PATIENT INFORMATION (PLEASE PRINT)

Last Name/Apellido	First Name / Nombre	Initial	Date of Birth/ Fecha de Nacimiento

Address/Direccion **(Please include apartment #)**	City/Cuidad	State/Estado	Zipcode/Codigo Postal

Social Security Number	Sex/Sexo	Marital Status/ Estado Civil
	[ ] F [ ] M	[ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widow

Home Phone Number* Required *	Cell Phone number/ Numero de Cellular	Email Address/ Correo Electronico

Employer/Empleador del Paciente	Employer Address (Direccion de Empleador)	Work Phone/Telefano de trabajo

Spouse's Name/Nombre del Esposo	Date of birth/ Fecha de Nacimiento	Social Security Number

Spouse's employer & address/Nombre y Direccion de trabajo	Spouse's work number/Telefono de trabajo del Esposo

In case of an Emergency please list the nearest relative (Not residing at the Same address as yours)

En caso de Emergencia por favor ponga el nombre del pariente mas cercano

Name/Nombre	Telephone Number/Numero de Telefono	Relationship to patient/ Relacion al paciente	
Address/Direccion	City/Cuidad	State/Estado	Zip Code/Codigo Postal

***PREFERRED PHARMACY (with phone # if available):** **

INSURANCE INFORMATION/INFORMATION DE SEGURO

Primary Insurance carrier		Subscriber (If not the Patient)/ Subscribidor
Policy Number (Usually SSN #) Numero de Poliza	Group Number/Numero de Grupo	Relationship to patient/ Relacion al paciente [ ] Self [ ] Spouse [ ] Child [ ] Other

Secondary Insurance carrier/Seguro Segundario	Subscriber/ Subscribidor	
Policy Number (Usually SSN#) Numero de Poliza	Group Number/ Numero de Grupo	Relationship to patient/ Relacion al paciente [ ] Self [ ] Spouse [ ] Child [ ] Other

How did you hear about us? [ ] Insurance Directory [ ] Direct Mail [ ] Telephone Directory [ ] Radio

Friend's Name: Physician:

1) I consent to treatment necessary for the care of the above named patient.	Yes	No
2) I consent to Gramercy gynecology contacting me by email and text messaging	Yes	No
3) I acknowledge that I was provided with a copy of the Gramercy Gynecology Notice of Privacy Practices.	Yes	No
4) I authorize payment of all accounts for services rendered to me. For payment of said accounts for services which I hereby waive all claims of exemption under the laws of the State of New York, and agree to pay if necessary all costs of collection handling, legal, and/or attorney's fee.	Yes	No
5) I have read and acknowledge the financial policy of this practice and agree to its terms and conditions.	Yes	No

Signature: _____ Date: _____

For Office Use Only WT _____ / HT _____ / BP _____ / Pulse Rate _____

NAME: _____ **DOB:** _____
PRIMARY PHYSICIAN: _____
PREFERRED PHARMACY (with phone # if available): _____
Reason for Visit: _____
OB/Gyn History:
Last menstrual period start date: _____ **How often do you get a period?** _____
Duration of menstrual flow: _____ Type of flow: Heavy Normal Light
Cramps with period? Y N If so, mild, moderate or severe?
Are you or have you been sexually active? Y N If so, men, women or both? _____
Do you experience pain with intercourse? Y N
Have you ever a sexual infection: [] Herpes [] Genital warts [] Gonorrhea [] Chlamydia
[] Trichomonas [] Syphilis [] Other: _____
Have you ever been pregnant? Y N
If so, how many: Children ____ Miscarriages _____ Abortions _____
Premature births ____ Stillbirths _____ Ectopic pregnancy _____
Present contraception (Condoms, pill, etc.):_____Prior contraception: _____
Last Well Woman (Preventative) Exam? _____/_____/_____
Month Day Year

****Last Pap Smear date**: _____
Did you have the HPV vaccine? Y N
Have you ever had an abnormal pap smear? Y N
If so, what treatment was done and when (colposcopy/LEEP): _____
Have you ever had fibroids on the uterus? Y N
Have you ever had cyst on the ovary? Y N
Date of last mammo if applicable: _____ Date of last Colonoscopy if applicable: _____
Date of last bone density if applicable: _____

Medications: _____
Allergies: _____

Do you have any of the following medical conditions?

[] Heart problems (murmur, palpitations)
[] High blood pressure
[] Diabetes
[] Thyroid dysfunction
[] Migraine headaches
[] Depression
[] Asthma
[] Sleep Apnea
[] Kidney disease
[] Seizure disorder
[] Anemia
[] Infertility
[] Anxiety
[] Blood clots
[] Cancer (please specify): _____
[] Autoimmune disease (Please specify): _____
[] Other_____
Have you ever had any surgeries (C-sections, abortions, implants)? If so, please list:
_____

Do you do or have you ever done of the following (please check all that apply)?
[] Smoke: If so, how much per day? _____ **How long?** _____
[] Use drugs: If so, what? _____
[] Alcohol: If so, how much per week? _____
Have you ever been abused physically, sexually or emotionally? Y N

NAME: _____ DOB: _____

Family History:

[] Heart disease
[] High blood pressure
[] Diabetes
[] Thyroid dysfunction
[] Genetic disease
[] Anxiety
[] Blood clots
[] Anemia
[] Seizure disorder
[] Infertility
[] Depression
[] High cholesterol
[] Autoimmune disease (please specify): _____
[] Cancer (please specify type, family member, and age of onset if known):

_____

Do you currently have any of the following symptoms?

Weight loss	Y	N
Weight gain	Y	N
Fatigue	Y	N
Vision changes	Y	N
See wavy lines	Y	N
Blind spots	Y	N
Headaches	Y	N
Mouth sores	Y	N
Sore throat	Y	N
Difficulty breathing on exertion	Y	N
Chest pain	Y	N
Shortness of breath	Y	N
Chronic cough	Y	N
Diarrhea	Y	N
Constipation	Y	N
Bloody stool	Y	N
Bloating	Y	N
Nausea/vomiting	Y	N
Abnormal vaginal discharge	Y	N
Abnormal periods	Y	N
Painful intercourse	Y	N
Urinary incontinence	Y	N
Urinary frequency	Y	N
Pain with urination	Y	N
Breast pain	Y	N
Breast lump	Y	N
Nipple discharge	Y	N
Hot flushes	Y	N
Vaginal dryness	Y	N
Abnormal thirst	Y	N
Mood swings	Y	N
Depression	Y	N
Anxiety	Y	N
Abnormal hair growth	Y	N
Excessive acne	Y	N
Hair loss	Y	N

SIGNATURE OF PATIENT:

_____

NEW York STATE DEPARTMENT OF HEALTH
AIDS Institute

HIV-Specific Model Consent Form

Informed Consent to Perform

My health care provider has answered any questions I have about HIV/AIDS. I have been provided information with the following details about HIV testing:

- HIV is the virus that causes AIDS and can be transmitted through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV; contact with blood as in sharing needles (piercing, tattooing, drug equipment including needles), by HIV-infected pregnant women to their infants during pregnancy or delivery, or while breast feeding.

There are treatments for HIV/AIDS that can help an individual stay healthy.

- Individuals with HIV/AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or being infected themselves with different strains of HIV.
- Testing is voluntary and can be done anonymously at a public testing center.
- The law protects the confidentiality of HIV test results and other related information.
- The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences.
- The law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV test or expires by its terms.

I agree to be tested for HIV infection. If the results show I have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time. If I test positive for HIV infection, I understand that my health care provider will talk with me about telling my sex or needle-sharing partners of possible exposure.

I may revoke my consent orally or in writing at any time. As long as this consent is in force, my provider may conduct additional tests without asking me to sign another consent form. In those cases, my provider will tell me if other HIV tests will be performed and will note this in my medical record.

Patient Name: _____ Date: _____

Signature: _____

Medical Record #: _____

☐ I Decline

GRAMERCY GYNECOLOGY, PC

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

Name: _____ **DOB:** _____

I INTEND TO PAY MY MEDICAL EXPENSES AS FOLLOWS (Check one or more):

☐ Cash/Check ☐ Credit Card ☐ Insurance

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentation thereof, unless prior arrangements have been made in writing prior to the billing date. IT is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereof, and all proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for collection.

Your health plan is an arrangement between you or your employer and your insurance company. While Gramercy Gynecology may participate in the plan and make every effort to verify your benefits, your plan will ultimately determine your coverage and requirements for pre-certification, prior authorization or referrals. It is your responsibility to know and understand your particular coverage and benefits.

At each visit, please verify your current demographics, including pharmacy of choice and your insurance information. It is imperative that Gramercy Gynecology have accurate information to ensure that the appropriate claims are sent to the correct insurance carrier with the appropriate information. This does not guarantee payment. You must disclose all appropriate insurance information, which should include primary and secondary insurance coverage to ensure in-network participation with your plan and that claims are filed in a timely manner with the appropriate insurance carrier. A list of participating insurances can be found on our website and are available upon request. A non-covered service may be denied by your insurance carrier due to benefit limitations, policy exclusions or waiting periods. Any non-covered service is your responsibility and payment is due at the time of service.

Preventative versus Problem examinations and financial information entities involved in your care:

A well woman exam is a preventative visit when a healthy woman comes to the office to undergo screening for various illnesses and diseases. Once a concern, symptom or complaint is voiced, this may lead to additional services exclusive of the well woman exam that must be rendered to address these issues. These additional services may be subject to deductibles, co-insurances and copays. Your insurance company will send you an Explanation of Benefits (EOB) that will detail how your bill was paid by them and any amount for which you are responsible. By law, you are responsible for these amounts as well as any non-covered services outlined in your plan. Payment of the patient portion is due at the time of service. If it is not paid at the time of service, you will receive an invoice (bill) for your portion.

If your visit requires a specimen, such as a Pap smear, bloodwork, a culture or biopsy, these specimens are sent to an outside laboratory, which is separate from your office visit. If you have services performed at a hospital, you may receive additional separate bills from the hospital, anesthesiologist, or other healthcare providers. If you have a surgical procedure performed at Gramercy gynecology that requires

anesthesia, these services are provided by Achievement Medical Anesthesia. They are in-network with major insurance plans such as Blue Cross/Blue Shield, United and Oxford. However, some providers may be out of network in other insurance plans. These services are billed separately from your in-office procedure performed by Gramercy Gynecology. Inquiries regarding billing and rates for any of these services should be directed to their particular billing departments. Some insurance companies require precertification for some services. We will make every effort to verify your benefits and obtain any necessary precertification's prior to your scheduled procedure, be advised this is not a guarantee of payment. Your insurance dictates if additional out of pocket fees apply to your Well Woman Visit.

Non-participating Insurance Accounts:

The financial obligations of patient who are insured by carriers with which Gramercy Gynecology does not participate in are considered self-pay accounts. It is your responsibility to verify with your insurance company, that the physician you are scheduled to see is an in-network provider (participating provider) in your specific plan. It is also your responsibility to inform Gramercy gynecology of any changes with your insurance carriers or plan. By signing this agreement, you are agreeing to be individually obligated to pay the full charge of services rendered at Gramercy Gynecology P.C. if you belong to a plan in which Gramercy Gynecology does not participate and you consent to treatment by an out of network provider.

Payments:

Gramercy Gynecology accepts cash, checks and all major credit cards. All returned checks are subject to a $35.00 returned check fee. If you have a balance due for previous services, your payment will be applied to the oldest balance first. In the event that your account has a credit, we reserve the right to transfer credits to any outstanding balances prior to issuing a refund. Patient accounts with a past due balance in excess of 120 days will be referred to a collection agency for resolution. Collection agency fees may be applied to your balance.

Assignment of Benefits

I hereby authorize Gramercy Gynecology, PC to release to my insurance company, or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such surgical or medical care. I also authorize and request my insurance company to pay directly to the practice referenced above the amount due me in my claim for basic medical, major medical, and/or surgical treatment or services by reason of such treatment rendered to: Gramercy Gynecology, PC.

I have read and understand all of the above. I consent to the evaluation and treatment offered to me by Gramercy Gynecology, PC and its associated entities.

Printed name Signature Date

GRAMERCY GYNECOLOGY	HEALTH INFORMATION EXCHANGE, CARE EVERYWHERE AND HEALTHIX CONSENT FORM	Patient MRN/Patient ID:

Please Fax signed consents to: **917-829-2096**

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange ("NYULMC HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU health care providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the NYULMC HIE. In order for a Care Everywhere Provider to know that information may be available through the NYULMC HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Medical Center program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749. Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The NYULMC HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.

Your Consent Choices. You can fill out this form now or in the future. You have the following choices:

Please check one box ☑ below:

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of** my electronic health information through the **NYULMC HIE** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access** my electronic health information through the **NYULMC HIE** or **HEALTHIX** for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

PRINT Name of Patient	**Patient Date of Birth**
Signature of Patient or Patient's Legal Representative	**Date**
Print Name of Legal Representative (if applicable)	**Relationship of Legal Representative to Patient (if applicable)**