Udita Jahagirdar, M.D., F.A.C.O.G., P.A.

GYNECOLOGY & INFERTILITY

DIPLOMATE, AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY

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We would like to welcome you to our practice and thank you for choosing Dr. Jahagirdar for your gynecological needs. In preparation for your upcoming appointment, please complete the enclosed forms and bring them with you to your first visit. We request that you not mail them in advance. We would appreciate you arriving 10 minutes before your appointment so that we can process your paperwork at that time.

In addition, please bring the following with you to your first appointment:

1. Insurance cards
2. Medical records/test results (applicable to your condition)
3. Authorization/Referral from your Primary Care Physician (if required)
4. List of your medications/dosages and any allergies
5. Preferred pharmacy name and phone number - PRINT ON BOTTOM OF 1ST PAGE
6. Please be prepared to pay any co-pays or deductibles at time of visit
7. List of surgical history(names of surgery and dates of surgery)

UDITA JAHAGIRDAR, M.D.

Date _____ **PATIENT INFORMATION** Acct. No. _____ (leave blank)

Patient's Last Name _____ First Name _____ M.I. _____

Billing Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Social Security # _____

Patient Referred By _____ Family Physician _____

Age _____ Marital Status: ☐ S ☐ M ☐ W ☐ D Driver's License # _____

Reason for Visit _____

EMail Address _____

****

INSURANCE INFORMATION (if applicable)

Name of Insurance Company _____

Mailing Address _____

Policy No. _____ Group Name/No. _____

Policyholder's Name _____ DOB: _____ Policyholder's SS# _____

Additional Insurance Company _____

Mailing Address _____

Policy No. _____ Group Name/No. _____

Policyholder's Name _____ DOB: _____ Policyholder's SS# _____

****

Occupation _____ Employer _____

Address of Employer _____

Name of Spouse or Parent _____ Phone # _____

Employed By _____ Phone # _____

****

Alternate Contact for Emergencies _____

Relationship _____ Phone # _____

Please let us know what phone #s you do not wish us to contact you at _____

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OFFICE POLICY

- Payment/Copayment for office visit is due at the time services are rendered.
- Please be thorough with your insurance information. Give your insurance ID card and any authorization to our receptionist.
- HMO or PPO patients requiring referrals: You are responsible for making sure all visits with our office are authorized by your primary care physician (PCP) as per the policy of your insurance company.
- For labs and radiology testing: please refer to your provider handbook for contracted facility.
- If this account necessitates legal action for collection, I will be responsible for the balance due plus any legal fees and court cost.

Signature _____

INSURANCE RELEASE

- I authorize any holder of medical or any other information about me to release to my insurance carriers any information needed for this or a related insurance claim.

Signature _____

INFORMATION FOR YOUR PHYSICIAN

Please answer the following questions prior to your first examination.
It will help your physician to know not only about your health, but also about your family and relatives.

TODAY'S DATE

NAME | ADDRESS

TELEPHONE NUMBER | DATE OF BIRTH | AGE | PLACE OF BIRTH | RACE OR NATIONALITY OF PARENTS

RELIGION | EDUCATION (Highest level attained) | OCCUPATION ▶ | HOW LONG

PRESENT MARRIAGE (Year married) | PREVIOUS MARRIAGE (Year married and duration)

WHERE AND WHEN HAVE YOU LIVED OR TRAVELED OUTSIDE THE U.S. AND CANADA?

ALIVE ▶ DECEASED ▶	FATHER ☐ ☐	Present health or cause of death	MOTHER ☐ ☐	Present health or cause of death	SPOUSE ☐ ☐	Present health or cause of death
BROTHERS ▶	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH		
SISTERS ▶	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH		
CHILDREN ▶	NO. ALIVE	AGES & HEALTH	NO. DECEASED	AGES & CAUSE OF DEATH		

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES** ☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease
☐ Tuberculosis ☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other

CHECK ANY ILLNESSES OR CONDITIONS **YOU** HAVE HAD ☐ Diabetes ☐ Glaucoma ☐ Heart trouble ☐ Syphilis ☐ Vein trouble
☐ Cancer ☐ Asthma ☐ Jaundice ☐ Gonorrhea ☐ Bleeding tendencies ☐ Tuberculosis ☐ Pneumonia ☐ Kidney disease
☐ Rheumatic fever ☐ Nervous disorder ☐ Other

LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC.?
☐ No ☐ Yes ▶ LIST:

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES?
☐ No ☐ Yes ▶ LIST:

Use of street drugs? ☐ No ☐ Yes

DO YOU USE TOBACCO NOW? ☐ No ☐ Yes	IN THE PAST? ☐ No ☐ Yes	TYPE AND DAILY AMOUNT	HOW LONG?
DO YOU USE ALCOHOLIC BEVERAGES? ☐ No ☐ Yes ▶	TYPE	WEEKLY AMOUNT	HOW LONG?
DO YOU DRINK COFFEE? ☐ No ☐ Yes ▶		WEEKLY AMOUNT	HOW LONG?

CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED
☐ Smallpox ☐ Tetanus ☐ Typhoid ☐ Polio ☐ Influenza ☐ Other

PREVIOUS OPERATIONS (Dates, hospitals and name of surgeon)

DENTAL (List any problems you have now)

MEDICATIONS (Name or otherwise identify medicines now or recently used)

ONSET DATE OF LAST MENSTRUAL PERIOD	PERIODS ARE ☐ Regular ☐ Irregular	NUMBER OF PREGNANCIES	NUMBER OF MISCARRIAGES

HAVE YOU TAKEN CORTISONE-TYPE DRUGS? ☐ No ☐ Yes	ORAL CONTRACEPTIVES? ☐ No ☐ Yes	HAVE YOU RECEIVED A BLOOD TRANSFUSION? ☐ No ☐ Yes ▶ DATE:

DRESSED WEIGHT | HOW LONG HAVE YOU BEEN AT THIS WEIGHT?

WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT?

WHAT IS YOUR MAIN SYMPTOM?

REVIEWED BY (Physician) | DATE

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided

Constitutional Symptoms
- Fever Y N
- Chills Y N
- Headache Y N
- Other_____

Eyes
- Blurred vision Y N
- Double vision Y N
- Pain Y N
- Other_____

Allergic/Immunologic
- Hay Fever Y N
- Drug allergies Y N
- Other_____

Neurological
- Tremors Y N
- Dizzy spells Y N
- Numbness/tingling Y N
- Other_____

Endocrine
- Excessive thirst Y N
- Too hot/cold Y N
- Tired/sluggish Y N
- Other_____

Gastrointestinal
- Abdominal pain Y N
- Nausea/vomiting Y N
- Indigestion/heartburn Y N
- Other_____

Cardiovascular
- Chest pain Y N
- Varicose veins Y N
- High blood pressure Y N
- Other_____

Integumentary
- Skin rash Y N
- Boils Y N
- Persistent itch Y N
- Other_____

Musculoskeletal
- Joint pain Y N
- Neck pain Y N
- Back pain Y N
- Other_____

Ear/Nose/Throat/Mouth
- Ear infection Y N
- Sore throat Y N
- Sinus problems Y N
- Other_____

Genitourinary
- Urine retention Y N
- Painful urination Y N
- Urinary frequency Y N
- Other_____

Respiratory
- Wheezing Y N
- Frequent cough Y N
- Shortness of breath Y N
- Other_____

Hematologic/Lymphatic
- Swollen glands Y N
- Blood clotting problem Y N
- Other_____

Psychologic
- Are you generally satisfied with your life? Y N
- Do you feel severely depressed? Y N
- Have you considered suicide? Y N
- Other_____

Physician use only: (Comments/Notes)

Physician: _____

PATIENTS NAME: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Udita Jahagirdar, M.D.,P.A.'s *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Udita Jahagirdar, M.D.,P.A.may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Udita Jahagirdar, M.D.,P.A.'s *Notice of Privacy Practices* by submitting a request in writing for a current copy of Udita Jahagirdar, M.D.,P.A.'s *Notice of Privacy Practices.*

_____
Printed Patient Name

_____ _____
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

_____ _____
Printed Patient Personal Representative Name Relationship to Patient

_____ _____
Patient Personal Representative Signature Date

For Udita Jahagirdar, M.D.,P.A
.Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Udita Jahagirdar, M.D.,P.A.made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other_____

_____
Employee Name (printed)

_____ _____
Employee Signature Date

FINANCIAL POLICY

INSURANCE: We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with but do not have an up-to-date card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

MEDICARE: We are a participating Medicare provider. Medicare will bill your secondary insurance (if any). You must provide Medicare with your secondary insurance information. They will crossover and bill your secondary insurance for you. However, that does not mean that all services are covered. Patients are responsible for paying their annual deductible if it has not been met. You are also responsible for any co-payments which are usually 20% of the allowed amount for an item or service.

COPAYMENTS AND DEDUCTIBLES: All co-payments and deductibles must be paid in full at the time of service. This arrangement is part of your contract with your insurance company.

SELF PAY: Payment in full is due at time of service if you do not have health insurance

REFERRALS/AUTHORIZATIONS: We are required to follow the guidelines of your managed care plan, which may require a referral from your primary care physician prior to your appointment when visiting a specialist office. Therefore, if a referral is required and not presented at the time of your visit your appointment will be rescheduled or you will be financially responsible for services received due in full upon completion of the visit.

CLAIM SUBMISSION: As a courtesy service to you, we will submit your insurance claims for services rendered in our office and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need information from. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

PATIENT BILLING: You will be sent up to three statements for your financial responsibility after your insurance has processed Claims. After the third notice your account may be forwarded to a Collection Agency. If your account is assigned to an outside collection agency an additional 40% of the amount owed will added. Please let the billing department know if you have difficulties resolving your bill. Payment arrangements may be considered on a case to case basis. We accept MasterCard and Visa for your convenience.
FORM COMPLETION: There is a $10.00 per form charge for any forms you request that the doctor complete. This Fee must be paid prior to form completion.

PAYMENT POLICY: All balances will be due in full at the time of your office visit whether or not you have received a statement from our office. We will provide you with a copy of your bill and the insurance credits upon request.

There is a $35.00 charge for checks returned unpaid by your bank
We reserve the right to charge $25.00 fee for missed appointments and $100.00 charge for surgical appointments.

If you are unable to make your appointment please cancel/reschedule at least 48 hours in advance.

I understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information and/or Contact information. I understand and accept these terms.

PRINT Patients Name: _____ Signature: _____

PRINT Responsible Party's Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

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NO SHOW APPOINTMENT POLICY

EVERY EFFORT IS MADE TO STAY ON SCHEDULE, SO WE RESPECTFULLY ASK PATIENTS TO BE PROMPT AND KEEP THEIR APPOINTMENTS. OUR STANDARD OFFICE POLICY REGARDING APPOINTMENTS IS AS FOLLOWS:

WE TRY TO REMIND PATIENTS BY TELEPHONE PRIOR TO THEIR APPOINTMENTS, BUT PLEASE DO NOT DEPEND ON THIS COURTESY. IF WE ARE UNABLE TO REACH YOU, YOUR APPOINTMENT, WHEN GIVEN TO YOU SHOULD SERVE AS CONFIRMATION OF THE APPOINTMENT AND IMPLIES YOUR OBLIGATION TO BE PRESENT. THAT APPOINTMENT DATE & TIME HAS BEEN RESERVED ESPECIALLY FOR YOU.

SURGERIES MUST BE CANCELLED AT LEAST ONE WEEK IN ADVANCE TO AVOID A CHARGE FOR LOST TIME, SINCE BOTH THE DOCTOR AND HOSPITAL HAS PUT THAT TIME ASIDE SPECIFICALLY FOR YOU. EXCEPTIONS TO THIS POLICY CAN BE DETERMINED ONLY ON AN INDIVIDUAL BASIS BY THE OFFICE MANAGER.

WE RESERVE THE RIGHT TO CHARGE FOR CANCELLED OR NO SHOW APPOINTMENTS WITHOUT A 48 HOUR NOTICE. THE NO SHOW APPOINTMENT CHARGE WILL DEPEND ON THE PROCEDURE AND TIME RESERVED. THESE CHARGES ARE ALLOWED BY YOUR INSURANCE COMPANY AND CONSIDERED AS THE PATENTS RESPONSIBILITY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS POLICY, DO NOT HESITATE TO SPEAK WITH THE OFFICE MANAGER. SHE WILL BE GLAD TO ASSIST YOU IN ANY WAY SHE CAN.

THANK YOU FOR YOUR COOPERATION

SIGNATURE:_____ DATE:_____