RINGHOFFER OBGYN

3715 Dauphin St Ste 6E
Mobile, AL 36608

P: (251) 344-3233
F: (251) 344-3203

www.ringhofferobgyn.com

Welcome To Our Practice:

We are pleased that you chose us for your obstetric and gynecologic care. We look forward to providing you quality medical care in a friendly environment. Dr. Ringhoffer will share her medical expertise with you and we hope you will take responsibility in working toward a healthy lifestyle that is so important to your well being.

We offer many comprehensive gynecologic services including annual exams and family planning. Also, we offer obstetric care that includes on site ultrasounds including 3D & 4D, non stress testing and prenatal education classes.

We value your time, which is why we ask that you arrive at least 15 minutes before your first scheduled appointment. This allows us time to process your insurance information before your appointment, so that you can be seen by the doctor in a timely manner. Please bring a photo id, your insurance card, and a list of your medications.

If you need to reschedule or are unable to keep your appointment, a 24-hour notice is appreciated.

We accept cash, check, and most credit cards for payment of co-pays and services.

Sincerely,

Ringhoffer OBGYN

RINGHOFFER OBGYN PATIENT INFORMATION

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Email Address:	Home Phone: ( )	Birth date: / /	Age:	Sex: ❑ M ❑ F

Preferred Method of Communication ☐Phone ☐ Email ☐ Fax ☐ No Preference ☐ Mail	Social Security Number:	Cell Phone: ( )

Address	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Legal Spouse's Name:	Legal Spouse DOB: / /	Legal Spouse's Employer:

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the receptionist) *Ringhoffer OBGYN will file your visit with your insurance company but it is not a guarantee of benefits. Any balance not covered by your insurance company is your responsibility.

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Please indicate primary insurance:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of relative or friend to contact in emergency:	Relationship to patient:	Home phone : ( )	Work phone : ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Ringhoffer OBGYN or insurance company to release any information required to process my claims. I also understand my right to file a complaint with my insurance carrier. I also authorize Ringhoffer OBGYN to evaluate and treat me for any condition I present with. I understand that any unpaid balance could generate a late fee and be turned over to an outside collection agency.

Patient/Guardian signature *Date*

Preferred Pharmacy and Location

_____

Ringhoffer OBGYN

OFFICE FINANCIAL POLICY

1. There will be a charge for all services performed by the doctor in the office and in the hospital. By allowing the doctor to care for you, you are agreeing to pay for the services rendered and are responsible for payment in full. We will bill your insurance as a courtesy to you. However, in order to do so, we must be supplied with the proper insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire balance. For all office visits, you must pay for your care at the time of your visit. We accept Cash, Check, and most major credit cards. There is an additional 3% service charge on all credit card payments, we apologize for any inconvenience this may cause. A $35 fee will be assessed for any check returned for insufficient funds. At that time only cash, charge or money order will be accepted for payment.

2. **Copays** We are required by your insurance plan to collect co-pays at the date of service. If the physician performs two different procedures on the same day of service, your insurance company may require a copay on both services. (ex. Preventive Annual Exam or Routine Obstetrical Exam and Office Visit to address medication or medical problems.)

3. **Referrals** Some insurance companies require a referral for services performed. It is your responsibility to obtain and ensure that a valid referral from your Primary Care Physician (PCP) is on file or you will be responsible for all non-covered services provided.

4. **Procedures** Any procedures which are performed, such as an ultrasound or biopsy, will be billed to your insurance company. However, if there are any co-payments or deductibles, payment in full is due at the time of service. If the procedure is not covered by your insurance, you will be responsible for payment in full.

5. **Surgery** Should it be deemed medically necessary for you to have surgery or you elect to have surgery, we will contact your insurance to determine an estimate of what your responsibility will be. If there are any co-payments or deductibles for surgeries to be performed, payment in full is due at least 7 days before the surgery date.

6. **Lab/Pathology Fees** are billed separately by the lab and pathologist. You may receive additional bills for these services.

7. **Understanding Your Office Visit** An *annual exam (preventative, routine, wellness and well woman)* includes an age appropriate history and physical exam, risk factor review, ordering of routine laboratory tests, along with general discussion about healthy lifestyle and preventative care. A *problem-oriented visit (menopause, depression, bleeding, etc.)* addresses specific problems. We understand that many insurances are now offering 100% coverage for wellness visits and you may have only intended to come in for a wellness visit because of this coverage; however, if you choose to have additional problems addressed you may be responsible for a portion. These charges are not considered part of your wellness visit, even though it was handled during your wellness visit. How your visit is billed *(annual or problem)* is determined by what happens during your visit, typically where the most focus is directed. However, it is possible that your visit may include both annual and problem services, which will be billed accordingly.

8. **Obstetrical Patients** Once pregnancy has been confirmed, we will contact your insurance carrier to determine your financial responsibility. You will receive a detailed payment plan with a breakdown of monthly installments that will be expected through the 7th month at which time your portion will be paid in full. This is only an estimate and determination of benefits will not be made until the claim is received by your insurance company.

9. **No Show/Cancellation Policy** The time reserved for your appointment is valuable. Our office requires at least 24 hours notice prior to the appointment time that is being canceled. We reserve the right to charge a $25 fee if we do not receive proper notification. Please be aware that we will bill any charges associated with missed appointments directly to you, even if you have insurance coverage. Insurance policies will not cover charges for canceled or missed appointments.

10. **Minor** If you are under 18 years of age on your first visit, you must be accompanied by a parent or guardian that has the authority to make decisions regarding your treatment. For each subsequent visit, a written authorization by a parent or guardian for routine treatment is sufficient.

11. **Forms** Should you require FMLA forms or disability paperwork to be completed, there is a $15 charge per set. Please allow 3-5 business days for completion.

12. If payment is received by the office for services that has been paid in full, a credit balance will be applied to your account. You may request a refund.

13. If your account becomes past due, we will take necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer your collection balance to a lawyer, you agree to pay the legal fees plus court costs. If your account is referred to a collection agency, you may forgo the patient/physician relationship.

Fees and Policies are Subject to Change

Patient Name (Print) _____ Patient/Guardian Signature _____ Date _____

RINGHOFFER OBGYN PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name: _____ Date of Birth: _____

_____(Patient/Representative initials) **Notice of Privacy Practices.**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient/Representative initials) **Release of Information.**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients.

Patients in our practice may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email address or text number below, you understand that you may get these communications from the Practice. You may opt out of these communications at any time. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

OR

_____ (Patient/ Representative Initials) I decline to receive communication via text.
_____ (Patient/ Representative Initials) I decline to receive communication via email.

If you have previously consented to receive communication via text/email and wish to remove the consent- Opt Out/Revocation of communications via email and/or text. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**.*
*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.*

Patient Name: _____

Patient/Patient Representative Signature: _____
Date: _____ *Time:* _____

Patient/Guardian Signature:_____ **Date:**_____

Patient/Guardian (Print):_____

Patient Name (Print): _____ **Date of Birth:**_____

Ringhoffer OB/GYN Confidential Health History

Today's Date:____/____/____ Main reason for visit:_____

Name: _____ Birth date:_____ Age:_____ Height:_____

Primary Care Physician:_____ Occupation:_____

Current Medications: Please include herbs and/or nutritional supplements.

Medication	Dose	How Often	Medication	Dose	How Often

Allergies: Please list any allergy you have to medication(s), food(s) and/or other substances:

Medication	Reaction	Medication	Reaction

Medical History: *Check the appropriate box(and date if past event)*

	current	past		current	past
Anxiety			Chlamydia		
Depression			Gonorrhea		
Other mental health illness			Genital herpes		
Asthma			Genital warts (HPV)		
COPD			Pelvic inflammatory disease		
Sleep Apnea			Pain during intercourse		
Cancer - type			Chronic pelvic pain		
Chronic pain disorder			Uterine fibroids		
Chronic narcotic use			Ovarian cysts		
Diabetes			Frequent vaginal infection		
Eating disorder			Sexually transmitted disease		
Heart disease			Deep vein thrombosis (DVT)/Blood clots		
High blood pressure			Pulmonary embolism (PE)		
High cholesterol			Breast biopsy		
Migraines			IBS		
Osteoporosis/osteopenia			Crohn's disease/Ulcerative colitis		
Seasonal allergies			Sexual abuse		
Seizures			Domestic violence		
Thyroid disorder			OTHER		

Gynecological History:

First day of last normal menstrual period was: ____/____/____ Age of menopause, if applicable:_____

Age of first period:_____ Cramps: ☐ mild ☐ moderate ☐ severe Heavy flow: ☐ Yes ☐ No

How long are your menstrual cycles (ie: 28-30 days apart)?_____days Average days of flow: _____days

Present Birth Control Method:_____ Sexually active ☐ Yes ☐ No ☐ Never

Have you ever had an **abnormal** pap smear? ☐ Yes ☐ No When _____Where_____

Did you have the HPV/cervical cancer vaccine? ☐ Yes ☐ No Did you complete the series (3 injections) ☐ Yes ☐ No

Screening History:

Date of last pap smear: ____/____/____ Date of last colonoscopy: ____/____/____

Date of last mammogram: ____/____/____ Date of last bone density: ____/____/____

Pregnancy History:

Number of: Pregnancies_____ Live Births_____ Miscarriages: *spontaneous*_____ *D&C*_____

Ectopic Pregnancies:_____ Elective Abortions: *medication* _____ *D&C*_____

Child	DOB	# of weeks At delivery	C/S or vaginal del	Epidural Y/N	Sex M/F	Weight	Complications	Place of Birth
1st								
2nd								
3rd								
4th								

Surgical History: Please list surgeries or hospitalizations you have had in chronological order and approximate date:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Family History: *Check the appropriate box, age of diagnosis if known*

	Mother	Mom's Mom	Mom's Dad	Father	Dad's Mom	Dad's Dad	Children	Siblings	Other
Birth Defects									
History unknown									
Breast cancer									
Colon cancer									
Ovarian cancer									
Uterine cancer									
Other cancer									
Heart disease									
Hypertension									
Diabetes									
Stroke									
Dementia									
Seizures									
Osteoporosis									
Other diagnosis									

Social History:

Do you drink alcohol? ☐ Yes ☐ No *How much*_____

Do you use recreational drugs or abuse prescription medications? ☐ yes ☐ past ☐ never

Type/amount _____

Do you smoke: ☐ *cigarettes* ☐ *vape* ☐ *medical marijuana* ☐ *recreational marijuana* *How much* _____

Relationship: ☐ single ☐ married ☐ widowed ☐ same gender ☐ multiple partners

Do you have other concerns or comments?_____

RINGHOFFER OBGYN

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.

What is this Notice and Why Is It Important?
By law, Ringhoffer OBGYN must protect the privacy of your identifiable medical and other health information ("health information").

We are also required by law to give you this notice to tell you how we may use and give out ("disclose") your health information. This notice is effective as of July 1, 2013.

How Ringhoffer OBGYN May Use Your Health Information
As a general rule, you must give written permission before your health information can be used or released. There are certain situations where we are not required to obtain your permission. This section explains those situations where your health information may be used or disclosed without permission. Records may also be disclosed electronically as necessary.
Except with respect to Highly Confidential Information (described below), Ringhoffer OBGYN is permitted to use your health information for the following purposes:

• **Treatment:** We use and disclose your health information to provide you with medical treatment or services. This includes uses and disclosures to:
- treat your illness or injury, including disclosures to other doctors, practitioners, nurses, technicians or medical personnel involved in your treatment, or
- contact you to provide appointment reminders, or
- give you information about treatment options or other health related benefits and services that may interest you.

• **Payment:** We may use and disclose your health information to obtain payment for health care services that we or others provide to you. This includes uses and disclosures to:
- ***submit health information and receive payment from your health insurer, HMO, or other company that pays the cost of some or all of your health care (payer), or***
- ***verify that your payer will pay for your health care***.

• **Health Care Operations:** We may use and disclose your health information for our health care operations, such as internal administration and planning that improve the quality and cost effectiveness of the care we provide you. This also includes uses and disclosures to:
- evaluate the quality and competence of our health care providers, nurses and other health care workers,
- to other health care providers to help them conduct their own quality reviews, compliance activities or other health care operations,
- train students, residents and fellows, or
- identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

We may also disclose your health information to third parties to assist us in these activities (but only if they agree in writing to maintain the confidentiality of your health information).
In addition, we may use and disclose your health information under the following circumstances: .

• **Relatives, Caregivers and Personal Representatives:** Under appropriate circumstances, including emergencies, we may disclose your health information to family members, caregivers or personal representatives who are with you or appear on your behalf (for example, to pick up a prescription). We may also need to notify such persons of your location in our facility and general condition. If you object to such disclosures, please notify your health care provider. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, we would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care.

• **Public Health Activities:** We may disclose your health information for the following public health activities:
- To report to public health authorities for the purpose of preventing or controlling disease, injury or disability;
- To report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports;
- To alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease; or
- To report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

• **Victims of Abuse, Neglect or Domestic Violence:** If we reasonably believe that you are a victim of abuse, neglect or domestic violence, we may disclose your health information as required by law to a social services or other

governmental agency authorized by law to receive such reports.

• **As Required by Law:** We may disclose health information when required to do so by any other law not already referred to in the preceding categories.

Your Written Authorization
FOR ANY PURPOSE OTHER THAN THE ONES DESCRIBED ABOVE WE MAY ONLY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION WHEN YOU GIVE US YOUR WRITTEN AUTHORIZATION.

Highly Confidential Information
Federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including your health information that is maintained in psychotherapy notes or is about: (1) mental health and developmental disabilities services; (2) alcohol and drug abuse prevention, treatment and referral; (3) HIV/AIDS testing, diagnosis or treatment; (4) communicable disease(s); (5) genetic testing; (6) child abuse and neglect; (7) domestic or elder abuse; or (8) sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

Your Rights Regarding Your Health Information:

Right to Request Access to Your Health Information: You have the right to inspect and maintain a copy of the patient records we maintain to make decisions about your treatment and care, including billing records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you would like access to your records, please ask your healthcare provider for the appropriate form to complete. If you request copies, we will charge you a reasonable fee for copies. We also will charge you for our postage costs, if you request that we mail the copies to you. If you are a parent or legal guardian of a minor, certain portions of the minor's medical record may not be accessible to you under state law.

Right to Request Amendments to Your Health Information: You have the right to request that we amend your health information maintained in your medical record file or billing records. If you wish to amend your records, please obtain an amendment request form from your healthcare provider. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is already accurate and complete or other special circumstances apply.

Right to Revoke Your Authorization: You may revoke (take back) any written authorization obtained by us for use and disclosure of your protected health information, except to the extent that we have taken action in reliance upon it. Your revocation must be in writing.

Right to Request how Information is Provided to You: You may request, and we will try to accommodate, any reasonable written request for you to receive health information by alternative means of communication or at a different address or location.

Right to Request Restrictions on the use of your Health Information: YOU MAY REQUEST THAT WE RESTRICT THE USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. ALL REQUESTS FOR SUCH RESTRICTIONS MUST BE MADE IN WRITING.

While we will consider a request for additional restrictions carefully, we are not required to agree to a requested restriction, except for requests to restrict disclosure of information to a health plan in cases where you have paid for the service out of pocket and in full.

Right to be Notified of Breach: You have the right to be notified by us if we discover a breach of your unsecured protected health information.

Right to a Paper Copy of this Notice: Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such information electronically.