Grande Dunes ObGyn & Facial Aesthetics

913 Medical Circle, Myrtle Beach, SC 29572
Tel 843.839.2229 Fax 843.839.2230

Patient Registration Form Date:____________

First Name:____________________________ MI:________ Last Name:____________________________________

Date of Birth:____________________ Age:_______ Race:_____________Social Security #:________________

Address:____ Apt/Unit#:_________

City:_______________________________________ State:_____________ Zip Code:______________________

Primary Phone#:____________________________________ Other Phone #:______________________________

Driver's License #:_____________________________ Marital Status (circle): Single / Married / Divorced / Widow

Email:____

Employment (circle): Full Time / Part Time / Student / None May we contact you at work? Yes / No

Employer/School name:____________________________________ Employer Phone #:___________________

Emergency Contact:___________________________ Relationship to you:_____________ Phone#:__________

Spouse Information or Responsible Party (if Minor)

First Name:____________________________ MI:________ Last Name:____________________________________

Date of Birth:____________________ Age:_______ Race:_____________Social Security #:________________

Address:____ Apt/Unit#:_________

City:__________________________________ State:_____________ Zip Code:_______________________

Primary Phone#:____________________________________ Other Phone #:______________________________

Email:____ Relationship to Patient:_________________________

Employer:____ Employer Phone #:___________________________

May we contact them at work? Yes / No

Primary Insurance Information

Name of Policy Holder:____ Date of Birth:___________________

Policy Holder's Relationship to Patient (circle): Self / Spouse / Parent

Name of Insurance Company:_______________________________ Insurance Co. Phone#:________________

Policy Number:____________________________________ Group Number:_____________________________

Policy Holder's Employer:_________________________________ Employer Phone #:___________________

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for the patient listed above.

____ _____________________________________

Signature of Patient / Guardian Date

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COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:____ **Date of Birth**:______________

Grande Dunes ObGyn & Facial Aesthetics is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Please CHECK entities / persons that YOU approve to receive information:

1.) **Can we leave information on your voicemail?** YES _____ NO _____
Telephone #:________________________________
If yes to the above, what information may we leave?
Lab Results ___ Pap Results ___ Imaging Results ___ Financial Info ___ Billing Info ___ Appts ___
Medical as follows: ____

2.) **Can we email information to you?** YES _____ NO _____
Email:____
If yes to the above, what information may we leave?
Lab Results ___ Pap Results ___ Imaging Results ___ Financial Info ___ Billing Info ___ Appts ___
Medical as follows: ____

3.) **Please list anyone else you authorize us to leave information with:** (ie: **spouse / significant other / parent / etc)**
Name: _______________________________ Telephone #: ________________ Relationship to you:___________
Name: _______________________________ Telephone #: ________________ Relationship to you:___________
Name: _______________________________ Telephone #: ________________ Relationship to you:___________
What information may we leave?
Lab Results ___ Pap Results ___ Imaging Results ___ Financial Info ___ Billing Info ___ Appts ___
Medical as follows: ____

Rights of the Patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification to Grande Dunes ObGyn & Facial Aesthetics. I understand that a revocation is not effective in cases where information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

____ ______________________________
Signature of Patient or Personal Representative Date

Description of Personal Representative (attach necessary documentation) ____

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Tatiana Vu-Molaschi, MD
ABOG Board Certified

FINANCIAL POLICY

PATIENT RESPONSIBILITY:

Patients are responsible for payment in full on their account regardless of insurance coverage. Patients are responsible for presenting current insurance information at the time of service, and for understanding the provisions and limitations of their insurance plan. The Doctor neither knows, nor can she adjust billing according to what is or not covered.

If Grande Dunes ObGyn & Facial Aesthetics is a participating provider with the patient's insurance, the patient will be responsible for payment of any deductible and co-payment at the time of service. Grande Dunes ObGyn & Facial Aesthetics will accept and bill the insurance company for the contracted fee. However, if the insurance company denies the charges or fails to pay any portion of the bill, the patient agrees to pay that portion immediately.

If Grande Dunes ObGyn & Facial Aesthetics is not a participating provider with the patient's insurance company, the patient will be responsible for payment in full of all charges at the time of service. As a courtesy, Grande Dunes ObGyn & Facial Aesthetics will bill the insurance company on the patient's behalf.

- Many insurance companies DO NOT cover preventative services (routine annual exams). Patients are responsible for payment pf all non-covered services at the time of service.
- We are frequently asked to call in prescriptions. There is a $10.00 administrative fee for refills outside of an office visit. This charge is not covered by any insurance company and will be billed to the patient.
- There is a $20.00 fee for all forms that patients request our office to complete. This charge is not covered by any insurance company and will be billed to the patient.
- Medical appointments require at least 24 hour cancellation prior to appointment time otherwise will incur a $25.00 fee.
- Cosmetic appointments require at least 48 hour cancellation prior to appointment time otherwise will incur a $50.00 fee.
- Refunds for overpayment will be subject to a 3% service charge if original payment was made by credit card.

MEDICAID:

Medicaid is s federal and state funded program designed to provide coverage of medically necessary services for individuals that meet a minimum income criteria. We do not accept Medicaid when the patient has any other primary insurance coverage.

We DO NOT accept or file insurances (including Medicaid) retroactively from the date of services rendered.

NOTE: ***The waiver of deductibles and co-pays is unlawful and may be construed by the Federal Government as Insurance Fraud***

YOU WILL BE RESPONSIBLE FOR ALL COLLECTION FEES.

I have read and agree to the above terms and conditions. I authorize the release of any medical information necessary to process insurance claims. I authorize payment of medical benefits directly to Grande Dunes ObGyn & Facial Aesthetics for services rendered.

______________________________ ______________

PATIENT SIGNATURE DATE

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Tatiana Vu-Molaschi, MD
ABOG Board Certified

The American Congress of Obstetrics and Gynecology recommends HPV co-testing with pap smears on patients 30-65 years old. An HPV test may be done at the time of your pap smear as a result. Standard of care may involve HPV testing once every three years or more frequently. Please be aware of your insurance coverage regarding this testing. Ie: some insurance companies will only cover testing once every 5 years.

If you are 21-29 years of age, an HPV test may be done depending on the results of your pap smear.

Please sign below to acknowledge that you have read and understand this information.

______________________________ ____________________
Patient Signature Date

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GYNECOLOGY QUESTIONNAIRE

Name:______________________________________ DOB:____________ Age:________ Date:_____________

Pharmacy you would like prescriptions sent to:____

Problems or Symptoms you wish to discuss:____

____

____

HEALTH MAINTENANCE

Date of last Mammogram:______________________ If abnormal, please give details:______________________

____

Date of Last Pap Smear:________________________ If abnormal, please give details:______________________

____

Date of Last Bone Density Scan:________________ If abnormal, please give details:______________________

____

Date of Last Blood Work:______________________ If abnormal, please give details:______________________

____

Date of Last Colonoscopy:_____________________ If abnormal, please give details:______________________

____

GYNECOLOGIC HISTORY - Date of Last Period:_________ Current Birth Control Method:___________

How many days does your period last?___________ How many days between periods?___________________

Sexually Active? YES / NO Desire Sexually Transmitted Infection Screening? YES / NO

History of previous STI? YES / NO If yes, please list:____

____

Have you received treatment for this?____

Do you experience any hot flashes or other menopausal symptoms? YES / NO
If yes, would you like to discuss treatment for them today? YES / NO

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OBSTETRIC HISTORY

Number of Vaginal Deliveries:__________________ Number of Abortions:_____________

Number of Cesarean Sections:__________________ Number of Ectopics:______________

Number of Miscarriages:_______________________ Number of Living Children:________

Additional Details:____

MEDICAL HISTORY

Please list all Medical Conditions:____

____

Please list all Surgeries/Hospitalizations:____

____

Please list all Prescription Medications:____

____

____

Please list any Drug Allergies:______________________________________ Latex allergy? YES / NO

SOCIAL HISTORY

Tobacco use: YES / NO If yes, how much?____

How often do you drink alcohol?_____________________________ Do you use Illicit Drugs?_______________

Do you exercise / How often?____

Weight Gain / Loss?____

Changes in bowel or urinary habits?____

FAMILY HISTORY (Please give details, Paternal or Maternal)

Family history of Breast Cancer?____

Family history of Ovarian Cancer?____

Family history of Uterine Cancer?____

Family history of Cervical Cancer?____

Family history of Gastro-Intestinal Cancers?____

Notice Of Privacy Practices
for the office of

Grande Dunes OBGYN & Facial Aesthetics

913 Medical Circle Myrtle Beach, SC 29572
843-839-2229 Fax: 843-839-2230 Email: GRANDEDUNESOBGYN@AOL.COM

PRIVACY OFFICER: TATIANA VU-MOLASCHI, MD

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and disclosures to carry out treatment, payment, and health care operations

Treatment- This practice may use or disclose your protected health information in consultation between health care providers relating to your treatment or for your referral to another health care provider for your treatment.

Payment- This practice may use or disclose your protected health information for billing, claims management, collection activities, or obtaining payment.

Health care Operation- This practice may use or disclose your protected health information for reviewing the competence or qualifications of health care professionals, or for conducting training programs in which students, trainees, or practitioners participate. This practice may use or disclose your protected health information for accreditation, certification, licensing, or credentialing activities. This practice may use or disclosure your protected health information to our business associates who participate in our healthcare operations. These disclosures will only be made after we have satisfactory assurances in the form of a Business Associates Agreement from the business associate. These assurances will include their agreement to comply with the HIPAA rules and the compliance of any subcontractor with which they do business.

Authorized Uses or Disclosures

The following uses or disclosures require a valid authorization as defined by the HIPAA standards.

Uses or Disclosures for Psychotherapy Notes- Not applicable to this practice

Uses or Disclosures for Marketing Purposes- Not applicable to this practice

Disclosures for a Sale of Protected Health Information- This practice will require an authorization for any disclosures that would constitute a sale of protected health information.

For any other use or disclosure you wish us to make, you can give us a written, valid authorization. Your authorization must have specific instructions for the use and disclosure you want us to make. You will have the right to revoke the authorization in writing at any time before the information is used or disclosed.

Uses or disclosures requiring an opportunity for the individual to agree or object

For disclosures to others involved with your health care or payment, we will inform you in advance and give you the opportunity to agree or object. These disclosures will be limited to the information necessary to help with your health care or payment. These disclosures will only be made if you do not object.

Uses and disclosures for which an authorization or opportunity to agree or object is not required

The following uses or disclosures do not require an authorization or the opportunity for you to agree or object.

Uses and disclosures required by law-This practice may use or disclose protected health information to the extent required by law. The use or disclosure will comply with and be limited to the relevant requirements of such law.

Uses and disclosures for public health activities-This practice may use or disclose protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, and vital events such as birth or death.

Disclosures about victims of abuse, neglect or domestic violence
This practice may disclose protected health information about an individual whom this practice reasonably believes to be a victim of abuse, neglect, or domestic violence.

Uses and disclosures for health oversight activities-This practice may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, inspections, licensure, or disciplinary actions.

Disclosures for judicial and administrative proceedings- This practice may,
in response to an order of a court or administrative tribunal, provide only the protected health information expressly authorized by such order or a subpoena.

Disclosures for law enforcement purposes- This practice may disclose protected health information as required by law including laws that require the reporting of certain types of wounds or other physical injuries.

Uses and disclosures about decedents- This practice may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to a funeral director, as authorized by law, to carry out their duties. This disclosure will be made in reasonable anticipation of death.

Uses and disclosures for cadaveric organ, eye or tissue donation purposes- This practice may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Uses and disclosures for research purposes- This practice may use or disclose protected health information for research, when the research has been approved by an institutional review board or privacy board, to protect your protected health information.

Uses and disclosures to avert a serious threat to health or safety- This practice may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, in good faith, if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Uses and disclosures for specialized government-This practice may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register.

Disclosures for workers' compensation-This practice may disclose protected health information as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Patient rights under HIPAA

The following information describes your rights under the HIPAA Standards. This practice requires that all requests for the various rights be made in writing and we will provide our decision on your request in writing. You should be aware that there may be some situations when there could be limitations placed on your rights. We are required to permit you to request these rights, but we are not required to agree to your request, except as discussed in the Right of Restriction section**.**

Right of an individual to request a restriction of uses and disclosures
This practice will permit an individual to request that we restrict uses or disclosures of protected health information about the individual to carry out treatment, payment, or health care operations or to others involved in your care or in payment. We will consider these requests, but we are not required to agree to them, except as discussed in the next section.

Under your right of restriction, you may restrict certain disclosures of protected health information to a health plan for payment or healthcare operation, where payment in full is made out of pocket for a healthcare item or service

Confidential communication requirements
This practice will permit an individual to request and will accommodate reasonable requests to receive communications of protected health information from our practice by alternative means or at an alternative location.

Access of individuals to protected health information
An individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set except as prohibited by state or federal law or certain other exemption. Your access may be provided in electronic form if producible at your request or in another form or format. As permitted by state and federal law, we may charge you a reasonable cost based fee for a copy of your record. Questions about the fee should be addressed to our Privacy Officer at the phone number listed at the end of this document.

Amendment of protected health information
An individual has the right to ask to have this practice amend protected health information or a record about the individual in a designated record set for as long as the protected health information is maintained in the designated record set.

Accounting of disclosures of protected health information
An individual has a right to receive an accounting of disclosures of protected health information made by this practice in the past six years but not before April 14, 2003. The accounting will not include disclosures made for treatment, payment, or operations, as well as authorized disclosures or disclosures made for which you had an opportunity to agree or object. You may receive one free accounting in a 12 month period. There will a reasonable cost based fee for additional requests.

Right of Breach Notification
An individual has the right to and will receive a notification of any breach of their unsecured protected health information as defined by the Breach Notification Rule. We will fulfill our obligation to provide notice in accordance to HIPAA standards.

Copy of this notice You have a right to a copy of this notice. Even if you agreed to receive an electronic copy, you may request and receive a paper copy.

Our Duties This practice is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This practice is required to abide by the terms of the notice currently in effect.

This practice is required to notify you of any change in a privacy practice that is described in the notice to protected health information that we created or received prior to issuing a revised notice. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. Revised Notices will be available and posted at our offices(s) and posted on our web site, if applicable.

Complaints

If at any time you feel we have violated your HIPAA rights, please contact our Privacy Officer or the Secretary of Health and Human Services. This practice will not retaliate against any individual for filing a complaint.

Contact

You have the right to file a complaint with our Privacy Officer at the address and phone number at the top of this notice, or with the Office of Civil Rights, US Department of Health and Human Services, 61 Forsyth St., SW, Suite 3B70, Atlanta, GA 30323.

Effective Date of the Notice is September 20, 2013.