Partners in Obstetrics & Gynecology
a division of Southern New England Healthcare for Women, LLC

333 School Street, Pawtucket, RI 02860 - 1525 Wampanoag Trail East Providence, RI 02915
1050 Main Street, East Greenwich, RI 02818 - 2168 Diamond Hill Rd., Woonsocket, RI 02895

office: 401-724-0600 fax: 401-724-1147

Tawfik F. Hawwa, M.D. Lisa R. Domagalski, M.D. Tolga N. Kokturk, M.D. Stacey P. Lievense, M.D.
Jeannine S. Connolly, M.D. Megan D. McMahon, M.D. Karen Iannucci, R.N.P.

The Doctor's and staff of Partners in Obstetrics & Gynecology would like to welcome you to our practice. We look forward to providing you 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 to 5. 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 • Ultra Sound
- Complete Pre & Post-Natal Screening • Compassionate Postpartum Treatment
- Normal & High Risk Pregnancies • The latest in Surgical, Laser & Laparoscopic Procedures
- Non-Surgical Treatment of Gynecological Disorders • Family Planning

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 $5.00, 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 to us prior to your appointment or bring them with you.

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 the nearest emergency room.

Partners in Obstetrics & Gynecology
a division of Southern New England Healthcare for Women, LLC
PATIENT REGISTRATION

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

Maiden Name: _____ Marital Status: ___S ___M ___D ___W Social Security # _____

Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred method of contact: (please circle one) Home # Work # Cell #

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

Employer: _____ Occupation: _____ Phone: _____

Partner's 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 _____

Policy Holder Date of Birth _____

Policy # _____ Group # _____

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

Insurance Co. Address _____ City _____ State _____ Zip _____

Policy Holder Name _____ Relationship _____

Policy Holder Date of Birth _____

Policy # _____ Group # _____

I hereby authorize release of information necessary to file claim with my insurance company and assign benefits to Southern New England Healthcare for Women, LLC (SNEHW). I agree that I will pay any collection or attorney fees and costs incurred in collection of my account by 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.

I also acknowledge that the practice has made the Health Insurance Portability and Accountability Act (HIPPA) notice effective April 13, 2003 available to me on the date indicated below.

Signature _____ Date _____

Partners in Obstetrics & Gynecology
A division of Southern New England for Women, LLC

Cynthia M. Hanna, MD
A division of Southern New England for Women, LLC

Notice of Privacy Practices Written Acknowledge Form

I, _____ (please print) have read and received a copy of the Notice of Privacy Practices from the office of Partners in Obstetrics & Gynecology & Cynthia M. Hanna, MD

Patients Signature: _____

Today's Date_____

PARTNERS IN OBSTETRICS AND GYNECOLOGY
a division of Southern New England Healthcare for Women, LLC

PRIVACY NOTICE

I. 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.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION ("PHI")

This notice explains how we use and share your protected health information. We are required by law to protect the privacy of PHI and to follow the privacy practices described in this notice.

PHI includes information that we create or receive about your past, present, or future health or condition, the provision of health care to you, or the payment for health care provided to you. In general, we may not use or share any more PHI than is necessary to accomplish our purpose.

We may change the terms of this notice and our privacy policies at any time. Any change will apply to the PHI we already have. When we change our policies, we will promptly change this notice and post it in our main reception area.

III. HOW WE MAY USE AND SHARE YOUR PHI

We use and share PHI for many different reasons. Below, we describe the different reasons and give you some examples of each category.

A. Use of PHI for Treatment, Payment, or Health Care Operations. We may use and share PHI for the following reasons:

1. For treatment. We may use and share PHI with physicians, nurses, medical students, and others who provide you with health care services or are involved in your care. For example, if you're being treated for gestational diabetes, we may share PHI with the nutritionist in order to coordinate your care.

2. For payment. We may use and share PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may share PHI with your health plan, to get paid for the health care services we provided to you. We may also share PHI with billing companies and companies that process our health care claims.

3. For health care operations. We may use and share PHI in order to operate this facility. For example, we may use PHI in order to evaluate the quality of health care services that you receive, or to evaluate the health care professionals who provide health care services to you. We may also share PHI with our accountants, attorneys and others in order to make sure we are complying with the laws that affect us.

B. Other Uses of PHI. We may also use and share your PHI for the following reasons:

1. Reports required by law. We may report PHI when the law requires us to give information to government agencies and law enforcement about victims of abuse, neglect, or domestic violence; when dealing with gunshot and other wounds, or when required in a legal proceeding.

2. Public health. We may report PHI about births, deaths, and other diseases to government officials in charge of collecting that information. We may provide PHI relating to death to coroners, medical examiners, and funeral directors.

3. Health oversight. We may report PHI to assist the government when it investigates or inspects a health care provider or organization.

4. To avoid harm. We may report PHI to law enforcement, in order to avoid a serious threat to the health or safety of a person or the public.

5. Other government functions. We may report PHI for certain military and veterans' activities, national security and intelligence purposes, protective services for the President of the United States, or correctional facility situations.

6. Workers= compensation. We may report PHI in order to comply with workers= compensation laws.

7. Appointment reminders and health-related benefits or services. We may use PHI to give you appointment reminders; or give you information about treatment choices or other health care services or benefits we offer.

C. When You May Object to Our Use of PHI.

1. Disclosures to family, friends, or others. We may share your PHI with a family member, friend, or other person that is involved in your care or the payment for your health care.

D. When Our Use of PHI Requires Your Prior Written Authorization. We must ask for your written authorization for any other use of PHI not described in sections III-A, B, and C above. If you authorize us to use your PHI, you can later remove the authorization and stop any future use of your PHI. You can remove an authorization by written request to the Office Manager, Partners in Obstetrics and Gynecology, 333 School Street, Pawtucket, RI 02860.

IV. YOUR RIGHTS REGARDING YOUR PHI.

A. Your Right to Request Limits on Our Use of PHI. You may ask that we limit how we use and share your PHI. We will consider your request but are not legally required to agree to it. If we agree to your request, we will follow your limits, except in emergency situations. You cannot limit the uses and reports that we are legally required or allowed to make.

B. Your Right to Choose How We Send PHI to You. You may ask that we send information to you at a different address (for example, to your work address rather than your home address) or by different means (for example, by fax instead of regular mail). We will agree to your request, as long as we can easily provide it in the way you requested.

C. Your Right to View and Get a Copy of PHI. You may view or obtain a copy of your PHI (except for mental health notes.) Your request must be in writing. If we do not have your PHI, but know who does, we will tell you how to get it. We will reply to you within 30 days of your request. If we deny your request, we will tell you, in writing, our reasons for the denial. You will then have the right to have the denial reviewed.

If you request a copy of your PHI, we may charge a fee of at least .25 per page. Instead of providing the PHI you requested, we may offer to give you a summary or explanation of the PHI, as long as you agree to that and to the cost in advance. This fee is subject to change.

D. Your Right to a List of the Reports We Have Made. You have the right to get a list of the parties to whom we have reported your PHI. The list will not include reports for treatment, payment, or health care operations; reports you have previously authorized; reports made directly to you or to your family; reports from our facility directory; reports made for national security purposes; reports to corrections or law enforcement personnel; or reports made before April 14, 2003.

We will respond to your request within 60 days. We will include the reports made in the last six years unless you request a shorter time. The list will include the date of each report, the identity of the person(s) receiving the report, the type of information reported, and the reason for the report.

We will not charge you for the list. If you make more than one request in the same year, however, we may charge you a fee for each additional request. For a list, you must make a request to the Office Manager, Partners in Obstetrics and Gynecology, 333 School Street, Pawtucket, RI 02860.

E. Your Right to Correct or Update Your PHI. If you feel that there is a mistake in your PHI, or that important information is missing, you may request a correction. Your request must be in writing and include a reason for the request. Your request must be made to the, Office Manager, Partners in Obstetrics and Gynecology, 333 School Street, Pawtucket, RI 02860.

We will respond within 60 days of your request. We may deny your request if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be shared with you, or (iv) not in our records. If we deny your request, we will inform you of the reason for the denial. You may then file a written statement of disagreement, or you may ask that your original request and our denial be attached to all future reports of your PHI.

If we agree to honor your request, we will change your PHI, inform you of the change, and tell any others that need to know about the change to your PHI.

F. Your Right to a Paper Copy of This Notice. You can ask us for a copy of this notice at any time.

V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice, wish to file a complaint about our privacy practices, feel that we may have violated your privacy rights, or disagree with a decision we made about access to your PHI, please contact our Privacy Officer at Partners in Obstetrics and Gynecology, 333 School Street, Pawtucket, RI 02860.

You also may send a written complaint to the Secretary, U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Washington, D.C. 20201. Your complaint will not alter or affect the care we provide to you.

VI. EFFECTIVE DATE OF THIS NOTICE

This notice is in effect as of April 14, 2003.

Partners in Obstetrics & Gynecology

a division of Southern New England Healthcare for Women, LLC.
333 SCHOOL STREET
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 _____

TELLS 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 the 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 ever 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?							
Have you had an HPV vaccine?							
If Post Menopausal, Age at Menopause							
Are you currently taking any Hormone Replacement Therapy medications?	Yes	No	Have you ever taken any Hormone Replacement Therapy medications?			Yes	No
Have you had any post menopausal bleeding?	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 delivery(s) _____ □ number of premature delivery(s) _____

□ number of terminations/abortions _____ □ number of miscarriages _____

□ number of tubal pregnancies _____ □ number of twins/triplets _____

How many children living? _____

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

PAST PREGNANCIES

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

PAST MEDICAL HISTORY: Circle all that 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 (please specify)	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 at death: _____

Father □ Living □ Deceased - Cause and Age at death: _____

Number of Siblings: _____ Living _____ Deceased _____ Cause _____

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

Dear Patient:

In order for us to establish proper treatment for you, we need your current medical records.

Please contact your current physician's office to give proper authorization and have your medical records sent to us.

Please request these records as soon as possible so that our physician can receive and review them before your scheduled appointment date. If we do not receive your records prior to your appointment, unfortunately you will need to reschedule.

Have your records sent to:

Partners in Obstetrics & Gynecology
Attn: Medical Records Department
333 School Street, Suite 205
Pawtucket, RI 02860

Thank you in advance for your cooperation.

We look forward to meeting you.

Sincerely,

The Physicians and Staff of Partners in Ob/Gyn

Partners in Obstetrics & Gynecology
A division of Southern New England Healthcare for Women, LLC

Office Locations:

323 School Street
Pawtucket, RI 02860

1525 Wampanoag Trail
East Providence, RI 02915

1060 Main Street
East Greenwich, RI 02818

2168 Diamond Hill Road
Woonsocket, RI 02895

(401) 724-0800

Fax (401) 724-1147

www.partners-in-obgyn.com

To Our Patients:

The goal of Partners in Obstetrics & Gynecology has always been to provide the best care for our patients. Within the last few years, health care reform has become a topic that both physicians and patients have to address.

In order to continue the excellent care given to our patients and maintain the efficiencies required to be successful in this new environment, we have formed an affiliation with another group of physicians, Broadway Ob/Gyn, Bahram Shah-Hosseini, MD, David Carceiri, M.D., and Michael Coppa, M.D. These doctors are people we have known for years, and for whom we have great respect.

This practice has a philosophy and practice pattern very similar to our own. We have set up an ongoing system of cross coverage for evenings and weekends. A physician from the above-mentioned practice might attend to our deliveries and hospital care. Please be assured that your medical record will be available to the physician managing your labor, delivery and care.

If you have any questions, please speak with one of our physicians.

Thank you,

Partners in Obstetrics & Gynecology

Partners in Obstetrics & Gynecology
A division of Southern New England Healthcare for Women, LLC

Patients Financial Policy

Participating Insurance

- Partners in OB/GYN 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, a $5.00 fee will be charged.

Non-Participating Insurance

- If Partners in OB/GYN does not participate with your insurance plan, you are responsible for payment of all charges associated with the services you received.

No Insurance

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

Outstanding Balances

- Patients with an outstanding balance with Partners in OB/GYN will be expected to pay that balance, or commit to a payment plan before additional services are rendered.
- Outstanding balances may 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 our physicians at Partners in OB/GYN or Women & Infants Hospital.
- We reserve the right to reschedule your appointments if you have a balance that is greater than 60 days, have been sent to collections, and/or no payment arrangements have been made.

Billing Department representatives are available Mon – Fri from 9:00 a.m. to 4:30 p.m.; please call (401) 724-0600. 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 below

I hereby authorize release of information necessary to file claim with my insurance company and assign benefits to Partners in OB/GYN. I understand that I am financially responsible for balances not covered by my insurance carrier. A copy of this signature is valid as original.

_____ _____ _____

Signature of patient or responsible party **Date** **Account Number**

THANK YOU FOR CHOOSING PARTNERS IN OBSTETRICS & GYNECOLOGY