BLOSSOM
GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

MARJORIE A. CHORNESS, MD FACOG

Today's date	**Social Security #**	**DOB:** / /

PATIENT INFORMATION

PATIENT'S Last Name First MI	Address		
City/State	Zip Code	Home #	Cell #
Employer	Employer Address	Work #	Pharmacy #
Email Address	Primary Care Physician		
Marital Status ❑ S- Single ❑ M- Married ❑ D-Divorced ❑ X- Separated ❑ W- Widow	Employed ❑ FT ❑ PT ❑ R-Retired ❑ Self ❑ N- None	Student ❑ FT ❑ PT ❑ N- None	

INSURANCE INFORMATION (We must have this information in order to file your insurance)

Primary Insurance Co:

Subscriber's Name	Subscriber's S.S. #	Subscriber's Birth date / /	ID #	Group #	Co-Pay $
Patient's relationship to subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other	
Subscriber's Employer	Employer Address	Employer Phone #			

Secondary Insurance Co:

Subscriber's Name	Subscriber's S.S. #	Subscriber's Birth date / /	ID #	Group #	Co- Pay $
Patient's relationship to subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other	
Subscriber's Employer	Employer Address	Employer Phone #			

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize BLOSSOM Gynecology, Wellness & Infertility (Dr. Marjorie Chorness) to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. **As the responsible party, I agree that all charges not directly paid by my insurance company will be my responsibility.**

_____ _____

Patient/Guardian signature *Date*

MC/as 10/12/2015

(Please fill out information on reverse side)

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CHILDREN			
NAME	**AGE**	**NAME**	**AGE**

PERSONAL INTERESTS

LEVEL OF EDUCATION
❒ High School ❒ College 1 2 3 4 ❒ Post Graduate ❒ Other

EMERGENCY CONTACT				
Name	Relationship	Home #	Cell #	Work #

Other information pertinent to your medical care:

MC/as 10/12/2015

PATIENT CONSENT FOR TREATMENT

I have requested medical and/or surgical services from Blossom Obstetrics, Gynecology & Infertility, P.A.("Blossom Gynecology") and by signing below, I voluntarily consent to treatment by Blossom Gynecology personnel, including any physician and/or any other designee who may be involved in performing evaluation, lab tests (which may include urine drug screens and testing for HIV and other sexually transmitted diseases), physical exam, ultrasound, biopsy, administration of medication, and procedures.

I understand that I have the right to speak with the physician before any treatment or procedure, and I have been offered the opportunity to ask any questions about the care I may or may not elect to receive. I am aware that the practice of medicine, surgery, and gynecology is NOT an exact science and I acknowledge that no guarantees or assurances have been made to me as to the result of any treatment.

Blossom Gynecology is an office-based gynecology practice that does not provide emergency or hospital services. I understand that if I require hospitalization or inpatient services, or specialized services beyond the scope of Blossom Gynecology's practice, Blossom Gynecology will refer me to a different physician for further treatment. If I require immediate hospital or emergency care, Blossom Gynecology will send me to a hospital emergency department or direct me to call 911.

Blossom Gynecology is at times involved in health care education, and I agree that unless I specifically request otherwise; at times, care, examination, and treatment may be delivered by students or medical personnel in training who are under the supervision of a physician.

I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS, AND THEY HAVE BEEN ANSWERED OR EXPLAINED IN A SATISFACTORY MANNER. BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ THIS FORM OR HAD IT READ AND EXPLAINED TO ME. I UNDERSTAND THIS FORM AND I VOLUNTARILY CONSENT TO ALLOW BLOSSOM OBSTETRICS, GYNECOLOGY, & INFERTILITY PHYSICIANS, ALL MEDICAL PERSONNEL UNDER THE DIRECT SUPERVISION AND CONTROL OF SUCH PHYSICIANS, AND ALL OTHER PERSONNEL WHICH MAY OTHERWISE BE INVOLVED IN MY CARE TO PERFORM TREATMENT.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

BLOSSOM GYNECOLOGY, WELLNESS & INFERTILITY, P.A.
FINANCIAL POLICY

Thank you for choosing Blossom Gynecology, Wellness & Infertility, P.A. as your healthcare provider. We are committed to building a successful and long-term physician-patient relationship. The following is a statement of our Financial Policy.

Insurance: A valid photo ID and insurance card must be presented at the time of your visit. Our office is in network with most major insurance carriers. However, it is the patient's responsibility to understand the coverage details of the policy and to verify we are participating providers. Deductibles, co-insurances and co-pays, as outlined by your insurance carrier, will be due at the time of service.

Non-Covered Services: Any services that are not covered under the policy will be the patient's financial responsibility. Payment will be due at time of service. Should you have any questions on what services are non-covered, we encourage you to contact your insurance company to verify coverage.

Annual Exams: Annual exams are preventive care services. Any problems or concerns addressed during an annual exam are considered a separate service and may be a separate charge.

Collection Policy: Should your account become past due, the patient/guarantor of the account is responsible for resolving all outstanding balances in a timely manner. Any questions regarding balances can be directed to the front office receptionist or can be emailed to patientaccounts@blossomobgyn.com. If the balance is not paid within 60 days of the date of service, we reserve the right to forward the account to a third party collection agency and may affect your credit. The patient/guarantor of the account will assume all costs of collection, including but not limited to, collection agency fees (up to an additional 50% of the balance), interest and legal fees.

Payment Arrangements: If you are unable to pay your balance in full, please contact our office immediately to set up a payment arrangement and avoid collection action on your account.

Administrative Fees: A $35.00 fee will be charged when requesting medication renewals outside of a scheduled appointment or when prior authorization on a medication is required. A $35.00 fee will be charged for each set of forms or administrative letters the office completes on your behalf.

Missed Appointments: Unless cancelled/reschedule 24 hours prior to your visit, there is a $35.00 fee for missed appointments.

By signing below, I acknowledge I have understood, agreed to and given a copy of the financial policy as outlined above.

_____ _____
Patient/Guardian Signature Date

_____ _____
Patient/Guardian Printed Name E-mail Address

BLOSSOM
GYNECOLOGY, WELLNESS & INFERTILITY, P.A.
420 The Parkway, Suite C, Greer, SC 29650
(864) 662-5000

PATIENT INSURANCE WAIVER FOR THE DIGENE HIGH-RISK HPV TEST

The Digene® High-Risk HPV Test is a new, highly sensitive test used in cervical cancer screening to detect the high risk strain of HPV (human papillomavirus). HPV is a very common virus that most sexually active women are exposed to at some point in their lives. Fortunately, for most women HPV infection will resolve on its own after 1-2 years. However, if the virus is not eliminated by your body, it may cause abnormal changes to the cells of your cervix. HPV testing is not advised for women under the age of 30 due to the very high percentage of positive result in this group.

Unlike the Pap test alone, these two tests used together inform your doctor if you are at risk for cervical disease. If either test is abnormal, your doctor will suggest the best course of follow up. Studies have also shown that for women who are HPV and Pap test negative, there is virtually no risk of developing cervical cancer before the next annual visit.

You have the option to Accept or Decline HPV testing by signing this waiver below. If you accept, you are agreeing to pay for the test if your insurance company does not.

I have read the information above about The Digene® High-Risk HPV Test, and based on this information,

❒ I **AGREE** to have the HPV testing ❒ I **DO NOT** want to have the HPV testing.

Signed: _____ Date: _____

Printed Name: _____

IMPORTANT INFORMATION REGARDING QUEST BILLING/SERVICES

Lab services at Blossom OB/GYN & Infertility, such as pap smears, blood work and urine testing, are provided by Quest. Financial aspects of these services are handled directly by the billing department at Quest. This information is not shared with Blossom Gynecology, Wellness & Infertility, therefore, we are not equipped to assist you in these matters. **If you have concerns or questions regarding your lab charges, please refer to the toll free number on your Quest bill.**

It is your responsibility to notify us at the time of your visit if another lab must be used. If we do not receive this information from you at the time your labs are processed, any amount not paid by your insurance company is your responsibility.

Signed: _____ Date: _____

BLOSSOM
GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

Marjorie A. Chorness, MD, FACOG
420 The Parkway, Suite C, Greer, SC 29650
Phone: 864-662-5000 Fax: 864-662-5008

Acknowledgment of Receipt of Notice of Privacy Practices (HIPAA)

Blossom Gynecology, Wellness & Infertility, P.A. has made a copy of their Notice of Practices available to me for review. I understand that the purpose of this notice is to inform me of my rights pertaining to my Personal Health Information (PHI) and also the ways in which Blossom Gynecology, Wellness & Infertility, P.A. may use or disclose my PHI.

_____
Patient (or Legal Representative) Signature

I give Blossom Gynecology, Wellness & Infertility, P.A. permission to contact me in the following ways:

Home Phone	❒ Yes	❒ No	
Work Phone	❒ Yes	❒ No	
Cell Phone	❒ Yes	❒ No	
E-Mail	❒ Yes	❒ No	E-mail Address _____

With the following information:

Appointment Information	❒ Yes	❒ No	❒ OK to leave detailed messages?
Lab Results	❒ Yes	❒ No	❒ OK to leave detailed messages?
Prescription Information	❒ Yes	❒ No	❒ OK to leave detailed messages?
Returning Correspondence	❒ Yes	❒ No	❒ OK to leave detailed messages?

Blossom Gynecology, Wellness & Infertility, P.A. also has my permission to discuss my medical records, insurance concerns and appointment issues with the following people:

_____ _____
Name (Please print) Relationship to Patient

_____ _____
Name (Please print) Relationship to Patient

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date