

*Ricki Pollycove, M.D.*

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Patient Information

Date \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Name to be called \_\_\_\_\_

Date of Birth \_\_\_\_\_

SS# \_\_\_\_\_  
(Not Required)

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
MESSAGE YES / NO YES / NO YES / NO

Fax # \_\_\_\_\_

Cover Letter Necessary? YES / NO

Email Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ Title \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse/Domestic Partner Name \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Religious Preference/Practice \_\_\_\_\_

Please give your insurance card and photo id to the front desk.

We keep a copy for specimen send out and authorization purposes such as prescriptions or lab work.

# Ricki Pollycove, M.D.

## Medical History

Name \_\_\_\_\_ Age \_\_\_\_\_ Referred By \_\_\_\_\_  
Reason for Visit \_\_\_\_\_

### Medical History

Please check if you or a blood relative has had any of the following:

- ◆ Frequent Headaches or Neurological Disorder Self\_\_\_\_ Family\_\_\_\_
- ◆ Thyroid Disorder Self\_\_\_\_ Family\_\_\_\_
- ◆ High Blood Pressure or Heart Disease Self\_\_\_\_ Family\_\_\_\_
- ◆ Asthma, Tuberculosis or Lung Disorder Self\_\_\_\_ Family\_\_\_\_
- ◆ Jaundice or Hepatitis Self\_\_\_\_ Family\_\_\_\_
- ◆ Anemia or Blood Disorder Self\_\_\_\_ Family\_\_\_\_
- ◆ Diabetes Self\_\_\_\_ Family\_\_\_\_
- ◆ Cancer Self\_\_\_\_ Family\_\_\_\_
- ◆ Stomach, Bowel or Gallbladder Problems Yes\_\_\_\_ No\_\_\_\_
- ◆ Bladder or Kidney Problems Yes\_\_\_\_ No\_\_\_\_
- ◆ Do you frequently lose urine when you cough, laugh, sneeze? Yes\_\_\_\_ No\_\_\_\_
- ◆ Have you ever had a Blood Transfusion? Yes\_\_\_\_ No\_\_\_\_
- ◆ Other medical problems? Yes\_\_\_\_ No\_\_\_\_
  - If yes, please explain \_\_\_\_\_
- ◆ Are you allergic to any medications? Yes\_\_\_\_ No\_\_\_\_
  - If yes, please list all of the medications **and** adverse reaction \_\_\_\_\_
- ◆ Are you presently taking any medications or hormones? Yes\_\_\_\_ No\_\_\_\_
  - If yes, what medications are you taking? Please include strengths. \_\_\_\_\_
- ◆ Mental health disorders, past or present therapy? Yes\_\_\_\_ No\_\_\_\_
  - If yes, please explain \_\_\_\_\_

### Hospitalization/Surgery

Date	Illness/Operation
_____	_____
_____	_____
_____	_____
_____	_____

### Lifestyle/Habits

- ◆ Heterosexual \_\_\_\_\_ Homosexual \_\_\_\_\_ Bisexual \_\_\_\_\_ Transgender \_\_\_\_\_
- ◆ Exercise \_\_\_\_\_ # days/week Form of Exercise \_\_\_\_\_
- ◆ Smoking \_\_\_\_\_ cigs/day or week Number of Years \_\_\_\_\_
- ◆ Drugs (marijuana, cocaine, other) Daily \_\_\_\_\_ Occasionally \_\_\_\_\_ Never \_\_\_\_\_
  - Addictions - past/present treatment Yes\_\_\_\_ No\_\_\_\_
- ◆ Alcohol (beer, wine, other) Daily \_\_\_\_\_ Occasionally \_\_\_\_\_ Never \_\_\_\_\_
- ◆ Alcoholism - past or present treatment Yes\_\_\_\_ No\_\_\_\_

# Ricki Pollycove, M.D.

## Gynecological History

- ◆ 1st day of last menstrual period? \_\_\_\_\_ If post-menopausal, mo/yr of last menstruation \_\_\_\_\_
- ◆ Date of most recent Pap Smear (if applicable) \_\_\_\_\_ with Dr. \_\_\_\_\_
- ◆ Have you had a Mammogram? Yes \_\_\_ No \_\_\_ If yes, date \_\_\_\_\_ and location \_\_\_\_\_
- ◆ Do you have regular periods? Yes \_\_\_ No \_\_\_ If yes explain \_\_\_\_\_
- ◆ What do you use for contraception? \_\_\_\_\_
- ◆ Do you do monthly self breast exams? Yes \_\_\_ No \_\_\_

Please check the box if any of the following applies to you:

- ◆ Breast discharge or lumps Self \_\_\_ Family \_\_\_
- ◆ Recurrent vaginal infections (yeast, bacterial vaginitis, etc.)
- ◆ Recent vaginal itching, unusual discharge, or odor
- ◆ Genital Herpes
- ◆ HPV
- ◆ Condyloma (warts)
- ◆ Abnormal Pap Smears
- ◆ Ovarian Cysts or Tumors Self \_\_\_ Family \_\_\_
- ◆ Fibroids
- ◆ Endometriosis
- ◆ Infertility Self \_\_\_ Family \_\_\_
- ◆ Abnormal Bleeding
- ◆ DES Exposure
- ◆ Sexual problems/abuse
- ◆ Pelvic infection (PID), Gonorrhea, Chlamydia, Syphilis 
  - Do you want to be screened for these STDs? Yes \_\_\_ No \_\_\_
  - Do you want to be screened for the antibody for the AIDS virus (HIV)? Yes \_\_\_ No \_\_\_
- ◆ Since 1979 have you been involved in any of the following situations:
  - Used IV drugs or had a partner who used IV drugs? Yes \_\_\_ No \_\_\_
  - Had sexual contact with a bisexual man or a man who has developed AIDS? Yes \_\_\_ No \_\_\_
  - Had 5 or more sexual partners within 3 years? Yes \_\_\_ No \_\_\_
  - Received blood products? Yes \_\_\_ No \_\_\_
  - Lived in or had a sexual partner who lived in areas where AIDS is endemic? Yes \_\_\_ No \_\_\_  
(Haiti, Burundi, Rwanda, Zaire, Congo, Tanzania, Kenya)

## Pregnancy History

Times Pregnant \_\_\_ Abortion \_\_\_ Ectopic/Miscarriage \_\_\_ Premature Birth \_\_\_ Living Children \_\_\_

Name	DOB	Weight	Sex	Weeks	Vaginal/C-section	Complications

# *Ricki Pollycove, M.D.*

## OFFICE POLICIES

### **Appointments**

Appointments can usually be made up to 6 months in advance. Our office makes every effort to confirm appointments at least 2 business days prior to scheduled appointments. If an appointment needs to be canceled or rescheduled, it is the responsibility of the patient to make the changes in a timely manner.

### **Cancellation Policy**

This time is reserved for you exclusively. If you are unable to keep this appointment, no charge will be made provided notice has been given 2 business days prior to your appointment.

Otherwise, a fee of \$175 for existing patients and \$450 for new patients may apply.

### **No Shows**

A fee of \$175.00 for existing patients and \$450 for new patients will be assessed to all patients who miss their appointments without notification. **Please note:** In order to honor all of our patient's valuable time, if you are more than 10 minutes late for your appointment, it may need to be rescheduled.

### **Phone Appointment**

Phone appointments are charged approximately the same fees as an in office appointment. We will need your credit card information on file before the call.

### **Lab Review Protocol**

In order to improve the comprehensive care provided to all of our patients, please allow 10–14 days turnaround time on all blood draws or cultures. Once your results are in, Dr. Pollycove will review them along with your chart and delineate any changes needed to your plan of care. If there is anything to report, you will either be called by our staff, or this will then be discussed with you at a follow-up appointment with Dr. Pollycove.

### **Payment Information**

Dr. Pollycove does not accept insurance at this time and has chosen to opt out of Medicare as well. Dr. Pollycove made this decision based on insurance company's restricted guidelines for providing care, which conflicts with her own personal practice and quality of patient care. To facilitate your submitting your insurance claim to your insurance company on your own, you will be provided with the appropriate billing information at your time of check out.

**\*\*Payment is required at time of visit. We accept Visa, MasterCard, American Express, checks or cash.**

There is a fee of \$25 for all returned checks.

If you have questions regarding reimbursement on a claim that you have submitted, please contact your insurance company directly as we do not have access to that information.

\*Please note that any tests that are ordered by Dr. Pollycove, including specimens collected during your visit, are sent to the lab to be processed, and you may receive an invoice from an outside laboratory regarding these orders.

\*\*\*\*\*By Signing below you have acknowledged and agreed to our office policies.

**PATIENT SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

## HIPAA Patient Consent

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing.

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**Patient Name**

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**Signature**

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**Date**

## Information Release Authorization

I hereby authorize the office of Dr. Ricki Pollycove to share my Medical Information/Records with:

Primary Care Physician/Referring Physician/Any Physician I am referred to by Dr. Pollycove.

I also authorize release to the following individuals listed below:

{Please check all that apply and write name of individual}

Secretary: \_\_\_\_\_ Phone: \_\_\_\_\_

Personal Assistant: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse: \_\_\_\_\_ Phone: \_\_\_\_\_

Other: \_\_\_\_\_ Phone: \_\_\_\_\_

**\*\*\* Please Note: This shall be considered valid and effective until otherwise notified by you.**

Patient's Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

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# *Ricki Pollycove, M.D.*

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## Private Contract Between Medicare Beneficiary and a Physician Not Participating in the Medicare Program

- I Ricki Pollycove, M.D., have not been excluded from Medicare under [1128] §§1128, [1156] 1156 or [1892] 1892 of the Social Security Act.
- I the Medicare beneficiary, or my legal representative, accept full responsibility for payment of charges for all services furnished by Ricki Pollycove, M.D.
- I the Medicare beneficiary, or my legal representative, understand that Medicare limits do not apply to what Ricki Pollycove, M.D., may charge for items or services furnished.
- I the Medicare beneficiary, or my legal representative, agree not to submit a claim to Medicare or to ask Ricki Pollycove, M.D., to submit a claim to Medicare.
- I the Medicare beneficiary, or my legal representative, understand that Medicare payment will not be made for any items or services furnished by Ricki Pollycove, M.D., that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.
- I the Medicare beneficiary, or my legal representative, enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare. I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- The expected or known effective date and expected or known expiration date of the opt-out period is 10-01-2013 (effective date) and 10-01-2015 (expiration date).
- I the Medicare beneficiary or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
- This contract cannot be entered into by myself, the Medicare beneficiary, or by my legal representative, during a time when I, the Medicare beneficiary, require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with §3044.28 of the Medicare Carriers Manual)
- I the Medicare beneficiary, or my legal representative, will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract.
- I Ricki Pollycove, M.D., will retain the original contract for the duration of the opt-out period.
- I Ricki Pollycove, M.D., will supply CMS with a copy of this contract upon request.
- I Ricki Pollycove, M.D., understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

*Ricki Pollycove*

Ricki Pollycove, M.D. 01/01/2014

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(Patient's Signature)

-----  
(Date)

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(Patient's Printed Name)

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(Patient's Legal Representative Signature) (Date)

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(Representative Printed Name)

-----  
(Witness)

-----  
(Date)

-----  
(Witness Printed Name)

*Ricki Pollycove, M.D.*

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**Credit Card Authorization**

I authorize Dr. Pollycove to charge my credit card listed below for office visits, phone appointments, outstanding balances, and no show/cancellation fees.

CC# \_\_\_\_\_ Exp. Date \_\_\_\_\_

Type: \_\_\_\_\_

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Annual Administrative Fee

A wide variety of services that we provide require significantly more time on my part and that of my staff. They may include: negotiating on your behalf with individual pharmacy prescription plan formularies for you to continue on the product(s) that work best for you, overcoming barriers to patients obtaining insurance coverage for necessary/advisable Imaging tests, such as special types of ultrasounds, mammograms, MRI, PET and CT scans. Care and time are devoted to networking your care with other providers, making individualized referrals, obtaining lab test results and medical records from other providers or institutions. These and many more time-consuming services must accompany detailed, accurate and reliable health care if it is to be optimal in quality and exquisitely individualized and sensitive to your needs.

### Annual Administrative Fee:

Ages 40 +	\$1,250.00 per year
Ages -39	\$500.00 per year

- ❖ The first year is included with your New Patient Visit and is not charged separately.
- ❖ Annual fees start after your first year with our practice.
- ❖ Annual fees are due every year on the date that you signed up to participate.
- ❖ Annual fees are independent of appointment fees.
- ❖ If you elect not to participate after the first year we understand and will help provide you with referrals to other gynecology providers. As needed, please call our office for further information.

- ✓ By Signing Below you are acknowledging that we have informed you of our Annual Administrative Fee. Please note that you can elect to opt out at anytime.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date