thrive
OBSTETRICS & GYNECOLOGY

Patient Information and Demographics

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Patient Phone #: _____ (even if patient is under 18)

Additional Phone#: _____ Relation to Patient _____

Date of Birth: _____ Social Security #: _____

Ethnicity: _____ Preferred Language: _____

Preferred Pharmacy (name, street/ city, phone #): _____

_____

Insurance Preferred Lab: _____ Preferred Hospital: _____

Emergency Contact: _____ Phone #: _____
Relationship: _____

(if patient is a minor) Financial Responsible Party: _____

Primary Insurance

Name of Insured: _____ Date of Birth: _____

Social Security #: _____ Relationship to Patient: _____

Insured Party Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Phone #: _____

Member ID: _____ Group Number: _____

Secondary Insurance

Name of Insured: _____ Date of Birth: _____

Social Security #: _____ Relationship to Patient: _____

Insured Party Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company: _____ Phone #: _____

Member ID: _____ Group Number: _____

By signing below, I acknowledge all of the information provided is true and accurate. I acknowledge that I am responsible for contacting my provider office to update any information should something change. I understand that it is my responsibility to understand my insurance policy coverage and benefits. I have supplied the insurance preferred location as requested and I accept any financial responsibility if I supplied an incorrect lab. *(refer to Office Policy: Labs for further details)*

Patient Name: _____

Patient Signature: _____ Date: _____

5356 Reynolds Street, Suite 302, Savannah, GA 31405
Office: 912.721.9595 Fax: 912.298.0899

Office Policies

Communication with Office

Our office requires a direct request from the patient to execute any action regarding their healthcare- whether an appointment request, prescription refill or results information, we must talk with the patient. Unfortunately we are unable to speak to spouses, parents, siblings or friends to handle any medical care (this includes patients under 18 years old).

Emergencies

For pregnant patients who may be in labor, or for any obstetric or gynecologic emergency after hours, please call the office phone number at 912-721-9595 and the answering service will connect you to the physician on call. If you are experiencing an actual medical emergency, please report to your nearest Emergency Department.

Payments- See Payment Policy

Laboratory Policy

Patients are responsible for informing our office of the correct lab based on your specific insurance carrier to send your pap smear and blood work. If we are not informed of your preferred lab we will send it to the Lab Corps of America. Thrive is not responsible for lab invoices received by patients in the case of labs being processed by a non-participating lab. Most lab results are available within 2 weeks following your visit. All lab companies used by Thrive (Labcorp, Quest, etc) have access portals that patients can view their personal results on. If you are not scheduled for a lab follow-up visit, the office will call with any **abnormal** test results. Please do not hesitate to call the office, and if necessary schedule an appointment, for any additional questions regarding your results or any other concerns.

Please sign below acknowledging you understand your labs will be sent to the lab indicated on your patient paperwork for processing.

Patient Signature: _____ Date: _____

5356 Reynolds Street, Suite 302, Savannah, GA 31405
Office: 912.721.9595 Fax: 912.298.0899

Prescription Refills

We ask that you request prescription refills during your office visit. If you need refills, but are unable to be seen, please call during regular office hours. Refills will not be authorized after normal business hours or on weekends. Please allow 24-48 hours for prescription refills to be processed and authorized.

Family Medical Leave Act

Our office will complete FMLA forms upon the request of our patients when requested for maternity leave or post op recovery. Please allow 7-10 business days for our office to complete this request. We will notify you once all paperwork has been completed and ready for you to pick up. If you are requesting we fax your FMLA paperwork please provide our office with the correct point of contact and fax number. If the forms are to be mailed, please provide our office with an envelope and adequate postage.

Work and School Excuse Notes

Any excused note is at the discretion of the provider who treated you. We are only able to provide them for medical care provided within our office on the day of service.

Records Requests

Records requested from our office will only be processed if there is an authorization to release those records on file. The authorization must designate which Physician we are to release records to and your signature must be on the form. We can only release records to a Physician's office or hand them directly to the patient. Requests are subject to a $0.35 fee per page and the cost of postage. Please allow 7-10 business days for the requests to be processed.

Appointments

Keeping scheduled appointments is imperative. We make every effort to send out reminder calls to all patients. Calls are made 24-48 hours prior to the scheduled time. Untimely cancels, re-schedules, and no-showing for an appointment are disruptive to our daily schedule. We request a 24 hour notice to re-schedule or cancel. Keeping appointments is important to your personal health and well-being. *(refer to Payment Policy to see the potential charges accompanying frequent untimely cancellations, reschedules or no-shows)*

Please sign below to indicate that you have read and understand the above and agree to abide by the stated policies. We thank you for choosing Thrive Obstetrics & Gynecology.

Patient Name: _____

Patient Signature: _____ Date: _____

5356 Reynolds Street, Suite 302, Savannah, GA 31405
Office: 912.721.9595 Fax: 912.298.0899

Payment Policy

Thank you for choosing Thrive Obstetrics and Gynecology for your healthcare needs. We are committed to providing each patient with quality and affordable health care services. We strive to keep our patients informed of office policies and want to outline payment policies so all patients understand their accounts and processing procedures here at Thrive.

1. Insurance: Thrive participates with several health insurance plans, including Medicare. If you are not insured by a plan where we are participating, your insurance company will consider our physicians out of network and the amount billed will be your responsibility and payment will be expected at each visit. If you are unable to provide an up to date insurance card on the day of service for us to verify coverage, you will also be responsible for payment in full on the date of service. Each patient is responsible for knowing and understanding their personal insurance policy. We encourage you to contact your insurance company with any questions concerning coverage under your policy.
2. Co-Payments, Deductibles, and Co-Insurance: All co-payments, deductibles, and co-insurances are due at the time of service. This policy is part of your contract with your personal insurance carrier under your contract with them. Patients who have scheduled surgeries will be expected to make payment at their pre-operation appointment. Failure for Thrive to collect these payments from patients is considered fraudulent. Please assist us in upholding the law by making these payments on the date of service.
3. Non-Covered Services: Please be aware that some- and perhaps all- of the services you receive here at Thrive, may be non-covered or not classified as necessary by Medicare and other insurers. You will be responsible for charges associated with any services falling into this category at the time of service.
4. Proof of Insurance: All patients must fill out and complete our patient information form prior to seeing the physician. We must have a copy of your driver's license (or other form of government issued ID) and current, valid insurance card to verify proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the entire bill from the date services were rendered.
5. Claim Submission: Thrive will submit your claims and assist you in any way we reasonably can in order to help get the claims paid. In certain cases, the insurance company may request specific information from you in order to process the claim. It is your responsibility to provide the requested information to the insurance company in a timely manner. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance policy is a contract between you and the insurance company. Thrive is not party to your specific contract.
6. Coverage Changes: If there are changes to your insurance, please notify our office prior to your next appointment. Informing us prior to the appointment will allow us the time we

need to verify coverage and assist in maximizing your benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

7. Non-payment: If an account is not paid in full within 90 days of the response from the insurance company, the account will be transferred to collections. For any patient with an unpaid balance greater than 90 days, all non-urgent visits or services will be postponed until the account is paid in full. In addition, patients who are in the collections phase are subject to permanent dismissal from the practice.
8. Missed Appointment: Our practice policy is to charge for appointments that are missed or not cancelled within 24 hours of the scheduled time. (We make every effort to contact patients to offer reminders of the scheduled appointment.) The charge for a missed appointment or late cancelled appointment is $25 each and will be billed to your account. These charges are patient responsibility. Please help us to serve you better by keeping your regularly scheduled appointments.

Thrive Obstetrics and Gynecology is committed to providing you as our patient, the best treatment. Our fees and policies are customary for our area.

Thank you for understanding our payment policy. Should you ever have any questions or concerns regarding your account, please contact our office.

I have read and understand Thrive's payment policy. By signing below I agree to adhere to the policies as they are outlined above.

Patient Name: _____

Patient Signature: _____ Date: _____

5356 Reynolds Street, Suite 302, Savannah, GA 31405
Office: 912.721.9595 Fax: 912.298.0899

HIPAA Notice of Privacy Policies

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for purposes that are permitted or required by law. It also describes your rights to access and control PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition related to health care services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physicians, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you, or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging other business activities. For example, we may disclose your PHI to medical students that see patients in the office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situation without your consent. These situations include: as Required by Law, Public Health Issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates, Required Uses

and Disclosures. Under the law, we must make disclosures to you when required by the Secretary of Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other Permitted and Required Uses and Disclosures will only be made with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except in the instance that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

Release of Medical Records: HIPAA gives patients the right to view and request copies of all of their medical records. As a medical practice, we have an obligation to protect medical information, both ethically and as dictated by HIPAA. In addition to the provisions outlined in HIPAA, we have adopted further measures to safeguard private information.

In general, it is our office policy not to mail or email protected health information.

Protected health information may be picked up in the office by the patient, but it is our policy not to release records to anyone but the patient.

In the case of a move or transfer of care, protected health information can be faxed to a health care provider once a release has been signed by the patient in our office, or sent from the provider's office with the patient's signature. We do not fax protected health information to clinics or facilities without the name of a health care provider.

In the case of extenuating circumstances, release of protected health information will be handled on a case by case basis and as the provider sees fit.

You have a right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the Purpose of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your written request must state specific restrictions requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive a confidential communication from us by alternative means or at an alternate location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

Under HIPAA, minors are able to consent to healthcare treatment for the following health care needs without guardian or parental consent- contraceptive services, STI services, Pre-natal care, Adoption services or medical care for a minor's child. It is our obligation to protect the minor's patient privacy.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe that your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

I certify that I have reviewed a copy of Notice of Privacy Policies describing the types and uses and disclosures of my PHI that might occur in my treatment, payment of bills or in the performance of the healthcare operations of Thrive Obstetrics and Gynecology.

Patient Name: _____

Patient Signature: _____ Date: _____

thrive
OBSTETRICS & GYNECOLOGY

Office Policy on Release of Medical Records

HIPAA gives patients the right to view and request copies of all of their medical records. As a medical practice, we have an obligation to protect medical information, both ethically and as dictated by HIPAA. In addition to the provisions outlined in HIPAA, we have adopted further measures to safeguard private information.

In general, it is our office policy not to mail or email protected health information.

Protected health information may be picked up in the office by the patient, but it is our policy not to release records to anyone but the patient.

In the case of a move or transfer of care, protected health information can be faxed to a health care provider once a release has been signed by the patient in our office, or sent from the provider's office with the patient's signature. We do not fax protected health information to clinics or facilities without the name of a health care provider.

Proper protection of your private information is not possible if we are operating with haste; therefore, we require at least 7-10 business days to process medical records requests.

Patient Name: _____

Patient Signature: _____ Date: _____

5356 Reynolds Street, Suite 302, Savannah, GA 31405
Office: 912.721.9595 Fax: 912.298.0899

Patient Portal Consent

At Thrive, we are moving ahead with technology and offer our patients access to their personal health information. We have not set a definitive date to open the access to our patients. However, in preparation for this, we wanted to provide you with a brief description of how the portal works, as well as some of the conditions of participation. You may opt out of gaining access to your personal health information.

Thrive's electronic medical record system is provided by eClinicalworks. eClinicalworks offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communication tool but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal. Because the connection channel between your computer and web site uses secure socket layer technology, you can read or view your information on your computer but it is still encrypted in transmissions between the web site and your computer.

Protecting your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and that you inform us if it ever changes. You also need to keep track of who has access to your email account so you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in th e answers.

Access to Personal Health Information

☐ Yes I would like to gain access to my personal health information through the patient portal

☐ No I do not wish to gain web access to my personal health record

Patient Name: _____

Patient Signature: _____ Date: _____

Email Address: _____

5356 Reynolds Street, Suite 302, Savannah, GA 31405
Office: 912.721.9595 Fax: 912.298.0899

Maryanna Barrett M.D.
Maria Paasch M.D.
5356 Reynolds Street, Suite 302 Savannah, Ga.31405
Phone: 912.721.9595 Fax: 912.298.0899

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____

Phone#: _____ Fax#: _____

to release healthcare information of the patient named above to:

Name: Thrive Obstetrics and Gynecology

Address: 5356 Reynolds Street Suite 302

City: Savannah State: Georgia Zip Code: 31405

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.