UTICA
WOMEN'S SPECIALISTS

NEW PATIENT LETTER

Welcome to Utica Women's Specialists! We are delighted you have chosen our practice to provide your obstetric and gynecologic care. In order to familiarize you with how our office works, we are providing this information.

OUR PRACTITIONERS

Our practice has two physicians. Our physicians are Lynn E. Frame, M.D. and Daran L. Parham, M.D. They specialize in obstetrics, gynecology, and gynecologic surgery. Each of our doctors has dedicated their lives to providing compassionate and quality healthcare to women.

APPOINTMENTS

In order to serve you most effectively, we see patients by appointment only. Appointments can be scheduled by calling **918-749-1413**. If you find that you are unable to keep your appointment, we ask that you inform us at least 24 hours in advance so that we may make that time available for another patient. You may be subject to a $25.00 fee should you fail to notify us in advance as stated above or "no show" your appointment time. We urge you to be on time for your appointment.

We recognize that your time is valuable and we make every effort to keep to our schedule. Unfortunately, the nature of our specialty is such that deliveries can occur and surgical emergencies may arise during office hours. If this should occur, we will use our best efforts to notify you in advance, reschedule your appointment, or arrange for you to see another physician in our office. We appreciate your patience and understanding.

TELEPHONE CALLS

Please call during our regular office hours **(M-Th 8:00-4:30, F 8:00-4:00)** with questions regarding your care, for prescription refills or lab results. For prescription refills, please have your pharmacy fax a refill authorization to our office at **918-748-7511**. Prescription refills will be completed within 24 hours of notification. Please know that our staff has been trained to answer your questions and will consult with your physician in this regard.

EMERGENCIES AND LABOR

If you think you are in labor, go to the labor and delivery unit of your delivering hospital. If you have an emergency during office hours, please call the office at **918-749-1413**. If your emergency is after hours, you must call our office number and our 24-hour answering service will contact the physician on call to return your call promptly. All after-hour situations of a true emergency will be handled accordingly to provide you the best of care. Our doctors at Utica Women's Specialists share weekend and night call coverage with Patricia Lodes, M.D. and Kenneth Wiemar, M.D.

We are here to answer any problems or concerns you have. Please do not hesitate to ask someone to help you understand any of the above policies.

I have read and understand the above stated office policies.

Signature: _____ Date: _____

Print Patient's Name _____ DOB: _____

Lynn E. Frame, M.D.
Daran L. Parham, M.D.

FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Our fees are reasonable and customary in accordance with other specialists' offices in this area. In case of financial hardship, please make financial arrangements with the Collections Representative prior to being seen. The following is intended to provide a clear understanding of our Financial Policy and your financial responsibility:

PAYMENTS: We accept cash, debit cards, Visa, Mastercard and personal checks with a photo ID. Your co-pay, deductible, or co-insurance will be collected prior to services being rendered.

INSURANCE: Remember, your insurance is a contract between you and your insurance company. Utica Women's Specialists is pleased to directly bill your insurance for services rendered, but it is our policy that the patient is ultimately responsible for payment for services received from Utica Women's Specialists. The physicians at Utica Women's Specialists are not responsible for your deductibles, co-payments, co-insurance, percentages, non-covered services or services rendered without proper referral authorization, or denied services.

Please remember: **YOU MUST HAVE A CURRENT COPY OF YOUR INSURANCE CARD WITH YOU AT THE TIME OF SERVICE.** If you do not, we may ask you to pay for the services rendered or we will reschedule your appointment.

You may get better benefits with a referral from your Primary Care Physician. Please check your benefits packet to see if this is an option. If you have an HMO plan, please check your benefits packet to see if a prior authorization will be required for your visit.

A current list of insurance companies with whom Utica Women's Specialists are contracted can be found on our website at www.uticaobgyn.com. If your doctor is not contracted with your insurance company, please be prepared to pay for your services at the time of your visit. We will provide you a copy of your bill to file with your insurance company for reimbursement, or we can directly bill your claim as a courtesy.

We will not change diagnosis codes in order to get your claim paid unless it is documented in the chart by your doctor, as this action is illegal. If your insurance does not cover certain procedures or office visits, this dispute remains between you and your insurance company.

INSURANCE DEADLINES: Many insurance companies have timely filing deadlines. It is your responsibility to inform us of any insurance changes. If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered.

OUT-OF-NETWORK: It is your responsibility to know if our physician is a valid provider with your insurance company. We try to verify every patient's insurance benefits before they are seen by the doctor. If you are out of network and still want to be seen by the physician, please be advised that you will be responsible, at the time of the visit, for the full amount that your insurance does not pay.

CO-PAYMENTS: All co-payments are expected at time of service and will be asked for prior to seeing the physician. Patients may be rescheduled if the co-payment is not made.

UNDERAGE PATIENT RESPONSIBILITY: We hold the patient financially responsible unless the patient is underage. The parent or legal guardian who accompanies the underage child is responsible for the bill.

APPOINTMENT POLICY: Your scheduled appointment time is reserved just for you. We try not to overbook appointment times, in order to provide excellent care and guarantee sufficient time to adequately treat you.

In an effort to ensure that all of our patients can be seen in a timely manner, we ask you to arrive *on time* for your appointment. If you are unable to make your scheduled appointment, we ask you to provide our office advanced notice of at least two business days. Patients who do not call within 24 hours of their scheduled appointment to cancel or who do not show up for their scheduled appointment may be charged a $25.00 administrative fee. If a charge is incurred, we will not be able to reschedule an appointment for you until the balance is cleared.

NO-SHOW POLICY: It is the policy of Utica Women's Specialists to charge a fee for two or more missed APPOINTMENTS during a three month period, unless our office has been given at least 24 hours notice prior to the cancellation. Additionally, patients may be subject to dismissal.

FMLA, WIC OR OTHER FORMS: There may be an administrative fee for completion of any FMLA, WIC, disability or return to work forms. Please allow our office a minimum of 48 hours to process your request.

RETURNED CHECK POLICY: In the unlikely event that your check is returned for insufficient or held funds, *Cybercollect* will debit your checking account electronically for the face amount of the check PLUS a $40.00 fee. If *Cybercollect* is unable to resolve this debt, your account will be turned immediately to a collection agency of our choice.

COLLECTION AGENCY: Outstanding balances are due within 30 days of the statement. Balances that reach 90 days past due, may be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees our office incurs through the process utilized to collect the delinquent balance. **Please remember, your account can legally be turned to a collection agency the day it is due. We want to avoid this and are willing to make arrangements with you**.

TRANSFER OF RECORDS: You will need to request, in writing, the transfer of your records and you may be required to pay a reasonable copying fee ($1.00 for the first page and .50 cents per page thereafter, plus postage, if mailed) to have copies of your records sent to another doctor or organization. You may find the appropriate form on our website at www.uticaobgyn.com under "Patient Center."

I have read and agree to the above policy. I hereby authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct unless notification is received, in writing, within 30 days of statement date. I agree to pay all charges within 30 days of statement date, unless other arrangements have been made prior to any treatment. I agree to assign my insurance benefits to Utica Women's Specialists and the physicians therein, if applicable.

_____ _____

Printed Patient Name Signature

_____ _____

Date Responsible Party Name (if different than patient)

Lynn E. Frame, M.D.
Daran L. Parham, M.D.

PATIENT REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

Patient's Name: Last _____ First _____ Middle _____

Nickname _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____ Age _____

Street Address _____

City _____ State _____ Zip Code _____

Mailing Address _____
(if different than street address)

E-Mail Address _____

Cell Phone (_____)_____ Home Phone (_____)_____

Employment Status ☐ Employed ☐ Student ☐ Self-Employed ☐ Retired ☐ Other

Employer _____ Occupation _____

Work Phone (_____)_____

Spouse Name: Last _____ First _____

Spouse's Employer _____ Spouse's Date of Birth _____/_____/_____

Emergency Contact Name (other than spouse) _____

Patient's Relationship to Emergency Contact _____

Cell Phone (_____)_____ Home Phone (_____)_____

RESPONSIBLE PARTY INFORMATION (if other than self)

Responsible Party Name: Last _____ First _____

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____

Street Address _____

City _____ State _____ Zip Code _____

Cell Phone (_____)_____ Home Phone (_____)_____

Employment Status ☐ Employed ☐ Student ☐ Self-Employed ☐ Retired ☐ Other

Employer _____ Occupation _____

Patient Relationship to Responsible Party _____

INSURANCE INFORMATION - Must provide your insurance card to the front desk at check-in.

Primary Insurance _____ Secondary Insurance _____

If insurance is not under patient's name, please provide the following information about the subscriber:

Name _____ Relationship _____

Date of Birth _____/_____/_____ Social Security Number _____-_____-_____

PRIMARY CARE PHYSICIAN or REFERRING PHYSICIAN _____

Phone (_____)_____

It is the responsibility of the **patient to know what physicians, hospitals, laboratories and pharmacies are in network with her current insurance provider. Please check with your insurance company prior to seeing any health care provider. Additionally, Utica Women's Specialists, LLC will not be responsible for determining your insurance benefits for office visits.*

I agree that the information provided on this form is accurate to the best of my knowledge. I hereby authorize Utica Women's Specialists, LLC to furnish information to my insurance carrier(s) concerning my illness and treatment, and thereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any unpaid balance, regardless of insurance coverage.

_____ _____

Date Signature of Patient or Guardian

Lynn E. Frame, M.D.
Daran L. Parham, M.D.

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OBSTETRICAL HISTORY

Name_____ Date_____ Age_____
Date of birth_____/_____/_____ Race: ☐ White ☐ African American
Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Hispanic ☐ Asian
☐ Divorced ☐ Other ☐ Other _____
Address_____
City_____ State_____ Zip_____
Cell Phone (_____)_____ Home Phone (_____)_____
Occupation_____
Name of the father of the baby_____
Emergency Contact_____ Phone (_____)_____

How did you hear about us? ☐ Primary Care Physician (PCP) ☐ Internet/Publication ☐ Friend ☐ Other
If you were referred by your PCP or friend, please list:_____
Name Telephone
What was the **FIRST** day of your last period? _____/_____/_____
Was it a **NORMAL** period? _____
How often do you normally have periods? ☐ Not Applicable ☐ 21-30 days apart ☐ Greater than 40 days
☐ Less than 20 days ☐ 30-40 days apart
Do you know the exact day of conception? _____/_____/_____
What was the date of your positive pregnancy test? _____/_____/_____

PREVIOUS PREGNANCIES

PAST PREGNANCIES (LAST SIX)										
Date (Mo/Year)	Length of Pregnancy (in weeks)	Length of Labor	Type of Delivery (V, C/S)	Anesthesia (Yes/No)	Infant Sex	Weight (lbs/ozs)	Perinatal Mortality (Yes/No)	Place of Delivery	Preterm Labor (Yes/No)	Any complications?

MEDICAL HISTORY

Ear, nose, or throat problems? ☐ Yes ☐ No Type? _____
TB/Asthma? ☐ Yes ☐ No
Heart Disease? ☐ Yes ☐ No
High Blood Pressure? ☐ Yes ☐ No
Rheumatic Fever or Mitral Valve Prolapse? ☐ Yes ☐ No
Hepatitis or Liver Disease? ☐ Yes ☐ No
Kidney Disease or frequent UTI's? ☐ Yes ☐ No How often? _____
Have you ever had an abnormal Pap? ☐ Yes ☐ No
Have you ever been told you have an abnormally shaped uterus? ☐ Yes ☐ No

Have you ever had any infertility issues?	☐ Yes	☐ No
Have you ever been told your mother took DES while pregnant with you?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No
Thyroid problems?	☐ Yes	☐ No
Blood clots, phlebitis, DVT's?	☐ Yes	☐ No
Easy bleeding/von Willebrand's?	☐ Yes	☐ No
Neurological problems/Epilepsy?	☐ Yes	☐ No
Psychiatric problems?	☐ Yes	☐ No
Major accident/Trauma?	☐ Yes	☐ No
Any hospitalizations or operations?	☐ Yes	☐ No
Surgery on uterus, tubes, ovaries, cervix?	☐ Yes	☐ No
Anesthesia problems?	☐ Yes	☐ No
Have you ever had a blood transfusion?	☐ Yes	☐ No
Are you Rh sensitized?	☐ Yes	☐ No

Do you use tobacco?	☐ Yes	☐ No	Before pregnancy?	☐ Yes	☐ No
Do you use alcohol?	☐ Yes	☐ No	Before pregnancy?	☐ Yes	☐ No

Do you or your partner have genital herpes? ☐ Yes ☐ No

Have you been treated for a vaginal infection? ☐ Yes ☐ No

What type?

☐ Chlamydia	☐ Bacterial	☐ Pelvic Inflammatory Disease
☐ Trichomonas	☐ Gonorrhea	☐ HPV virus
☐ Syphilis		☐ HSV virus

FAMILY HISTORY FOR YOU AND FATHER OF BABY

Will you be 35 years old or older at the time of delivery? ☐ Yes ☐ No

Does anyone in either family have the following?

Thalassemia?	☐ Yes	☐ No	Neural tube defects?	☐ Yes	☐ No
Down syndrome?	☐ Yes	☐ No	Tay-Sachs?	☐ Yes	☐ No
Sickle cell?	☐ Yes	☐ No	Hemophilia?	☐ Yes	☐ No
Muscular dystrophy?	☐ Yes	☐ No	Cystic fibrosis?	☐ Yes	☐ No
Huntington chorea?	☐ Yes	☐ No	Mental retardation?	☐ Yes	☐ No
Fragile X syndrome?	☐ Yes	☐ No	Any other genetic problems?	☐ Yes	☐ No

Have you or the baby's father had any children with a birth defect not listed above? ☐ Yes ☐ No

Type: _____

Have you taken any medications since becoming pregnant (prescription or over the counter)? ☐ Yes ☐ No

Type: _____

Have you used any street/illegal or IV drugs since becoming pregnant? ☐ Yes ☐ No

Type: _____

Have you ever used IV drugs? ☐ Yes ☐ No

Are there any medical problems in your family that are significant? ☐ Yes ☐ No

Type: _____

What is your height?	
What is your usual weight?	
What is your normal blood pressure?	

Do you own cats? ☐ Yes ☐ No
Do you eat fish regularly? ☐ Yes ☐ No
Do you plan to have a tubes tied? ☐ Yes ☐ No
Have you had the Hepatitis B vaccine? ☐ Yes ☐ No
Are you in a relationship with someone who threatens you or physically hurts you? ☐ Yes ☐ No
Has anyone ever forced you to have sexual activities that made you feel uncomfortable? ☐ Yes ☐ No
Would you accept a blood transfusion to save your life? ☐ Yes ☐ No

Please list any allergies to **medications** _____
_____
Please list any **food** allergies (nuts, shellfish, eggs, etc.) _____
_____
Any allergies to: ☐ Latex ☐ Adhesive/Tape ☐ Iodine ☐ Nickel ☐ Contrast Dye

Please list all current prescriptions and over-the-counter medications you currently take.

PRESCRIPTIONS					
Name of Medication	Dosage (total mg)	Number per day	Prescribing Doctor	Reason for medication	Side effects?
OVER-THE-COUNTER MEDICATIONS, VITAMINS, HERBAL OR NATURAL SUPPLEMENTS					

Reviewed with Patient _____ _____
Physician Date