred laboratory. Please inform us if you need to use a lab other than the South Bend Medical Foundation.

If you need a referral from your primary care physician, it is your responsibility to obtain the referral prior to your appointment. If you are unsure if you need a referral or if you have any questions regarding your benefits, please contact your insurance company.

Thank you.

Just a reminder that your appointment is scheduled for \_\_\_\_ / \_\_\_\_ / \_\_\_\_ @ \_\_\_\_ : \_\_\_\_ pm

**Please bring a list of your current medications with strengths and dosages.**

**OBGYN ASSOCIATES OF NORTHERN INDIANA, P.C.**

DATE \_\_\_\_\_  
LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ INIT \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_ EXT \_\_\_\_\_  
ALTERNATE CONTACT NUMBER (\_\_\_\_) \_\_\_\_\_  
BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_ SOCIAL SECURITY \_\_\_\_\_  
MARITAL STATUS: SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_

EMPLOYER \_\_\_\_\_  
ADDRESS \_\_\_\_\_

PARENT/SPOUSE NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
SOCIAL SECURITY \_\_\_\_\_ WORK PHONE \_\_\_\_\_

NEAREST RELATIVE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_ ID# \_\_\_\_\_ ACC# \_\_\_\_\_  
CARDHOLDER NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
ADDRESS \_\_\_\_\_ SOCIAL SECURITY \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ ID# \_\_\_\_\_ ACC# \_\_\_\_\_  
CARDHOLDER NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
ADDRESS \_\_\_\_\_ SOCIAL SECURITY \_\_\_\_\_

REFERRED BY \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

I authorize OBGYN Associates of Northern Indiana to release information concerning illness or treatments to my insurance carrier and also direct payment to the physician(s) who rendered medical services. I will accept responsibility for payment of fees submitted by OBGYN Associates of Northern Indiana for any balance not covered by my insurance.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

As parent/guardian, I give my permission to consult with and/or treat \_\_\_\_\_  
\_\_\_\_\_. I also authorize OBGYN Associates of Northern Indiana to submit fees for services rendered to my insurance carrier for payment. If, for any reason, the fees are not covered I agree to accept responsibility for the outstanding balance.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Based on the commitment we have made to our patients, the profession and ourselves, we will not accept as patients those who refuse to accept blood or blood products. This decision is based on the possibility of an emergency situation occurring whereby the patient needs a life-saving transfusion. In this case permission would first be obtained from the patient or their family if the patient is unable to make that decision. In the case of a planned and scheduled surgery, a patient may donate their own blood prior to surgery or have a family member donate in their behalf.

I fully accept and understand the above statement. \_\_\_\_\_ (Initial)

**OBGYN ASSOCIATES OF NORTHERN INDIANA, PC**

**MEDICAL INFORMATION RELEASE**

I hereby authorize OBGYN ASSOCIATES OF NORTHERN INDIANA, P.C., to release any medical or appointment information to the following persons:

(i.e. – spouse, parents, children or significant other)

<u>NAME</u>	<u>RELATIONSHIP</u>
1. _____	_____
2. _____	_____
3. _____	_____

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**TO BE KEPT IN PATIENT'S CHART AT ALL TIMES**

# OB-GYN ASSOCIATES OF NORTHERN INDIANA, P.C.

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

## INITIAL PATIENT SELF-HISTORY FORM

Provide all information requested to the best of your ability

### ALLERGIES (Include medications, Latex, Iodine)

### GYNECOLOGIC HISTORY

Age at first menses (period) \_\_\_\_\_ Age at menopause (if applicable) \_\_\_\_\_

(The following questions refer to your "natural" periods when not on birth control pills or hormones)

Usual # of days of period \_\_\_\_\_ Period interval (1<sup>st</sup> day to 1<sup>st</sup> day) \_\_\_\_\_ days

How many days are: Heavy \_\_\_\_\_ Medium \_\_\_\_\_ Light \_\_\_\_\_

Have you ever had an abnormal pap smear? \_\_\_\_\_

If yes, how was it treated? \_\_\_\_\_ When? \_\_\_\_\_

Date of last pap smear \_\_\_\_\_ Have you had a mammogram? \_\_\_\_\_ When? \_\_\_\_\_ Result \_\_\_\_\_

Types of birth control used, including vasectomy \_\_\_\_\_

Have you had any gynecologic surgery? (Including Tubal Ligations, D&C's, Cryo, Leep, Ovarian surgery)

If yes, what kind? \_\_\_\_\_ When? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have any knowledge of your mother using hormones (DES, Diethylstilbestrol) during her pregnancy with you? \_\_\_\_\_

### PREGNANCY HISTORY

# of full-term deliveries \_\_\_\_\_ # of premature deliveries \_\_\_\_\_ # of miscarriages \_\_\_\_\_ Was surgery needed? \_\_\_\_\_

# of abortions \_\_\_\_\_ Any complications? \_\_\_\_\_ Any "tubal" pregnancies? \_\_\_\_\_ When? \_\_\_\_\_

# of vaginal deliveries \_\_\_\_\_ # of Cesarean sections \_\_\_\_\_ Years of deliveries \_\_\_\_\_

Any serious complications during your pregnancies or deliveries? \_\_\_\_\_

### RISK FACTORS

Your answers to these questions help us to determine if you have risk factors for cancer, infections or AIDS:

Have you ever received a blood transfusion? \_\_\_\_\_ Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you consume alcohol? \_\_\_\_\_ How often? \_\_\_\_\_

Have you ever used marijuana, cocaine, heroin, barbituates, or speed? \_\_\_\_\_ If yes, last used? \_\_\_\_\_ Any needles? \_\_\_\_\_

Age at first intercourse \_\_\_\_\_ Total # of sexual partners \_\_\_\_\_ Total # of sexual partners in last year \_\_\_\_\_

Have you had any sexually transmitted infections? \_\_\_\_\_ If yes, what? \_\_\_\_\_ When? \_\_\_\_\_

Do you believe yourself to be at risk of exposure to the AIDS virus? \_\_\_\_\_

**SURGERY** (Other than gynecologic)

TYPE	WHEN	DOCTOR	COMPLICATIONS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**HOSPITALIZATIONS** (Non-surgical, other than pregnancy)

CONDITION	WHEN	DOCTOR	TREATMENT
_____	_____	_____	_____
_____	_____	_____	_____

**PAST AND PRESENT MEDICAL PROBLEMS**

CONDITION	NO	YES NOW	YES PAST	IF PAST, DATE	COMMENTS
Anemia/ Blood Disorder					
Arthritis					
Asthma/ Lung Problems					
Bladder Infections/Problems					
Bowel Disorders (Colitis, Crohn's)					
Breast Disease					
Cancer					
Depression					
Diabetes					
Epilepsy/Neurologic Problems					
Eye Problems					
Gallbladder Problems					
Heart Problems					
Hypertension (High Blood Pressure)					
Kidney Problems					
Liver Problems (Hepatitis, Cirrhosis)					
Migraine Headaches					
Skin Disease					
Stomach Disorders (Ulcer, H. Hernia)					
Stroke / Blood Clot					
Thyroid Disease (Metabolism)					
Urinary Incontinence					
Varicose Veins / Phlebitis					

**FAMILY HISTORY** (Include Parents, Grandparents, Siblings and Children, only)

CONDITION	NO	YES	RELATIONSHIP	COMMENTS
Alcoholism				
Arthritis				
Asthma				
Bleeding Tendencies				
Cancer: Breast				
Cancer: Colon				
Cancer: Ovarian				
Cancer: Uterine				
Cancer: Other				
Colitis				
Diabetes				
Epilepsy				
Gallbladder Disease / Ulcer				
Heart Disease / Attacks				
Hypertension (High Blood Pressure)				
Kidney Disease				
Mental Illness				
Stroke				
Thyroid Disease				

# ObGyn Associates of No. Indiana, PC

## Financial Policy

We are committed to providing you with the best possible medical care. We are available to work with you if you have special financial needs. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Our office participates in a variety of insurance plans. **It is your responsibility to:**

- Bring your insurance card to every visit;
- Obtain the necessary physician referral or pay all office fees at time of service or completion of services. NOTE: if the referral has not been obtained, you will be asked to sign an Insurance Referral Waiver.
- Remit payment for medical care not covered under your insurance (deductibles, co-pays, non-covered services, etc.) at time of service;
- Be prepared to pay your co-pay at each visit. Payment may be made by cash, check or credit card.
- All private pay fees will be collected at time of service.

If we do not participate in your insurance program, our office is happy to file the claim; however, payment in full is expected from you within 30 days.

For patients 17 years and younger, a parent or guardian must accompany them and sign below (exception: patients 17 years and younger declared emancipated minors). It is the parent or guardian's responsibility to bring the necessary referrals and insurance cards and also to make any payment due at time of service.

Our charges are determined by what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company's member services department (the number is on your insurance card).

Our practice firmly believes that a good physician/patient relationship is based upon understanding and communication. Questions about financial arrangements should be directed to the Central Billing Office. The office may be reached by dialing 574-251-2100.

**Please sign below to indicate that you have read and agree to this Financial Policy.**

I understand and agree to this Financial Policy:

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Signature of Patient or Responsible Party

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Date