MARICOPA OBGYN
AOA family of obgyn physicians

Welcome to Maricopa Obstetrics and Gynecology Associates. We are pleased that you have chosen to have your medical care with us. We hope the following information will prepare you for your upcoming visit. Please see attached reminder notice of the date, time and location of the appointment.

Information To Bring to Your Appointment

- Insurance Card (so we may make a copy).
- Driver's License or other picture ID.
- Insurance Referral from primary care physician, if required.
- Required co-pay, deductible or co-insurance. Payments methods accepted are cash, check or credit card.
- Any medical records requested by our staff when you called to make your appointment.
- Updated and signed Patient Information Sheet. Note – it is critical that we have your current contact information so we can communicate clinical results to you, as needed.
- Completed Patient Medical Questionnaire.

Arrival Time

Please arrive 30 minutes before your appointment time to check-in and complete all your paperwork. If you do not arrive in time to complete the check-in process, your appointment will be rescheduled.

Need to Cancel

If you need to cancel your appointment, please contact the office at least 48 hours in advance so another patient may have the appointment time. To cancel or reschedule please call:

E. Camelback Road Office	(602) 241-1671
E. Ray Road Office	(480) 759-9191

Parking

Parking is readily available at both locations in the parking area designated for visitors. Please do not park in any spaces marked reserved for any other practice or business in the building.

MARICOPA OBGYN
AOA family of obgyn physicians

Dear Patient,

We appreciate you trusting us with your healthcare.

Maricopa Ob/Gyn is a group practice comprised of seven physicians, both male and female. Our goal is to provide you with the best care possible when you need it, therefore you may need to be cared for by someone other than your selected physician in both the office and hospital.

We ask that you please take the time to fill out the following forms carefully and correctly. We are transferring all of our medical records to an electronic platform.

Although you may have completed these forms many times in the past, we need to update this information to ensure that we have the most current and complete health history at this time.

Please return them to us within the next five days.

You may return these pages to us in one of the three ways:

Mail: Maricopa OB/GYN
1661 E. Camelback Rd. #160
Phoenix, AZ 85016

Email: mogaforms@aoafamily.com

Fax: 602-230-7982

Thank you for your attention to this matter.

PATIENT INFORMATION

For office use only	Abstracted (Y / N)

Date: _____

Full Name (First, Middle, Last):_____ DOB: _____

Nickname: _____ Preferred language: _____ Occupation: _____

How did you hear about us? _____

Primary Care Physician: _____ Phone _____

Pharmacy name and location: _____

Phone: _____ Fax: _____

I am being seen today for: _____

Do you want to be tested for STD? YES NO

Be aware that insurance companies do not allow you to be seen for *pap/annual/ wellness care on the same day* that you have a specific complaint/problem that needs to be addresssed.

Medication: Please list all current medications
None _____

Medication	Dose

Drug Allergies:
None _____

Drug	Reaction

Herbal Supplements _____

Vitamins YES NO

Calcium YES NO

Medical History:

Condition/Treatment	Date

Surgical History (including cosmetic)**:**

Procedure	Date

Review of Systems

Any complaints with: (Y/N)

Heart	Yes	No	Vaginal Area	Yes	No
Joints	Yes	No	Lungs	Yes	No
Skin Problems	Yes	No	Breasts	Yes	No
Weight	Yes	No	Bowels	Yes	No
Vision/Hearing	Yes	No	Kidneys/Bladder	Yes	No
Headache	Yes	No			

Are you allergic to latex? Y / N

GYN History

Menstrual cycle:

Age periods began _____ or age that you stopped having periods _____

Last menstrual period _____

Are they: Regular _____ Irregular _____ # of days you bleed _____

Pain with periods? Absent Mild Moderate Severe Just kill me

Medication used for menstrual pain? _____ How many days? _____

Do you have bladder concerns (leaking, pain, etc.) Yes No

Sexual History:

Are you currently sexually active? YES NO Ever active? YES NO

Current birth control method: _____

Past birth control methods: _____

Are you finished having children? _____

Have you ever been a victim of sexual assault/abuse? YES NO When? _____

Have you had a sexually transmitted disease in the past 5 years? YES NO Type_____

Health Maintenance History

	Never	Date of Last	Abnormal Results/ Date & Treatment
PAP Smear			
Mammogram			
Dexa Scan (Bone Density)			
Cholesterol			
Colonoscopy			

Obstetrical History

Year	Vaginal/ C-Section	Weeks	Sex	Weight	Obstetrical/ Neonatal Problems	Delivery Doctor

Miscarriages_____ # Abortions_____

Social History

Marital Status: single married separated widowed partnered Name: _____

Currently smoke? YES NO

Drink alcohol? YES NO Amount _____ Frequency _____

If sober when did you achieve? _____

Vaccines: Please indicate the date of your last vaccine

Tetanus (Td)	_____	Varicella	_____
Pertusis (Whooping cough)	_____	Shingles/Zoster	_____
HPV/Cervarix/Gardasil	_____	Hepatitis A	_____
Seasonal Influenza	_____	Hepatitis B	_____
Pneumonia (pneumovax)	_____	TB skin Test	_____

Family History: No family History available _____ I am adopted _____

Condition	**Yes or No**	**Which Relative**
Heart Problems		
High Blood Pressure		
Diabetes		
Breast Cancer		
Ovarian Cancer		
Other Cancer		
Other Conditions		

NOTICE OF ARIZONA OB/GYN AFFILIATES, P.C. PRIVACY PRACTICES
dba: Maricopa OB/GYN

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

Uses and Disclosures

Treatment. Your health information may be used by our staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan or from other sources of coverage such as an automobile insurer. For example, your health plan may request and receive information on dates of service, the services provided, medical condition being treated, and past medical history pertaining to the condition being treated. Your health information will also be used in obtaining benefit information and prior authorization for treatment and requesting and acknowledging referrals.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of Maricopa OB/GYN. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Appointment Reminders. Your information will be used by our staff to contact you regarding appointment reminders.

Law Enforcement. Your health information may be disclosed to law enforcement to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the states public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights
You have certain rights under the federal privacy standards. These include:

* the right to request restrictions on the use and disclosure of your protected health information
* the right to receive confidential communications concerning your medical condition and treatment
* the right to inspect and copy your protected health information
* the right to amend or submit corrections to your protected health information
* the right to receive an accounting of how and to whom your protected health information has been disclosed
* the right to receive a printed copy of this notice

Maricopa OB/GYN Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of privacy practices.

We also are required to follow the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our check in desk or our privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Arizona OB/GYN Affiliates, P.C.
dba: Maricopa OB/GYN
1661 E. Camelback Rd., Ste. #160
Phoenix, AZ 85016

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

NAME _____ DATE _____

EMAIL AUTHORIZATION FORM

☐ Arizona Wellness ☐ Maricopa OBGYN Associates ☐ Estrella Women's Health Center

☐ New Horizons Women's Care ☐ Paradise Valley OBGYN

Patient Name: _____

Email Address: _____

Patient Signature: _____ Date: _____

I hereby authorize Arizona OBGYN Affiliates to send me newsletters, bulletins, and other documents via email. I understand that Arizona OBGYN Affiliates will not share my email address with any other persons or agencies without my express, written consent. This authorization will remain in effect until I revoke this authorization.

MARICOPA OBGYN
AOA family of obgyn physicians

Demographic Questionnaire

Our office is participating in a national initiative to measure and improve quality of care. We are asking about your race and ethnicity for demographic purposes. However, providing this information is completely voluntary and will not affect your healthcare. Please circle your answer below.

Name: _____

DOB: _____

Please specify your **race**
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander White
Caucasian
Decline to answer

Please specify your **ethnicity**
Hispanic or Latino
Not Hispanic and Not Latino
Declined to answer

Preferred Language_____
Decline to answer

MARICOPA OBGYN
AOA family of obgyn physicians

FINANCIAL POLICY

Welcome to Maricopa OB/GYN. We are committed to giving you the best care possible. We would like to take this opportunity to inform you of our office policy.

We will bill insurance claims as a courtesy to our patients provided we have your current insurance information and any necessary referrals. Should your insurance require a referral, and we have not received it prior to your appointment, you will be responsible for payment at the time of service. We accept payment from insurance companies, but require that you pay your portion, including co-pays, deductibles or coinsurance at the time of service.

Changing or re-coding claims once they have been billed constitutes fraud and we **do not** do this under any circumstances.

This office bills **only** for services performed by our providers. The laboratory company is a separate entity, and will bill you or your insurance company for labs that are performed. If you have any questions regarding your lab bill, please contact that laboratory or your insurance company.

As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. We ask that you notify us 48 business hours in advance to cancel and/or reschedule your appointment. Please be aware that failure to do so may result in a missed appointment fee of $25.00. A fee in the range of $50 - $100 will be charged for a missed procedure appointment.

It is your responsibility to notify our office if there is a change of name, insurance coverage, residence, and/or phone number.

I have read the above Financial Policy. I understand and agree to these terms. _____
(Please initial)

Acknowledgement of Notice

I acknowledge receipt of the Notice of Privacy Practices for Maricopa OB/GYN. _____
(Please initial)

Release of Information

I authorize my Personal Health Information to be disclosed as specified below:

Primary number:_____. Acceptable to leave a message on this number: YES NO

Secondary number:_____. Acceptable to leave a message on this number: YES NO

To the following family member(s) or other person(s):

_____/_____/_____
Name **Relationship** **Phone Number**

_____/_____/_____
Name **Relationship** **Phone Number**

_____ ____/____/____
PATIENT NAME (Please Print) **DATE OF BIRTH**

_____ ____/____/____
SIGNATURE OF PATIENT/GUARDIAN **DATE**