Acadiana Ob/Gyn

Kim A. Hardey, M.D.   Damon T. Cudihy, M.D.

Respecting the Dignity of Women and building a new Culture of Life

155 Hospital Dr., Suite 302   Lafayette, LA 70503

Telephone: (337) 261-5433   Fax: (337) 269-9652

DATE ___________   **FILE_________**

______________PATIENT INFORMATION______________

PATIENT NAME

(Last)__________________________(First)____________________________(maiden/middle)________________

STREET____CITY,STATE, ZIP_________________________________

HOME PHONE (   )_________________WORK(   )_____________________CELL(   )_________________

DATE OF BIRTH______________________SOCIAL SECURITY NUMBER______________________________

ARE YOU: **[   ] CONSECRATED CELIBATE   [   ] SINGLE   [   ] MARRIED**
[   ] SEPARATED   [   ] DIVORCED   [   ] WIDOWED

ARE YOU EMPLOYED? **[   ] YES [   ] NO**

EMPLOYER ____ WORK PHONE #_________________________

ADDRESS____POSITION HELD________________________

HOW LONG THERE?__________________   INSURANCE COVERAGE? [   ] YES   [   ] NO

WHO REFERRED YOU HERE?___________________________ PRIMARY CARE DOCTOR________________

_________________________________SPOUSE INFORMATION___________________________________

SPOUSE'S NAME____

SPOUSE'S DATE OF BIRTH_________________SOCIAL SECURITY NUMBER____________________________

SPOUSE'S EMPLOYER____WORK PHONE #_________________

EMPLOYER ADDRESS_________________________________POSITION HELD________________________

HOW LONG THERE?__________________________________INSURANCE COVERAGE? [   ] YES [   ] NO

_________________________EMERGENCY CONTACT INFORMATION__________________________

PERSON TO CONTACT IN CASE OF EMERGENCY OR IF WE ARE UNABLE TO CONTACT YOU AT HOME OR AT WORK:

(NAME)_________________________________DATE OF BIRTH___________PHONE_____________________

(ADDRESS)____RELATIONSHIP__________________

_________________________________INSURANCE INFORMATION_________________________

PRIMARY INSURANCE

__________________________________POLICY#__________________________________GROUP#__________

NAME OF INSURED____RELATIONSHIP TO YOU______________

INSURED'S BIRTHDATE_______________________________

SECONDARY INSURANCE

__________________________________POLICY#__________________________________GROUP#__________

NAME OF INSURED____RELATIONSHIP TO YOU______________

INSURED'S BIRTHDATE______________________________

Acadiana OB/GYN
Dr. Damon T. Cudihy

Name: ____ Age: ___________ Date of Birth: ________________
Preferred Pharmacy: ____City:___________________________

Major reason for this visit: (CIRCLE ALL THAT APPLY) Check-up, Newly pregnant, Irregular cycles, Heavy bleeding, Unexplained infertility, Pelvic pain, Vaginal discharge or Itching, Possible hormone issue, Painful or too Frequent Urination, Breast Lump:
Right breast/Left breast, Breast pain, OTHER
Details of Reason for this visit:
____
____
____

GYNECOLOGIC HISTORY

Age menstrual periods began	___________________
Age or Year menstrual periods stopped (Menopause)	___________________
Date of First Day of Last Normal Menstrual Period	___________________
Number of days last normal menstrual period lasted	___________________
Do you have pelvic pain with menstrual periods? (Circle One)	Yes No
Do you have P.M.S. symptoms?	Yes No
Do you have excessive bleeding at menstrual periods?	Yes No
Do you have bleeding between menstrual periods?	Yes No
Date of your last Pap test	___________________
Was your last pap test normal or abnormal?	___________________
Date of your last mammogram	___________________
Was your last mammogram normal or abnormal?	___________________

SOCIAL HISTORY

Marital Status: (Circle One)	Married, Single, Engaged, Divorced, Widowed
Home/Environment: (Living with)	Spouse, children, partner, other:___________________
Are there any issues with domestic violence? (Circle One)	Yes No
Religion: (Circle One)	Catholic, Protestant, Methodist, Baptist, Jewish, Christian, Other: ___________________
Do you smoke cigarettes?	Yes Never Former
If you smoke, how many cigarettes do you smoke a day?	___________________
Describe your alcohol use: (Circle One)	Never, 1-2 times/year, 1-2 times/month, 1-2 times/week, Daily
Do you drink coffee? (Circle One)	Yes No
If you drink coffee, how many cups do you drink a day?	___________________
Do you exercise regularly and if so, how many times per week?	___________________

MEDICATIONS

List all medications you are now taking (including prescription and no-prescription):
____
____
____

ALLERGIES

List allergies to medications first, then all other allergies and your allergic reaction:
____
____
____

PAST SURGICAL HISTORY

Month/Year	Operation

PAST MEDICAL AND FAMILY HISTORY

	Self	Fam		Self	Fam
1. Heart disease			17. Chicken pox		
2. High Blood Pressure			18. Weight loss/gain		
3. Diabetes without insulin use			19. Headache/Migraine		
4. Diabetes with insulin use			20. Peptic ulcer		
5. Bladder infection			21. Bowel disorder		
6. Kidney disease			22. Anemia		
7. Hepatitis/Jaundice			23. Blood transfusion		
8. Gallbladder disease			24. Phlebitis/Stroke/Blood clots		
9. Seizure/Epilepsy			25. Thyroid disease		
10. Breast disease			26. Cancer		
11. Breast cancer			27. Skin disease		
12. Ovarian and/or Uterine cancer			28. Gonorrhea/Chlamydia/Syphilis		
13. Bladder control problems			29. Herpes		
14. Tuberculosis			30. Genital warts		
15. Asthma			31. HIV/AIDS		
16. Severe arthritis			32. Abrnomal pap smear		
			33. OTHER		

Details: If you wish to add details, list the reference number from above and write additional information:
____
____
____

OBSTETRICAL HISTORY

Date	Vaginal/ C-sec	Gender/ Name/ Weight	Provider	Location	Epidural/Spinal/ Unmedicated	Weeks @ Delivery	Live Birth/ Still Birth/ Miscarriage	Complications?

Patient Signature: ____ Date: __________________

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PRIVACY POLICY ACKNOWLEDGMENT

I acknowledge that I have been informed about and am aware of the Privacy Practices of this office.

______________________________ __________________
Signature of Patient or Legal Representative Date

____
If Legal Representative (relationship to patient)

Release of Information Questionnaire

May we inform family members about your appointments,treatment, general medical condition, diagnosis, healthcare operations and/or your payments?

YES______________ NO______________

If you want to limit this information to only specific family members, please print their full names here:

____________________________________ ________________________________

____________________________________ ________________________________

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other healthcare information if other than your home phone number.

( ) __________________________

Can confidential messages be left on your telephone answering machine?

YES_______________ NO______________

Acadiana OB/Gyn, LLC
Financial Policy

Payment is required for all services at the time they are rendered. Acadiana OB/Gyn, LLC accepts payment in the form of cash, checks, Visa, MasterCard, Discover and American Express.

- If a check is returned to the office due to insufficient funds, the original check amount plus a $25 returned check fee must be received within 30 days from the date the check was returned to avoid further late fees and/or collection action.
- After a balance has reached 45 days past due, a late fee will be assessed, after 90 days past due, your account will be turned over to an outside collection agency for further action. The patient will be responsible for any charges incurred in such action.
- Please help us better serve you and our other patients by keeping all scheduled appointments. If you must change an appointment, please do so before 48 hours prior to your scheduled appointment time. ***Your account will be charge a $50.00 cancellation fee for any appointment made with less than a 48 hour notice.***

PATIENTS WITH PRIVATE INSURANCE

Acadiana OB/Gyn, LLC is pleased to participate in a number of different insurance plans. While we are pleased to be able to participate in these plans, it is impossible for our office staff to be aware of each plan's specific requirements. Your plan may have limitations on the frequency of services performed or where service may be performed. Some plans may require a referral from your primary care physician as well. It is the patient's responsibility to inform Acadiana OB/Gyn, LLC of specific limitations set forth by their insurance plan(s). If Acadiana OB/Gyn, LLC is to order services that are considered non-covered by a patient's insurance carrier, payment for these services becomes the financial responsibility of the patient. **Due to the overwhelming number of insurance plans, it is impossible for our office staff to guarantee coverage by any individual plan. It is your responsibility to verify that we are a member of your network before presenting to our office for treatment. It is in your best interest to verify this information directly by calling the customer service number on your insurance card before being seen by a new health care provider**. If we participate with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of your annual deductible, co-payments, and any non-covered charges. In the event that we are not aware of a charge that is not covered by your plan, you will be billed for the balance after we obtain a denial from your insurance carrier. For those patients who have chosen a medical insurance plan that we do not have a contractual relationship with, we will require payment in full at the time of service. You will be responsible to file the charges for your treatment with your insurance company and we will give you a fee bill that contains all the necessary codes and information that you can file with your insurance plan for reimbursement. **It is your responsibility to verify that you have insurance coverage for any services rendered to you by Acadiana OB/GYN, LLC.**

PATIENTS WITH MEDICARE

We are Medicare participating providers. You will be responsible at the time of service for payment of the annual deductible, co-payments, co-insurance and charges for non-covered serivces.

FINANCIAL OBSTETRIC POLICY

Unlike other types of services, prenatal care is billed globally and will be billed at the end of your pregnancy, after delivery. Prenatal care includes your office visits and delivery charges.

During your pregnancy, physicians may order additional studies, such as ultrasounds and non-stress test. These services will be billed to your insurance at the time of the service, and are not included in the global prenatal care fee. You will be responsible for co-pays and/or additional fees for these services, which will be determined by your contract with your insurance.

In addition, please be aware of the cost of delivery. Some insurance companies require the patient to pay part of the delivery charge as a coinsurance and/or deductible. The coinsurance or deductible is considered part of the total reimbursement to the doctor. **We will arrange a monthly payment plan to pre-collect your deductible which you will be required to pay prior to delivery.**

It is your responsibility to inform our office of any changes in your insurance during your pregnancy. If your insurance coverage changes during your pregnancy, it is imperative that you inform the front desk or billing department as soon as possible. We need to obtain a maternity pre-certification to assure your delivery will be covered by the new insurance. You will be responsible for all unpaid balance if you fail to provide the office with a change in your insurance and you deliver without providing our office proper notification.

If these financial obligations are not met by the specified date, you will be instructed to reschedule appointments until your payments are made current and up to date.

Your signature below signifies that you understand our financial policy and agree to the terms of your responsibility regarding charges incurred at this office.

Patient's Signature ________________________________ **Date** _______________________________

Email Address _________________________________

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As many of us know understanding our Health Insurance Coverage is sometimes very difficult. We thought it would be useful to try and clear up some of the confusion by explaining some of the basics when it comes to health insurance coverage.

Preventive health care (yearly annual exam) which includes a routine pap smear, breast and pelvic exam are done in order to detect problems early that you may not know you have, before you become sick. For many women, the OB-GYN is their primary care physician-the doctor they turn to first for healthcare.

In most cases your yearly annual exam is routine without any concerns or problems, but in some cases, your doctor might decide that you need additional time and medical care on this visit. Insurance companies determine what tests, drugs and services they will cover. Your insurance company may decide that these services are not covered under your insurance policy and therefore may not cover the additional services.

Remember that your insurance company makes the decision about what will be paid for and what will not. Our main concern is and will always be, to help our patients maintain optimum health and treating their individual needs.

Damon T. Cudihy, M.D.
Kim A. Hardey, M.D.

__________________________________ __________________________________
Patient Signature Date

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ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process any claim(s) filed with my insurance company(s). I hereby authorize an assignment of benefits directly to Kim A. Hardey, M.D. or Damon T. Cudihy, M.D. of all benefits that are payable under each insurance plan. I agree to pay whatever insurance does not pay as is necessary to pay my bill in full.

________________________________ ________________

Patient Signature **Date**

PATIENT AUTHORIZATION AND RELEASE

Insurers and managed care companies occasionally review medical charts to insure compliance with company procedures. I understand that my chart may be selected for such review and that the confidentiality of the information in my chart will be preserved and I hereby consent to such review and release this physician and any such insurer or managed care company for liability for any reasonable review of my chart.

________________________________ ________________

Patient Signature **Date**

PRIVATE PAY AGREEMENT

I understand that because I agree to pay for my medical care without the benefit of health insurance, I will comply with the arrangements that are made between myself and Dr. Hardey/Dr. Cudihy's financial policy. I understand that these arrangements have been made to best suit my financial situation. In the event that I later find it necessary to apply for financial assistance from the State of Louisiana (Medicaid), I understand that I may not be able to use it to pay for any balance or future charges that I may incur while under the care of Dr. Kim Hardey/Dr. Cudihy.

________________________________ ________________

Patient Signature **Date**

INSURANCE CHANGES

In the event that my insurance policy is changed, canceled, or my condition is considered pre-existing, I will comply with the arrangements that are made between myself and Dr. Hardey's/Dr. Cudihy's financial policy. I understand that these arrangements will be (have been) made to best suit my financial situation. In the event that I later find it necessary to apply for financial assistance from the State of Louisiana (Medicaid), I understand that I may not be able to use it to pay for any balance or future charges that I may incur while under the care of Dr. Kim Hardey/Dr. Cudihy.

________________________________ ________________

Patient Signature **Date**

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Please be advised we do not take Medicaid (of any type) as **Secondary** to your Primary Commercial Insurance. Please sign below stating that you have been informed of this office policy.

_____________________ _________________
Patient's Signature Date

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Health Information Exchange Consent:

Lafayette General Health System's Health Information Exchange ("HIE") is a way of allowing your health information to be shared by participating medical groups, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose of the HIE is to give each of your participating providers the benefit of having access to all of your health information that is maintained by the participating providers when providing healthcare to you.

Your participation in the HIE is voluntary and your receipt of treatment will not be conditioned on whether or not you chose to participate. By signing below, you consent to participate in the HIE, and you acknowledge and agree as follows:

1. My health care providers that participate in the HIE may disclose my health information to the HIE and my health information may be shared with all health care provider participants involved in my care. The HIE may also share my health information with members of other health information exchanges to which the Lafayette General Health System HIE connects and who are involved in my care.
2. My health information that will be shared will include health information from both before and after today's date. My health information that will be shared through the HIE includes information about my diagnoses, test results (such as x-rays or laboratory), and medications that have been prescribed to me. Such information may also include health information that may be considered particularly sensitive to me, including:
   - Mental health information
   - Psychotherapy notes
   - HIV/AIDS information and test results
   - Genetic information and test results
   - Sexually transmitted disease test results and treatment
   - Family planning information
   - Alcohol and substance abuse treatment records
3. Health care providers who receive health information about me through the HIE may copy or include my health information into their own medical records when caring for me. If I cancel this consent, such cancellation will have no effect on the health information such providers already accessed and copied.
4. You may withdraw consent at any time by signing a new Consent Form. Providers that have accessed your health information while your consent was in effect may copy or include your health information in their own medical records. If you decide to withdraw your consent, those providers are not required to return or remove your health information from their records.
5. I have the right to request a copy of this form.

____ I Approve sending my information to an HIE
____ I do not approve sending my information to an HIE

Patient Signature: ________________________ Printed Name __________________ Date________