SNE Women's Health Partners in Obstetrics & Gynecology

333 School Street, Pawtucket, RI 02860 – 1525 Wampanoag Trail, East Providence, RI 02915
1050 Main Street, East Greenwich, RI 02818
Office: 401-724-0600 Fax: 401-724-1147

Lisa R. Domagalski, M.D. Tolga N. Kokturk, M.D. Stacey P. Lievense, M.D.
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The Doctor's and staff of SNE Women's Health Partners in Obstetrics & Gynecology would like to welcome you to our practice. We look forward to providing quality care and will do our best to make your visit positive and successful. Enclosed you will find new patient forms for your upcoming appointment, and other reading material. Please take a moment to complete all forms and bring them with you to your visit. Our office hours are Monday thru Friday from 9 AM to 5 PM. We are closed on Holidays. Appointments are scheduled on physician's availability.

Our Office has State of the Art On-site Testing

- Doctors on call 24/7
- Lab Work
- Non-Stress Testing
- Fetal Surveillance
- Ultrasounds
- Family Planning
- Complete Pre & Post-Natal Screening
- Compassionate Post-Partum Treatment
- Normal & High-Risk Pregnancies
- The latest in Surgical, Laser & Laparoscopic Procedures
- Non-Surgical Treatment of Gynecological Disorders

Release of Medical Records – For your protection, we allow for the release of medical records only with your Written consent. However, there is a fee associated with the release of medical records. Simply contact our office and we will be happy to provide you with the medical record request form that outlines the fees, and necessary information needed to initiate your request.

Medical Reports – Most medical reports regarding your appointment are usually completed within 14 days of your visit. A copy will be forwarded to your primary care physician at your request. Pap smear results usually take 4-6 weeks.

Prescription Refills – The request for prescription refills should be called in during normal business hours. Monday thru Friday from 9am and 3pm. Refills will not be filled during non-business hours.

Fees: Returned Check (NSF) $50.00, Completion of forms $10.00, Record Copies $15.00 and up.

Missed Appointments – You share in the responsibility of your medical care and are obligated to keep your Scheduled appointments. If you are unable to keep your appointment, we require 24 hours' notice. If you miss your scheduled appointment, you will be charged $50.00. Patients who are more than 15 minutes late may have to reschedule.

Insurance Cards – Please be sure to bring your insurance card(s) and a Picture ID with you to your appointment. If your insurance requires a referral, please be sure to bring it with you or have them fax it to us.
If you have had blood work, mammograms, or any other testing done, please have your doctor forward copies.

Financial Responsibility – You are responsible for all financial aspects of your medical care. Co-pays are required at time of visit. A service charge of $5.00 will be applied if payment is not made. We accept all major credit cards.

Emergencies – If you have an emergency during office hours, please call us. If you have an emergency after hours, our answering service will contact the physician on call. If necessary, call 911 or go to your nearest emergency room.

SNE WOMEN'S HEALTH
PARTNERS IN OBSTETRICS & GYNECOLOGY

Information regarding cross coverage

To best serve our patients, we have established an affiliation with a group of obstetrical physicians to provide coverage at the hospital when we are not available. The Physicians are highly trained and a caring group of individuals, whom we have known and practiced medicine with for years and whom we have great respect. This cross coverage group include physicians from our affiliated practices Broadway OB/GYN, Comprehensive OBGYN, and solo provider, Amr Kader, MD.

One aspect of this affiliation that may directly affect you, is our system of cross-coverage, which includes some weekdays, evenings, weekends and holidays. One of the Physicians from this group may respond to your phone call through our answering service and may also be at Women & Infants Hospital to manage your labor and delivery.

Please be assured that your prenatal medical record is available to the physician that will be managing your labor and delivery. That Physician will also be aware of any special problems or needs that you may have voiced or that have been identified during the course of your pregnancy.

If you need to speak to a Physician, please contact us at: 401-724-0600

If you would like any further information regarding the cross-coverage system,
please feel free to speak to your physician during your next prenatal visit.

PATIENT REGISTRATION

Last Name:_____ First Name:_____ Date of Birth:_____

Maiden Name: _____ Social Security: _____ Martial Status: ___S ___M ___D___W___

Address:_____ Apt # _____City: _____State: _____Zip: _____

Home Phone:_____ Cell:_____ Work Phone:_____

Method of Contact: (please circle one) Home # Work # Cell # Email Address:_____

Language: ☐ English ☐ Spanish Other: _____ Race: _____ Ethnicity:_____

Gender Identity: (circle) Female Transgender Male/ Female to Male Non-conforming Other:_____

Assigned Sex at Birth: Female Male Unknown Pronouns: (circle) she/her he/him they/them

Employer:_____ Occupation:_____ Phone:_____

Partners Name: _____ Date Of Birth: _____ Phone:_____

PRIMARY CARE PHYSICIAN: _____ PCP PHONE:_____

PCP Address:_____ City:_____ State:_____ Zip:_____

Pharmacy: _____Pharmacy Phone:_____

EMERGENCY CONTACT

Name:_____ Relationship:_____Phone:_____

INSURANCE INFORMATION

INSURANCE PLAN NAME_____

Insurance CO. Address_____ City_____ State_____ Zip_____

Policy Holder Name:_____Relationship:_____ DOB:_____

Policy # _____Group #_____

IF YOU HAVE TWO INSURANCES, PLEASE COMPLETE THE FOLLOWING:
SECONDARY INSURANCE NAME:

Insurance CO. Address_____ City_____ State_____ Zip_____

Policy Holder Name: _____Relationship:_____ DOB:_____

Policy # _____Group #_____

I hereby authorize the release of information necessary to file claim with my insurance company and assign benefits to Southern New England Healthcare for Women (SNEHW). I agree that I will pay any collection or attorney fees and costs incurred in collections on my account with SNEHW. I understand that I am financially responsible all charges not covered by my insurance, including those resulting from my failure to provide the practice with current/updated insurance information or obtain the necessary referral and/or other authorization from my primary care and/or referring physician when required a copy of this signature is a valid original.

Signature: _____ Date: _____

SNE Women's Health Partners in Obstetrics & Gynecology
333 School Street suite 205 Pawtucket RI 02860

Today's Date: _____

Last Name:_____ First Name:_____ Date of Birth:_____

Important: In order to provide the highest quality health care possible, it is important that we have the following information. Please answer all the questions as accurately as possible. If you do not understand the question, please ask for assistance. Thank you

PHARMACY: _____ PHARMACY PHONE: _____

Address _____ City_____ State_____ Zip_____

PRIMARY CARE PHYSICIAN _____ PCP PHONE: _____

Address _____ City_____ State_____ Zip_____

TELL US ABOUT OTHER PHYSICIANS WHO YOU MAY SEE:

PHYSICIAN:_____ SPECIALTY:_____

Phone: _____ Address: _____

PHYSICIAN:_____ SPECIALTY:_____

Phone: _____ Address: _____

LIST ANY ALLERGIES:_____

_____

LIST ALL MEDICATIONS: PRESCRIBED, OVER THE COUNTER AND HERBAL:

May we have your permission to contact your insurance to obtain a list of medications you have had filled during the last 13 months? YES NO

MEDICATION/DOSE/FREQUENCY	MEDICATION/DOSE/FREQUENCY

Last Name: _____ First Name: _____ Date of Birth:_____

GYN HISTORY

Age your period began: _____

Date of last Pap Smear: _____

Have you had an abnormal pap smear? YES NO

Are you sexually active? YES NO If Yes, MEN WOMEN BOTH

Current Birth Control Method: _____

Have you ever been diagnosed with any sexually transmitted infection or Disease? YES NO

Have you had an HPV vaccine? YES NO

If Post-Menopausal, Age at Menopause. _____

Have you had any Post-Menopausal bleeding? _____

Are you currently take any Hormone Replacement Therapy Medications? YES NO

Have you **ever** taken any Hormone Replacement Therapy medications? YES NO

Date of Last Mammogram: _____

Date of Last Colonoscopy: _____

Date of most recent bone density: _____

OBSTETRICAL HISTORY:

Have you ever been pregnant (Including termination of pregnancy) Yes NO

How many times have you been pregnant? _____

- Number of full-term deliveries: _____
- Number of premature deliveries: _____
- Number of terminations/abortions: _____
- Number of miscarriages: _____
- Number of tubal pregnancies: _____
- Number of twins/triplets: _____

How many living children? _____

Last Name: _____ First Name: _____ Date of Birth:_____

PAST PREGNANCIES:

	Delivery Date	# of fetuses	Weight	Sex	Delivery Type:	Full-term or Pre-Mature	Complications during pregnancy of delivery
1							
2							
3							
4							
5							
6							

PAST MEDICAL HISTORY: Circle ALL the Apply

Arthritis	YES NO	GI Problems (Please Specify)	YES NO
Acid Reflux (GERD)	YES NO	GYN Cancer (Please Specify)	YES NO
AIDS/HIV	YES NO	Headaches/Migraines	YES NO
Anemia	YES NO	Heart Problems	YES NO
Anxiety/Depression	YES NO	Hematologic Disorders (Please Specify)	YES NO
Asthma	YES NO	Hepatitis	YES NO
Bladder Disorder (please specify)	YES NO	High Cholesterol	YES NO
Breast Cancer	YES NO	High Blood Pressure	YES NO
Cancer	YES NO	Kidney Disorder (Please Specify)	YES NO
Coronary Artery Disease	YES NO	Lung Disease (Please Specify)	YES NO
Diabetes	YES NO	Osteoporosis/Osteopenia	YES NO
DVT/PE	YES NO	Psychiatric Illness	YES NO
Endometriosis	YES NO	Stroke	YES NO
Glaucoma	YES NO	Thrombophilia	YES NO
Fibromyalgia	YES NO	Thyroid Disorder	YES NO
Other:			

SURGICAL HISTORY-Please list any surgery you may have had in the past:

Type of Surgery	Date of Surgery

Last Name: _____ First Name: _____ Date of Birth:_____

FAMILY HISTORY:

Mother ☐ Living ☐ Deceased-Cause and Age of death: _____

Father ☐ Living ☐ Deceased-Cause and Age of death: _____

Number of Siblings: _____ Living: _____ Deceased: _____ Cause: _____

Has any of your blood relative (s) had the following, also specify the age relationship:

	YES/NO	Relative		YES/NO	Relative
Ovarian Cancer			High Blood Pressure		
Uterine Cancer			Kidney Disease		
Colon Cancer			Hyperlipidemia		
Breast Cancer			Diabetes		
Melanoma			Depression		
Prostate Cancer			Bipolar Disorder		
Heart Disease			Stroke		
Thyroid Disease			Osteoporosis		
Other					

SOCIAL HISTORY:

Occupation:_____

Level of Education:_____

Marital Status: (circle one) Single Married Divorced Separated Widowed Domestic Partner

Exercise Level: (circle one) None Occasional Moderate Heavy

Smoking Status: (circle one) Never a Smoker Former Smoker Smoker Have been smoking since_____ years old

Alcohol Intake: (Circle one) None Occasional Moderate Heavy

Do you use recreational drugs? NO YES,_____

Have you ever had abuse or domestic violence directed at you: NO YES

Do you routinely use a seat belt? NO YES

Do you use sunscreen regularly? NO YES

Is a blood transfusion acceptable in an emergency? NO YES

Do you have an advanced directive? NO YES

SNE WOMEN'S HEALTH PARTNERS IN OBSTETRICS & GYNECOLOGY

Patient Financial Policy

Participating Insurance

- SNE Women's Health Partners in Obstetrics & Gynecology participates with most medical insurance plans in the area.
- We will file a claim on your behalf and accept contracted payments for covered services.
- You are responsible to pay for plan deductibles, co-insurance and co-payments associated with the services rendered (out of pocket expenses).
- You are responsible to pay for services that your medical insurance plan does not cover or that they determine are not medically necessary
- Co-payments will be collected at the time of service. If not, an additional $5.00 fee will be charged.

Non-Participating Insurance

- SNE Women's Health Partners in Obstetrics & Gynecology does not participate with your insurance plan, you are responsible for payment of all charges associated with the services you

No Insurance

- Payment is expected at time of service.
- Payment plans are available but must be established before service are rendered.

Outstanding Balances

- Patients with an outstanding balance with SNE Women's Health Partners in Obstetrics & Gynecology will be expected to pay that balance, or commit to a payment plan before additional services are rendered.
- Outstanding balances may also include co-insurance, co-payments and/or non-covered services from prior visits, etc.
- Outstanding balances may also include amounts due for services provided by physicians at SNE Women's Health Partners in OB/GYN or Woman and Infants Hospital.
- We reserve the right to reschedule your appointments if you have a balance that is greater than 60 days, has been sent to collections, and/or no payment arrangements have been made.
- **Balances must be paid within 3 months of the first billing cycle unless arrangements have been made with the billing office to extend an additional 3 months, totaling 6 months. After 6 months balances will be sent to collection.**

Billing Department representatives are available on weekdays from 9:00 AM to 4:30 PM; please call 401-724-0600 OPT: 3. We accept cash, personal checks, MasterCard, Visa, American Express and Discover.

We reserve the right to charge $50.00 for appointments cancelled or broken without a 24-hour advance notice.

Please Read and Sign

I hereby authorize the release of any information necessary to file a claim with my insurance company and assign Benefits to SNE Women's Health Partners in OBGYN. I understand that I am financially responsible for balances not covered by my insurance carrier. Any copy of this form with your signature is as valid as the original.

_____	_____	_____
Signature of patient or responsible party.	Date	Account Number

Thank you for choosing SNE Women's Health Partners in OBGYN

Southern New England Healthcare for Women, LLC

HIPAA Notice of Privacy Practices

Effective as of April/14/2003
Revised March/26/2013

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may file a complaint with us by notifying our Compliance Officer at 401-722-5033 or contacting the Privacy Officer at your doctor's office. You may also contact the U.S. Secretary of Health and Human Services if you believe your privacy rights have been violated. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Southern New England Healthcare for Women, LLC

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of the Southern New England Healthcare for Women, LLC (dba SNE Women's Health) Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____	_____
Patient Name (Type or Print)	Patient's Date of Birth
_____	_____
Signature of Patient or Parent/Legal Guardian	Date

SNE WOMEN'S HEALTH PARTNERS IN OB/GYN **Designation of Personal Representative**

WHY IS THIS FORM NECESSARY?

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have a right to authorize another individual and/or entity to act on your behalf as a personal representative to manage your health care affairs, specifically when it comes to the use and access of Protected Health Information (PHI). Please complete this form completely so that we may provide you with the correct information you are requesting.

Member Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Patient account ID#: _____

1: Designation of Personal Representative. At my request, I hereby name the following individual as my personal representative and authorize my PHI be released to him/her.

Name: _____ Relationship to Member: _____

2: Release of PHI. I authorize the following disclosures of my PHI to the individual listed above.

- ☐ My entire PHI
- ☐ Claims and Explanation of Benefits (EOB) Information
- ☐ Enrollment and Benefits
- ☐ Premium Payment Information
- ☐ Any Documents Related to an Appeal
- ☐ Mental Health & Substance Abuse Information
- ☐ All Service for a specific date from (start date):_____ TO (end date):_____
- ☐ Other (Please list specific PHI):_____ _____

3: Reason for Release: The Information may be released for the following reason(s) ("at the request of the requestor" is a sufficient description): _____

_____

4: Expiration of Request. This request will expire when I am no longer an eligible member of my current health coverage. Unless I specify the following:

☐ Date: _____ OR ☐ After specific event (i.e., surgery, and of pregnancy, etc.)_____

5: Revocation/Cancellation of Designation. I understand that I may revoke this request and/or cancel the designation at any time by notifying the office of SNE WOMEN'S HEALTH PARTNERS IN OB/GYN writing. I understand and acknowledge that revocations/cancellations of this designation shall not apply to information that has already been released or affect actions taken by SNE WOMEN'S HEALTH PARTNERS IN OB/GYN prior to this request.

6: Rights. I understand and acknowledge this designation is voluntary and I may refuse to sign this designation. The plan shall not condition treatment, payment, enrollment or eligibility for benefits upon receipt of this authorization.

7: Denial of Request. I understand and acknowledge MY DESIGNATION OF PERSONAL REPRESENTATIVE MAY BE DECLINED IF: (1) the information I provide is not accurate; (2) this form is not completed in its entirety; (3) I do not sign below. If SNE WOMEN'S HEALTH PARTNERS OB/GYN denies the request, it will provide me with a written explanation of the reason(s).

8: Acknowledgement: By Signing below, I hereby designate the above names individual to act on my behalf in making health care and health care payment related decisions through SNE WOMEN'S HEALTH PARTNERS OB/GYN The individual I name as my personal representative may be a family member, friend, attorney or unrelated party and will have access to my PHI, including diagnoses, medical procedures, medications, treating providers and information such as my date of birth and address. If SNE WOMEN'S HEALTH PARTNERS OB/GYN accepts the request. The information described on this form is protected by law and shall only be used as indicated above, and shall not be re-used and/or permitted by law. However, I also understand and acknowledge that the potential for the information disclosed pursuant to this designation may be subject to re-use and/or re-disclosure by the recipient and may no longer be protected by Federal privacy regulations. I understand and acknowledge this request shall not apply to information that has already been released or affect actions taken by SNE WOMEN'S HEALTH PARTNERS OB/GYN prior to the request. I further understand and acknowledge that SNE WOMEN'S HEALTH PARTNERS OB/GYN is not responsible for any action taken by any authorized recipient for the information released pursuant to this designation. The information described on this form is protected by law and shall only be amended as indicated above, unless otherwise required and/or permitted by law.

Signature: _____ Date: _____

If you are signing as a personal representative, complete the section below. A parent/legal guardian must sign below for a minor under the age of eighteen (18). You may be required to provide additional documentation to show that you have a legal right to request the information, unless you have completed a Designation of Personal Representative sign by the member naming you as personal representative. Examples of these documents include Letters of Representation or Guardianship Papers.

Signature of Personal Representative: _____

Print Name: _____ Date: _____

Relationship: ☐ Parent/Legal Guardian ☐ Personal Representative ☐ Other

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TO BE COMPLETED BY THE OFFICE OF PARTNERS OB/GYN

- ☐ Request is Approved. Effective Date: _____
- ☐ Request is Denied. Reason: _____
- ☐ Additional Comments: _____

SNE WOMEN'S HEALTH PARTNERS OB/GYN Representative Signature: _____