IMPORTANT INFORMATION PLEASE READ COMPLETELY

PLEASE COMPLETE AND SIGN **ALL** FORMS BEFORE YOU ARRIVE AT OUR OFFICE. THIS ALLOWS US TO SEE ALL PATIENTS PROMPTLY AT THEIR SCHEDULED APPOINTMENT TIMES. WE REQUIRE A PHOTO ID AS WELL AS YOUR INSURANCE CARD(S).

ALL SECTIONS MUST BE COMPLETED. IF IT DOES NOT APPLY TO YOU , PLEASE WRITE "N/A". IF YOUR FORMS ARE NOT COMPLETED PRIOR TO YOUR ARRIVAL IT MAY RESULT IN THE RESCHEDULING OF YOUR APPOINTMENT.

IF YOU CANNOT KEEP YOUR SCHEDULED APPOINTMENT PLEASE CALL THE OFFICE 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT. FAILURE TO DO SO WILL RESULT IN A $35 FEE WHICH IS NOT BILLABLE TO YOUR INSURANCE.

DR. MARINE **DOES NOT ACCEPT** MEDI-CAL OR GOLD COAST INSURANCE EITHER AS PRIMARY OR SECONDARY COVERAGE. IF YOU FAILED TO NOTIFY US WHEN YOU MADE YOUR INITIAL APPOINTMENT WE ASK THAT YOU CALL AND ADVISE OUR OFFICE SO THAT WE MAY REFER YOU TO A PHYSICIAN WHO ACCEPTS YOUR COVERAGE.

Patient information (Picture ID and Insurance Card(s) required)

Last Name: _____ First: _____ Middle _____
As it appears on your insurance card

Birth Date: _____ Race (new billing requirement) _____

Referred by: _____

Social Security #: _____ Driver's License #: _____

Street Address: _____ Marital Status: M S D W

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance information

Insured, Responsible Party: _____ Relationship: _____
(If insured under someone other than yourself, we need their name and Date of Birth)

Birth Date: _____ Social Security #: _____

Insured's Employer: _____ City: _____ Work Phone: _____

Insurance Carrier: _____

Policy #: _____ Group #: _____ Effective Date: _____

Secondary Insurance Information

Insured, Responsible Party: _____ Relationship: _____

Birth Date: _____ Social Security #: _____

Insured's Employer: _____ City: _____ Work Phone: _____

Insurance Carrier: _____

Policy #: _____ Group #: _____ Effective Date: _____

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT/AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby give authorization for payment of insurance benefits to be made directly to Dr. Michelle A. Marine and/or Dr. Stuart J. Fischbein for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay for any courtroom and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I hereby agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____

The Woman's Place for Health
Michelle A. Marine MD, Inc.
Stuart J. Fischbein MD
77 Rolling Oaks Dr. #306
Thousand Oaks, CA 91361
Phone 805/371-8775 FAX 805/379-3711

Advanced Beneficiary Notice

When we bill your insurance company, any deductible and co-insurance charges will apply. Any payment you make today will be credited to your account. Once the insurance company makes the payment, you will be responsible for any and all remaining balances. If there is a co-payment required, it must be paid at the time of service.

IT IS YOUR PRIMARY RESPONSIBILITY TO VERIFY YOUR INSURANCE BENEFITS AND CONFIRM IF OUR OFFICE IS A PROVIDER WITH YOUR INSURANCE COMPANY AT EACH VISIT.
We do not guarantee our provider status for your insurance plan.

Our practitioners only perform procedures which are deemed medically necessary for you and/or the health of your baby. They are discussed with you before they are performed.

You are responsible for any NON-COVERED expenses including 3D/4D ultrasound imaging, office visits, procedures deemed experimental or investigational, fetal cardiac ECHO evaluation with color & Doppler, etc.

As a courtesy, your insurance will be billed.

It is the **patient's responsibility** to obtain insurance authorization for any and all procedures and services for which they are referred, in addition to any services recommended by the consulting physician and/or accepted by the patient. If, at the time of your visit, the consulting physician recommends additional procedures, we will make every effort to advise you of any additional patient costs in advance.

I HEREBY AUTHORIZE **MICHELLEL A. MARINE MD, INC.** TO BILL MY INSURANCE COMPANY AND RECEIVE PAYMENT FROM THEM ON MY BEHALF. I ACKNOWLEDGE, HOWEVER, THAT I AM RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT AND ANY AND ALL CHARGES ACCOCIATED WITH ITS COLLECTION.

I ALSO AUTHORIZE **MICHELLE A. MARINE MD, INC.** TO PROVIDE MEDICAL TREATMENT FOR ALL OF MY VISITS ASSOCIATED WITH MY CURRENT PREGNANCY OR MEDICAL CONDITION AS REQUESTED BY MY REFERRING PHYSICIAN OR MYSELF.

Signature	Print Name	Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided The right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home # _____

- ☐ O,K, to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Cell # _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other Authorizations

☐ O.K. to discuss billing information with another person: _____
Name Relationship

☐ O.K.to discuss medical information with another person: _____
Name Relationship

_____ _____
Patient Signature Date

_____ _____
Printed Name Date of Birth

The privacy rule generally requires healthcare providers take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

MICHELLE A. MARINE MD, INC.
77 ROLLING OAKS DR. #306
THOUSAND OAKS, CA 91361

You are scheduled for a Preventative Health Service/Annual visit. The Affordable Health Care Act of 2010 requires that the patient share of cost (co-pay or co-insurance) be waived for preventative services when certain criteria are met.

You may be financially responsible for additional charges under the following circumstances:

A. As a new patient Dr. Marine **must** discuss your past medical history in depth and in doing so additional charges (co-pay, co-insurance, deductible) may apply depending your your health care benefits.

B. If you are an existing patient and here for your annual/PAP appointment it should be covered in full. However, if any other concern or problem is discussed during the course of your visit, an office visit will be billed to your insurance as it is not included as part of your annual exam.

_____ _____

PATIENT SIGNATURE DATE

The Woman's Place

for Health & Midwifery Care

Name	Date of birth	
Address	Phone	

Date of last menstrual period_____Any problems with your periods?_____
Last pap smear_____Current birth control method_____
Have you or anyone in your immediate family had any changes in your health since your last visit? If so, what?

_____

_____

Do you have any allergies?_____Current medications?_____
Regular exercise?_____Vitamins or calcium supplements?_____
Do you smoke?_____ (per day) Use alcohol_____(oz/week) Drugs_____

WHY ARE YOU HERE TODAY?

_____

_____

CLIENT HISTORY

DATE:

for Health & Midwifery Care

Name_____
(last) (first)
Date of Birth_____ Age_____
Married / Single / Separated / Divorced / Widowed
Occupation_____

FAMILY HISTORY

(grandparents, parents, siblings, children)

Cancer (type)_____
Heart disease_____
High blood pressure_____
Blood clots / Stroke_____
High cholesterol_____
Varicose veins_____
Diabetes_____
Respiratory disease_____
Tuberculosis_____
Kidney disease_____
Thyroid disease_____
Seizure disorder_____
Mental illness_____
Alcohol or drug abuse_____

YOUR MEDICAL & SURGICAL HISTORY

Asthma_____
Respiratory disease_____
Tuberculosis_____
Diabetes_____
High blood pressure_____
Heart disease/ murmur_____
Blood clots or stroke_____
Cancer_____
Liver disease_____
Kidney disease_____
Bladder infections_____
Thyroid disease_____
Epilepsy_____
Sickle cell anemia or trait_____
Hepatitis_____
Migraine headaches_____
Rheumatic fever_____
Blood transfusion_____
Anorexia / Bulemia_____
Collagen vascular disease (Lupus)_____
Arthritis_____
German measles (rubella)_____
Chicken pox_____
Recent weight change_____
Change in bowel or bladder habits_____
Unusual bleeding_____
Depression_____
Have you ever been hospitalized or had surgery?
When and why?_____
_____

PERSONAL HISTORY

Allergies_____
Current Medications / Hormones / Vitamins / Herbs
_____
Caffeine (cups per day)_____
Cigarettes (number per day)_____
Past cigarette use (number of years)_____
Alcohol (number of drinks per week)_____
Recreational drug use_____
Any treatment for drug or alcohol use_____
Exercise (type & frequency)_____
Do you perform breast self exam?_____
Is there violence in any of your relationships?___
Explain_____
Have you ever been sexually abused?_____
Do you want to discuss it? _____

GYNECOLOGICAL HISTORY

Last menstrual period (first day)_____
Was it a normal period?_____
How long does your period last?_____
How often do you have your period?_____
Are your periods regular?_____
# of pads/ tampons you use in 24 hours_____
Are they soaked or spotted?_____
Do you have cramps?: none, mild, mod, severe
Age periods began_____
Date of last pap smear _____
Date of last mammogram_____
Do you have a history of:(include dates)
Abnormal pap smear_____
Colposcopy, cryo / laser surgery_____
Infertility _____
Endometriosis_____
DES exposure_____
Ovarian cysts_____
Fibroids_____
Breast lumps or tumors_____
Pelvic Inflammatory Disease (PID)_____
Gonorrhea_____
Chlamydia_____
Herpes_____
Syphilis_____
Genital Warts_____
Other gynecologic problems_____

SEXUAL ACTIVITY

Are you sexually active?_____
Sexual preference____men____women___both
Are you satisfied with your sexual relations?_____
Any pain or bleeding with intercourse?_____
Age of first intercourse_____
Frequency of intercourse _____
Number of partners in last 2 years_____

BIRTH CONTROL HISTORY

Are you using birth control now?_____
If so, what method?_____
Are you satisfied with that method?_____
Would you like a new method?_____
What methods have you used?:

Method	Problems
_____ Pill	_____
_____ IUD	_____
_____ Diaphragm	_____
_____ Cervical cap	_____
_____ Depo Provera	_____
_____ NuvaRing	_____
_____ Rhythm	_____
_____ Foam	_____
_____ Condom	_____
_____ Withdrawal	_____
_____ Sterilization	_____

PREGNANCY HISTORY

How many times have you been pregnant?_____
Number of children born alive_____
Number of miscarriages_____
Number of abortions_____
Number of tubal pregnancies_____
Number of children now living_____
Any problems with pregnancy or birth?_____
_____
Number of cesarean births_____
Do you plan on future pregnancies?_____

CURRENT PROBLEMS

Why are you here today?_____
_____
_____
_____
_____
_____