Women's Health Connecticut

CCOG Women's Health Group
Member of Women's Health Connecticut

Devoted to women, committed to excellence

Obstetrics & Gynecology
Amy S. Breakstone, M.D., FACOG
Wendy M. Latshaw, M.D., FACOG
Carmelina Luongo, M.D., FACOG
Suzanne E. Miller, M.D., FACOG
Candice Shea, M.D., FACOG

Nurse Midwifery
Jennifer Ahimsa, C.N.M.

Dear Patient,

Welcome and thank you for choosing CCOG Women's Health Group for your obstetric and gynecological care. The doctors and midwives, along with a well-trained support staff, are committed to providing you with the highest quality care.

In preparation for your upcoming visit, we are asking you to read and complete the enclosed forms in their entirety. **Please mail the completed forms to our office before your scheduled appointment.** We will always make an effort to confirm your visits with us a day prior to your appointment but, if you are unable to keep an appointment, please try to give us 24 hours notice.

We will submit claims for all insurances that we do participate with. **Please bring your insurance card and copay, if applicable, along with a photo ID with you each time you visit the doctor.** If your insurance is one that we do not participate with or a commercial type insurance, we will appreciate payment at the time of the visit and it will be your responsibility to submit the claim. We do accept Mastercard and Visa payments for your convenience.

You must arrive 15 minutes prior to your scheduled appointment.

Please feel free to contact our staff at any time with your questions or concerns. We look forward to working with you.

Thank you, and welcome to CCOG Women's Health Group.

Please visit our website at: ccogwomenshealth.com

02/12

1131 West Street
Building 2
Southington, CT 06489
860-276-6800
860-276-6801 fax

25 Newell Road
Suite E-35
Bristol, CT 060:0
860-276-6800
860-276-6801 f: x

www.womenshealthct.com/ccog

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Name______________________________ Date______________________

Date of Birth_________________________ Race______________________

Height____________ Weight____________ Religion______________________

Employer_____________________________ Occupation__________________

Primary Care Physician______________________

Pharmacy______________ ______________________ ______________

(Street Address) (City)

PLEASE LIST ANY MEDICAL PROBLEMS AND TREATING PHYSICIAN:

1.____
2.____
3.____

PLEASE LIST ALL SURGICAL PROCEDURES:

Year	Type of Surgery	Reason for Surgery	Complications
1.			
2.			
3.			

Age of first period______Last menstrual period______ How long do your periods last________________

How often do you receive your periods ______ Are your periods regular or irregular ________________

Are you: **Pre/Peri/Post** menopausal (**please circle**) Number of years on Hormone Replacement Therapy_____

PLEASE LIST ALL PREGNANCIES:

Date of Delivery	Sex	Type of Delivery/Complications
1.		
2.		
3.		

For Internal Use Only
PT ID Number
Last Verified ______

Visit our website at: www.GoToMyDoc.com

Patient Information

Last Name ______ First Name ______ M.I. ______ Maiden or Nickname ______

Street Address ______ Apt. ______ P.O. Box ______

City ______ State ______ Zip ______ DOB ______ Last Four Digits of SS # ______

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Other Home phone: ______

Work phone: ______ Ext ______ Cell Phone: ______ Primary # to call me: ☐ **H** ☐ **W** ☐ **C**

E-Mail Address ______ May we email you? ☐ Yes ☐ No

Clinical Research: We do clinical research to advance women's health. May we notify you of upcoming studies? ☐ Yes ☐ No

May we examine your medical record, and/or billing information to determine your eligibility for a Clinical Study? ☐ Yes ☐ No

Patient's Employer Information

Employer Name ______ Employer Phone # ______

Employer Address ______
Street City State Zip

Occupation: ______ If Student ☐ Full time ☐ Part time School ______

Insurance Information - Primary / Secondary / Other Do you have health insurance? ☐ Yes ☐ No

Primary Insurance ______ **Copy of Card?** ☐ **Yes** ☐ **No**

Subscriber ______ DOB ______ Relationship ______

Secondary Insurance ______ **Copy of Card?** ☐ **Yes** ☐ **No**

Subscriber ______ DOB ______ Relationship ______

☐ Spouse's Or ☐ Parent's Information

Name ______ Birth Date ______ Last 4 digits of SS# ______

Employer ______ Employer's Phone # (______) ______

Employer Address ______

Emergency Information: MUST BE COMPLETED (e.g. nearest relative preferably not living with you)

In case of an emergency / urgent matter, we may contact:

______ ( ) - ______ Telephone No. ______ Relationship to Patient

Other

Primary Care Physician: ______ Primary Physician in This Office: ______ Referring Physician: ______

Authorization for Treatment, Payment & Healthcare Operations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to the Physicians for Women's Health LLC, its successors and assigns, or any individual it may designate for services provided.

As part of this authorization, Physicians for Women's Health LLC will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law unless otherwise indicated. I understand that I have the right to request that services for which I have paid out-of-pocket, not be disclosed to my health plan.

I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as costs including attorney's fees, associated with the collection of any amounts due for services rendered. I understand that I am financially responsible to Physicians for Women's Health LLC, its successors and assigns or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I understand and acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered.

______
Signature of Patient or Parent of Minor Date

Medicare Authorization for Treatment, Payment & Healthcare Operations, Medicare Recipients Sign both Authorizations.

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Physicians for Women's Health LLC for services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

______
Patient's Signature Date

CT99990116 Rev. 1/11

Notice of Privacy: ☐ Received ☐ Refused ______
Signature of Patient or Parent of Minor Date

May release protected health information to: ______
Relationship

Confidential Communication Request

CCOG
1131 West St Bldg 2
Southington, CT

25 Newell Rd Suite 35
Bristol, CT

860-276-6800 / fax 860-276-6801

As required by the Health Insurance Portability and Accountability Act (HIPAA) as amended, you have a right to request communications concerning your personal health information, including appointment reminders, and other health-care related information, be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided. This medical practice will respond to your written request to make changes within 14 days after receiving a new request. Please complete entire form and forward to Privacy Officer at address listed above.

I, ______________________________ hereby request use of confidential channels for communication of
(print name)
information related to personal health, treatment or payment for treatment of ____________________________.
(print patient name)

Patient: Date of Birth: __________________ Social Security # (last 4 digits): ________________________________

Preferred Method of Contact

Home Phone Number ____
☐ Do NOT leave message ☐ May leave return number only ☐ May leave message

Work Phone Number ____
☐ Do NOT leave message ☐ May leave return number only ☐ May leave message

Cell Phone Number ______________________________________
☐ Do NOT leave message ☐ May leave return number only ☐ May leave message

Email Address (When Available) ____
☐ Do NOT send message ☐ May send return number only ☐ May relay message

☐ Authorized persons with whom we may share patient's personal health information:

****This Consent Has NO Expiration unless indicated otherwise in the "Note" area****

Name: __________________________________ Relationship: __________________ Note: _______________________

Name: __________________________________ Relationship: __________________ Note: _______________________

Name: __________________________________ Relationship: __________________ Note: _______________________

Describe below other means you may request for confidential communication:

____

I understand that it is my responsibility to notify the office of any changes to the above listed choices.

Patient Signature: ____________________________ **Date:** _______________________

If this form were not completed by the patient, please sign below and state relationship to patient:
Signature: ____________________________________ **Date:** _______________________

Relationship to Patient: ☐ Parent ☐ Legal guardian ☐ Conservator ☐ Personal representative

A division of Physicians for Women's Health

Effective April 14, 2003 with Updates: 4/29/04; 1/6/10; 4/14/11; 10/18/11; 11/1/13; 1/15/14; 8/14/14

Medical Records Release/Request Form

Patient Authorization for Use or Disclosure of Protected Health Information: As required by the Health Portability and Accountability Act of 1996 (HIPAA) and CT Law, a practice may not use or disclose identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you give permission for uses and disclosure described below. Review and complete this form entirely. You may wish to ask the person or entity you want to receive your information to complete those sections detailing the information to be released, and the purposes for the disclosure. Per DPH Regulation 192.14.43, if you are leaving the practice, we have the right to dispose of your records once copies have been transferred.

I hereby authorize ______________________________ to release health information on patient named below:

Patient Name (Print) ______________________________ Date of Birth ______________

Other name eg; (maiden) ______________________________ Telephone ______________

Address ______________________________ City/ State ______________ Zip __________

Date of Service Release ______________________ OR, the entire Medical Record ☐

Reason for release (must be noted): ______________________________

Send medical records to: ______________________ Address ______________________

City ______________ State ______ Zip ________ Phone ( ) ____________ Fax ( ) ____________

RESTRICTIONS: I understand the recipient of this information may not use or disclose this information except for the expressed purposes identified above; or such use or disclosure is specifically required or permitted by law.

I understand my medical record may include information relating to sexually transmitted disease; acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV); behavioral/mental health services; and/or treatment for alcohol and/or drug abuse. I request the following exclusions as indicated by my initials:

EXCLUSION(S): Alcohol/Drug ______, Behavior/Mental Health/Psychiatric______, Sexually Transmitted Disease ______,

HIV/AIDS ______, Other ______; specify other exclusion ______________________________

I understand I have the right to request that services I have paid out-of-pocket, not be disclosed to my health plan.

This authorization is effective ____________________ through ____________________ (dates must be specified).

Signature: ______________________ Print Name: ______________________ Date: ______________

If this form is completed by someone other than patient, please print name, address, and initial below to indicate relationship.

Name: ______________________ Address: ______________________________

Guardian: ______ Conservator: ______ Parent: ______ Patient's Representative: ______

I understand that I have the right to receive a copy of this authorization.

Refusal to Sign Authorization: I understand that:

- By declining to sign this form my medical (health care) treatment and insurance benefits will not be affected, however, my medical records CANNOT be released.
- I may revoke this authorization at any time by notifying this medical practice in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken prior to its receipt.
- if the recipient of my information is not a health care provider/health plan covered by HIPAA, the information may be re-disclosed by the recipient and no longer is protected by HIPAA. However, other State or Federal laws may prohibit recipient from disclosing specially protected information, such as abuse treatment information, HIV/AIDS-related information or psychiatric/mental health information.

As referenced in section 20c (b), CT Statutes, physicians may charge $.65 per page to copy medical records, plus any conveyance fees the office is required to pay. Fees are payable in advance, by cash or credit card.

Approved 6/09; Revised 11/11