Ricki Pollycove, M.D.

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 ____

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 and "No Shows"

New Patient Policy -The time sheduled is reserved for you exclusively. We require a **$350 Non-Refundable Deposit** to secure your first visit with us. This fee will be applied as a credit to your total visit cost. We understand that emergencies arise and do everything we can to accommodate you in rescheduling appointments when necessary.

If you are unable to keep a routine follow-up appointment, no charge will be made provided notice has been given 2 business days prior to your appointment. Otherwise, a fee of $175 will be charged. This is a courtesy to our office and other women who desire an appointment, yet Dr. Pollycove’s schedule is full.

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, with the cost reflecting not simply time on the call but Dr. Pollycove’s expertise and additional time we devote to completing laboratory orders, imaging needs, communication with other providers as individual women’s needs require. Your current credit card information must be valid and 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 laboratory results, blood draws, bacteriology cultures or imaging. Once your results are available, Dr. Pollycove reviews them, along with your chart, and determines any changes needed to your plan of care. If there is something Dr. Pollycove feels is urgent, you will be contacted by our staff (phone or email), in advance of a scheduled follow-up phone or in-office appointment. An in-depth discussion of non-urgent results (the majority) are comprehensively reviewed during a follow-up appointment with Dr. Pollycove.

Ricki Pollycove, M.D.
OFFICE POLICIES

Payment Information

Dr. Pollycove does not accept insurance and that includes Medicare as well. Dr. Pollycove made this decision based on insurance companies' restricted guidelines for providing care, which conflicts with her individualized, comprehensive, personalized practice and quality of patient care. To facilitate submission of your bill to your insurance company, an appropriately coded receipt, with appropriate billing information for your claim, will be provided at your time of check out to assist you in potential reimbursement. Our office does not file insurance claims as the contract with insurance companies is between the patient and her insurer.

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

There is a fee of $50 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. We do our best to be sure that the laboratory where specimens are submitted or patients are directed to have lab tests taken (blood tests, imaging, etc) are contracted with your insurer.

Although Dr. Pollycove is "out of network," and doesn't participate in PPO's or HMO's, this is why we ask for your current insurance information at the time of your visit, to save you money and frustration.

By Signing below you have read, acknowledged and agreed to all of 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.

____

Patient Name

____ ________________

Signature **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: __________________

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, M.D. 01/01/2014

____ ____

(Patient's Signature) (Date) (Patient's Printed Name)

____ ____

(Patient's Legal Representative Signature) (Date) (Representative Printed Name)

____ ____

(Witness) (Date) (Witness Printed Name)

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	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