Luminis Health
Annapolis OB GYN
2000 Medical Parkway, Suite 304
Annapolis, MD 21401
410.573.9530

Pre-Registration & Appointment Guidelines

- Please fill out **ALL** forms in the enclosed Pre-Registration Packet and return to the Pre-Registration Department as soon as possible. Completed forms should be returned in PDF format along with a copy of the front and back of your insurance card through any of the following confidential and secure ways:

  Email: ***AOGpreregistration@aahs.org*** or to ***awagner@aahs.org***
  Fax: 667.204.7241
  US Postal: 2000 Medical Parkway, Suite 304 Annapolis, MD 21401
  In person: dropped off at any of our 4 office locations

- **PLEASE NOTE THAT ALL COMPLETED FORMS MUST BE RECEIVED AT LEAST 1 WEEK PRIOR TO YOUR APPOINTMENT OR THE APPOINTMENT WILL BE CANCELLED AND YOU WILL NEED TO RESCHEDULE.** If you are a pregnant patient coming from Shady Grove or another Reproductive Endocrinologist Specialist, ***please be sure to turn in your Graduate Packet with your new patient paperwork.***

- **If your insurance requires a referral, it is your responsibility to present the referral at the time of your visit – failure to do so may result in needing to reschedule the appointment – or your insurance may leave you responsible for the visit charges.**

- You are expected to arrive ***15 minutes before your appointment time.*** Allow additional time for parking when scheduled at the Annapolis office, the garage can get quite busy. **You may be asked to reschedule your appointment if you arrive late at any office!**

- Items you ***must*** bring to your appointment: photo id, current insurance card, and copay. We will also need the name/address/phone number of your primary care physician. Additionally, any labs/radiology/other records relative to your visit with Annapolis OB GYN.

- Enrollment with the patient portal, **MyChart**, will serve as your electronic chart – allowing you to view lab results, medical records, and correspond with office staff and providers after your initial visit.

- **PLEASE NOTE - A "NO SHOW" FEE IS CHARGED FOR APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS.**

PATIENT REGISTRATION FORM

Last Name (Print)_____ (First) _____ (MI) _____ (Previous/Maiden)_____

DOB_____ Marital Status: _____Single _____Married _____Divorced _____Sep. _____Widow_____

Address _____City _____State_____ Zip_____

Home#_____Work#_____Ext_____Cell#_____ **Circle best way to reach you**

E-Mail _____Employer _____ Occupation_____

Race: ( )White ( )Black/African American ( )Hispanic ( )Other:_____

Ethnicity: ( )Hispanic or Latino ( )Not Hispanic or Latino ( )Decline Language: ( )English ( )Spanish ( )Other:_____

ARE YOU CURRENTLY PREGNANT: _____Yes _____No

I have been seen by Annapolis OB-GYN within the past 12 months ____Yes ____No
NOTE: If you checked "Yes", do NOT complete the rest of the form unless your information has changed. If you checked "No", please continue to complete the rest of the form below this box. YOU MUST SIGN AT THE BOTTOM.

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PRIMARY CARE DOCTOR(Other than at this practice) _____Phone_____

PHARMACY_____LOCATION_____Pharm Phone:_____

EMERGENCY CONTACT_____Relationship_____

Emergency Contact's Home #_____Work#_____Cell#_____

YOUR PARTNER'S INFORMATION **(SPOUSE /PARTNER/BABY'S OTHER PARENT) (Please circle one)**

Name (Last) _____ (First) _____(MI)_____ DOB_____ SS#_____

Address_____City_____State_____Zip_____

Home# _____Work# _____Cell#_____

PRIMARY INSURANCE: Insurance Co. _____ Phone# _____

Name of Insured_____Patient Relationship to Insured _____DOB_____

Insurance Address_____Employer_____

Subscriber ID#_____ Group ID# _____ Co-Pay Amount_____

SECONDARY INSURANCE: Insurance Co. _____Phone#_____

Name of Insured_____ Patient Relationship to Insured _____DOB_____

Insurance Address_____Employer_____

Subscriber ID#_____ Group ID# _____ Co-Pay Amount_____

****

I declare I have listed all the medical/health insurance plans from which I may receive benefits. I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I also understand that I am responsible for contacting AAMG Annapolis Ob-Gyn, in a timely manner, with any future changes in the above information, especially those that may affect the processing of my insurance claims.

Patient Signature _____Date_____

Parent or Guardian_____Relationship_____Date_____

For office use only

FD_____ CL_____

FAX TO: 443-837-2791 or E-MAIL TO: AOGpreregistration@aahs.org updated 03/11/2020

HISTORY AND PHYSICAL RECORD

Print Name:_____**Date:**_____**DOB:**_____

Marital Status: (circle one) S Sep M D W Previously divorced?____ Previously widowed?___ Where were you born:_____

Place of Employment: _____ **Occupation:**_____

YOUR MEDICAL HISTORY: (Check off if you have had this illness, and write what type if applicable)

Disease	√	Type	Disease	√	Type	Disease	√	Type
Asthma			Kidney Dis/Infections			Epilepsy/Seizures		
Pulmonary Disease			High Blood Pressure			Hepatitis /Liver Disease		
Diabetes			Gastrointestinal Prob.			STD/HPV (list kind)		
Cancer			Depression/Anxiety			Herpes (list kind)		
Heart Disease			Chronic Bladder Infec.			Thyroid Disorder		
Hyperlipidemia			Osteoporosis			Blood Clotting Disorder		
Migraines			Addiction			Other:		

YOUR PAST SURGICAL/INJURY HISTORY: (List a D&C for a miscarriage in the OBSTETRICAL HISTORY below.)

Disease/Diagnosis/Injury	Procedure or Surgery Type	Date	Physician/Surgeon	Hospital

GYN HISTORY:

Menstrual Cycle:	Response	Menopause/Gyn:	Response
Age when period started?		Are you having peri-menopausal symptoms?	
Last menstrual period?		What are your symptoms?	
Periods are how many days apart?		Are you post-menopausal?	
How long does your period last?		Your age at menopause?	
Pain with menstrual period?		Type: Natural, Surgical, Premature, Chemo, Other?	
Do you bleed in between periods?		Pain with intercourse?	
Is your flow heavy, moderate or light?		Vaginal Dryness?	
Do you have pain between periods?		Bleeding with intercourse?	
Do you have a vaginal discharge?		Vaginal itching or odor?	
Is this normal for you?		Are you sexually active?	
Color and consistency of discharge?		Sexual orientation?	
		State method of contraception:	

RECENT SCREENINGS:

Screening	Date	Result	Screening	Date	Result	Screening	Date	Result
Bone Density			Colonoscopy			Pap		
Chest X-Ray			Cholesterol			Mammogram		

SOCIAL HISTORY:

SMOKING:	Response	CAFFEINE	Response	DRUGS:	Response
Do you smoke?		Do you drink caffeine?		Do you use drugs?	
How much do you smoke?		Amount/frequency?		Recovering from addiction	
Did you quit smoking?		Type of caffeine?		What type of addiction?	
How many years did you smoke?		**EXERCISE/SAFETY**			
		Do you exercise?		**MISC:**	
ALCOHOL		Exercise frequency?		Have you traveled outside of the US in the past year?	
Do you drink alcohol?		Wear seat belts?			
Amount/frequency?		Have a Living Will?		Where did you visit?	
Recovering from addiction?		Do you feel safe at home?			

OBSTETRICAL HISTORY: **Patient's Name:_____**

Date of Delivery	Weeks of gest.	Type of Delivery	Physician	Sex	Wt.	Abortion (Elective)	Miscarriage	List other problems/complications, outcome, and/or infertility history.

TOTALS: Enter totals below:

Total Pregnancies	# of Full Term	# of Premature	Elective Abortions	Miscarriages	Ectopic Pregnancy	Live Children

ALLERGIES:

Allergy	Reaction	Allergy	Reaction

MEDICATIONS: (Include medications, birth control, vitamins & herbal supplements)

Name	Strength	Dosage	Reason	Name	Strength	Dosage	Reason

CHECK BELOW ANY DISEASE A BLOOD RELATIVE OF YOURS MAY HAVE, OR HAD: (Please write maternal or paternal side.)

Disease	Relative	Outcome	Disease	Relative	Age of Diagnosis
Addiction (list type)			Alzheimers		
Blood Disorder			Mental Illness (list type)		
Pulmonary			Epilepsy		
Depression			Cancer:		
Diabetes			Breast		
Osteoporosis			Colon		
Thyroid Disease			Ovarian		
High Blood Pressure			Uterine		
High Cholesterol			Skin		
Heart Disease (list type)			Other:		

AAMG ANNAPOLIS OB-GYN

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please read this form carefully. You will be asked to sign this form electronically upon arrival to your appointment. There is no need to bring this form to your visit.

I hereby give my consent for AAMG Annapolis OB-GYN to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (AAMG Annapolis OB-GYN Notice of Privacy Practices provides a more complete description of such disclosures)

I have the right to review the Notice of Privacy Practices prior to signing this consent. AAMG Annapolis OB-GYN reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to AAMG Annapolis OB-GYN Privacy Official at **2000 Medical Parkway Ste. 304, Annapolis, MD 21401.**

With this consent, AAMG Annapolis OB-GYN may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, AAMG Annapolis OB-GYN may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that AAMG Annapolis OB-GYN restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to AAMG Annapolis OB-GYN use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, AAMG Annapolis OB-GYN may decline to provide treatment to me.

NOTE: If you would like anyone else (spouse, partner, parent, etc.) to have access to your health information please ask for the appropriate form.

AAMG Annapolis OB-GYN

NOTICE OF PRIVACY PRACTICES

Effective date April 13, 2003, Revised September 2013

As Required by the Privacy Regulations Created as a Result of the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

WHO WILL FOLLOW THIS NOTICE:
This notice describes AAMG Annapolis OB-GYN ' Privacy Practices and those of:

- All employees of AAMG Annapolis OB-GYN
- All healthcare professionals authorized to enter healthcare information into your record
- All departments and offices of AAMG Annapolis OB-GYN
- All Business Associates

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we are required by law to:

- Make sure that medical information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the Notice that is currently in effect
- In the event your health information is breached, we are required to provide you with notice of the breach.

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this Notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. The effective date of the Notice, as well as the date of the most recent revision, is listed at the top of every page. You may Effective Date of this Notice: 4/13/2003, Revised September 2013, request a copy of our most current Notice at any time. This document is included in all new patient packets and is available on the practice website.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Susan Latonick, Director
2000 Medical Parkway, Suite 304
Annapolis, MD 21401
410 573-9530

C. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe the different ways in which we may use and disclose your IIHI.

1.Treatment - Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice-including, but not limited to, our doctors and nurses, may use or disclose your IIHI in order to treat you or to assist others in your

treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. **Payment -** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations -** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. **Appointment Reminders -** Our practice may use and disclose your IIHI to contact you for an appointment.

5. **Treatment Options -** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services -** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. **Release of Information to Family/Friends -** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. You may restrict sharing your health information with someone who is involved in your care.

8. **Disclosures Required By Law -** Our practice will use and disclose your IIHI when are we required to do so by federal, state or local law.

9. **Marketing** – We will obtain your authorization before we use or disclose your health information for marketing, except we may use your information to have a face-to-face discussion about a service or to provide you with a gift of nominal value.

D. USE AND DISCLOSURE WE MAY MAKE WITHOUT YOUR SPECIFIC AUTHORIZATION:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks -** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence): however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2.**Health Oversight Activities -** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings -** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement -** We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Serious Threats to Health or Safety -** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. **Military -** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

7. **National Security -** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

8. **Inmates -** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

9. **Workers' Compensation -** Our practice may release your IIHI for workers' compensation and similar programs.

10. **Organ and Tissue Donation** - If you are an organ donor, we may release medical information to organization handling organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

E. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding the IIHI that we maintain about you:

1. **Right to Confidential Communication -** You have the right to request to receive communications from us on a confidential basis by using alternative means for receipt of information or by receiving the information at alternative locations. For example, you can ask that we only contact you at work or by mail, or at another mailing address, beside your home address. We must accommodate your request, if it is reasonable. You are not required to provide us with an explanation as to the reason for your request. If you would like to receive copies of your medical information after your treatment, you will specify the method and location that information should be sent to you.

2. **Requesting Restrictions -** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing. Your request must describe in a clear and concise fashion:

a. The information you wish restricted;
b. Whether you are requesting to limit our practice's use, disclosure or both; and
c. To whom you want the limits to apply

We are not required to agree to your request unless your request pertains to not disclosing health information to a health plan for payment or operations related to services you paid in full from out of pocket. If we do agree with your request, we are bound by our agreement, except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. **Inspection and Copies -** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment -** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing.

You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures -** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12 month period is free of charge, but our practice may charge you for additional lists within the same 12 month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice -** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our privacy officer.

7. **Right to file a Complaint -** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our privacy officer**.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **Right to Provide an Authorization for Other Uses and Disclosures -** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer.

Annapolis OB-GYN Associates, P.A.

Our Locations

The Belcher Pavilion
2000 Medical Parkway, Ste. 304
Annapolis, MD 21401
(Park in Garage E)

AAMC Health Services Bldg.
1630 Main Street, Ste. 211
Chester, MD 21619

AAMC Health Services Bldg.
2401 Brandermill Blvd., Ste. 350
Gambrills, MD 21054

Pasadena Office
18 Magothy Beach Rd, Ste. A
Pasadena, MD 21122

11/29/16