Healthy Woman
Obstetrics Gynecology

312 Professional View Drive
Building 300, 2d Floor
Freehold, NJ 07728
P: (732) 431-1616
F: (732) 866-7962

PATIENT INFORMATION

Patient Name: _____
(First) (Middle) (Last)

Preferred Name: _____ Maiden Name: _____ Prefix: _____ Suffix: _____

Date of Birth: _____ Sex: ❑ Female ❑ Male Social Security #: _____

Race: ❑ Am Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ White ❑ Nat Hawaiian/Pacific Islander ❑ Declined ❑ Other

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Declined

Preferred Language: ❑ English ❑ Spanish Other: _____

Marital Status: Single Married Widowed Divorced

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: Home: _____ Work: _____ Cell: _____ Primary: ❑ Home ❑ Work ❑ Cell

Email: _____

Preferred Pharmacy: _____ Preferred Pharmacy Number: _____

Preferred Pharmacy Address: _____

Preferred Communication Method: ❑ Email/Patient Portal ❑ Mail ❑ Phone-Cell ❑ Phone-Home ❑ Phone-Work (automated appointment reminders) ❑Other: _____

PRIMARY INSURANCE

Primary Insurance Plan: _____ Policy Number: _____

Group Number: _____

Subscriber/Policy Holder Name: _____ Subscriber Date of Birth: _____

Subscriber SSN: _____ Subscriber Address: _____

Relationship to Patient: _____ Effective Date of Coverage: _____

SECONDARY INSURANCE (If applicable)

Insurance Company Name: _____ Insurance Phone: _____

Insurance Company Address: _____

Insurance Policy ID: _____ Group Name/Number: _____

Subscriber/Policy Holder Name: _____ Subscriber Date of Birth: _____

Subscriber SSN: _____ Subscriber Address: _____

Relationship to Patient: _____ Effective Date of Coverage: _____ Copay: $_____

EMERGENCY CONTACT

Name: _____

Home Phone: _____ Work Phone: _____ Relationship to Patient: _____

EMPLOYER INFORMATION

Employer: _____ Employment Status: ☐ Full time ☐ Part Time

Occupation: _____ Employer Phone: _____

Employer Address: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: _____
(Last) (First) (Middle)

Address: _____

Home Phone: _____ Work Phone: _____ Relationship to Patient: _____

Date of Birth: _____ Sex: ☐ Female ☐ Male Social Security #: _____

AUTHORIZATION AND CONSENT (Please initial each line item and sign and date below)

_____I authorize the providers at Healthy Woman OBGYN to render treatment deemed necessary in his/her professional opinion. I will make every effort to comply with the recommended course of treatment.

_____I understand that payment is due at the time service is rendered. I understand that copays are due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows Healthy Woman OBGYN to release any information to any of my insurers or

physicians. I authorize Healthy Woman OBGYN access to view my pharmacy benefits when available from my insurance company.

_____I authorize and direct my insurers to pay directly to Healthy Woman OBGYN and/or its physicians any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to Healthy Woman OBGYN including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to Healthy Woman OBGYN and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees. I hereby agree to pay all costs and reasonable fees in the event this account is turned over for collections. I authorize Healthy Woman OBGYN to contact me on any phone number provided by me for the purposes of conducting business with me or contacting me concerning my account. I understand that I am financially responsible to Healthy Woman OBGYN for all charges not covered, approved or considered necessary by my insurance company. I will pay at the time of service or will establish an agreeable payment arrangement with the Office Manager.

Signature: _____ Date: _____

Signature: _____ Date: _____

Responsible Party Signature (if different than patient)

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Obstetrics | Gynecology

Joseph Cipriano, MD FACOG
Rebecca Cipriano, MD FACOG
Susan Pacana, MD FACOG
Neeti Misra, MD FACOG
Borislava Burt-Libo, DO
Julie Leizer, MD
Frosty Romano, CNM

www.healthywomanobgyn.com

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COLTS NECK
340 Highway 34
Suite D-2
Colts Neck, NJ 07722
Tel: (732) 431-1616
Fax: (732) 866-8446

Authorization for Release of Protected Health Information

I authorize the staff and/or physicians at Healthy Woman OBGYN to discuss my healthcare, diagnosis, test results, procedures, prognosis, insurance and billing information with the following person(s) for the purpose of my treatment or payment of services rendered:

_____ _____
Name of Designated Person Relationship to patient

_____ _____
Name of Designated Person Relationship to patient

I DO NOT wish to designate any person(s)*

*Please note for children under 18 years of age, information will be released to the parent or legal guardian.

I authorize the release of my Protected Health Information to the following physician(s) or facility(s) for the purpose of my treatment.

_____
Name of Designated physician/facility Type

_____ _____
Name of Designated physician/facility Type

I understand that in order to ensure continuation of care, the staff and/or physicians at Healthy Woman may need to leave messages on the answering machine at my home or with any individual(s) who may answer my home phone. These messages may include but are not limited to: appointment confirmations, lab results, radiology results, pathology results, etc.

- ☐ I DO wish to have messages left
- ☐ I DO NOT wish to have messages left.
- ☐ I DO NOT wish to have email sent.

I understand that by designating the above individual(s) or facility(s), I am allowing my Protected Health Information (medical records/information) to be discussed or released to them. I know that this is my personal choice and I have not been forced to designate any individual(s) or facility(s) if I have chosen not to.

X _____ ____/____/____
Patient Signature DATE
Print name: _____

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MEDICAL SERVICES WAIVER

I understand that I am presenting myself in the office today for medical services to be performed. While many insurance companies cover the services that may be performed, such as an annual well exam (including pap smear, breast exam, other age appropriate screenings), biopsies, colposcopies, and injections, I have been informed that some insurance companies do not. If my insurance company does not pay Healthy Woman OBGYN for the services performed today I understand that any charges incurred during my exam will be my financial responsibility.

I understand that I will also be responsible for any copay or coinsurance payment due to Healthy Woman OBGYN at the time of services, per the requirements of my health insurance plan contract.

Lastly, I understand that if I require a referral or preauthorization for Healthy Woman OBGYN's services or any additional services recommended by Healthy Woman (including but not limited to radiology and lab work). I am responsible for either obtaining the correct referral OR notifying the office within forty eight (48) hours of the date of service to obtain an authorization. If I fail to do so, I will be responsible for the balances billed by Healthy Woman OBGYN or outside parties for these services.

X _____
Patient Signature

_____
Print Patient Name

If patient is under 18:

X _____
Parent/Guardian Signature

_____
Print Patient Name

Date: _____/_____/_____

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HEALTH QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name: **Age:**

Email: **Phone #:**

When is the best time to reach you?

HEALTH HABITS

Are you unhappy with your general health/weight? ☐ Yes ☐ No

Would you like to speak with the doctor about ways to improve your physical appearance without surgery? ☐ Yes ☐ No

Would you like to hear about a proven weight loss program? ☐ Yes ☐ No

MENSTRUATION

Are you done having children? ☐ Yes ☐ No

Do you experience heavy bleeding? ☐ Yes ☐ No

Would you like to hear about a 12 minute office procedure that lightens your cycle 90 per cent of the time? ☐ Yes ☐ No