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 ____

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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

CANCELLATION POLICY

In respect of Dr. Pollycove's time, if you have not notified us of an appointment change or cancellation **TWO BUSINESS DAYS** prior to your appointment, a $75.00 fee will be assessed to your account.*

NO SHOW/MISSED APPOINTMENT

A $175.00 fee will be assessed to all patients who miss their appointments without notification.*

**Your signed credit card authorization will be charged for the above policies.*

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.

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.

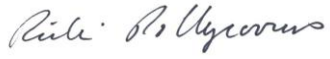
• This contract cannot be entered into by myself, the Medicare beneficiary, or by my legal representative, during a time when I, the Medicare beneficiary, require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare 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**