BLOSSOM
GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

NEW PATIENT INFORMATION

DATE:

Name (First, Middle Initial, Last):	**Age:**	**DOB :**

Referred by? _____

What brings you to the office today?

_____

_____

_____

History of Gynecologic Problems:

- ☐ Abnormal Paps
- ☐ Abdominal Pain
- ☐ Chlamydia
- ☐ Abdominal Pain
- ☐ Frequent UTIs
- ☐ Genital Warts
- ☐ Gonorrhea
- ☐ Herpes
- ☐ HPV
- ☐ Heavy Periods
- ☐ Infertility
- ☐ Menorrhagia
- ☐ Menopausal Problems
- ☐ Prolapse
- ☐ Pelvic Pain
- ☐ Pelvic Infections
- ☐ PMS
- ☐ Stress Incontinence
- ☐ Overactive Bladder
- ☐ Other Gynecological History: _____

Pregnancies

Year	Type of Birth (Vaginal/C-Section)	Location/Hospital	Gestation (Weeks)	Complications

Last Menstrual Period: _____ **How often:** _____ **Days of flow:** ___**Amount of flow:** _____

Using Contraception? ☐ **No** ☐ **Yes** **What kind?** _____ **For how long?** _____

Last Pelvic Exam (Date): _____ **Location:** _____

Last Mammogram (Date): _____ **Location:** _____

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NEW PATIENT INFORMATION – PAGE 2

Name:	**Date:**

List all Illnesses:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List all Surgeries:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List all medications and dosages including over-the-counter:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Allergies: ☐ No ☐ Yes If Yes, List:

1. _____
2. _____
3. _____

Family History

Mother's Age:	Medical Issues:
Father's Age:	Medical Issues:
Brother's Age:	Medical Issues:
Brother's Age:	Medical Issues:
Sister's Age:	Medical Issues:
Sister's Age:	Medical Issues:
Additional:	

Social History

☐ Non-Smoker ☐ Smoker—How Many Packs/Day? _____
☐ Non-Drinker ☐ Occasional/Social ☐ Frequent/Regular
Recreational Drug Use? ☐ Yes ☐ No
Exercise: ☐ None ☐ 1-2 times/week ☐ 3 or more times/week
Sexually Active? ☐ No ☐Yes Length of time with current partner: _____
Marital Status: ☐ Single ☐ Married – How long: _____ ☐ Divorced ☐ In a Relationship – How long: _____

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NEW PATIENT INFORMATION – PAGE 3

Name:	**Date:**

Review of Systems: Please check the boxes of any symptoms you are currently experiencing.

Head/Eyes	☐ Headache	☐ Hearing Problems	☐ Visual Problems	
Endocrine	☐ Excess Thirst ☐ Increased Appetite	☐ Heat Intolerance ☐ Decreased Appetite	☐ Cold Intolerance	
Cardiovascular	☐ Chest Pain	☐ Shortness of Breath	☐ Palpitations	
Gastrointestinal	☐ Diarrhea ☐ Vomiting	☐ Constipation ☐ Abdominal Pain	☐ Nausea ☐ Blood in Stool	
Genitourinary	☐ Dysuria ☐ Incontinence	☐ Frequency ☐ Blood in Urine	☐ Urgency	
Musculoskeletal	☐ Muscle Swelling	☐ Muscle Pain	☐ Joint Swelling	☐ Joint Pain
Psychological	☐ Depression ☐ Mood Instability	☐ Crying Spells ☐ Attention Problems	☐ Sleep Disturbance	☐ Anxiety

Please write the names of the medications/prescriptions you need at today's visit.

Thank You!

BLOSSOM
GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

MARJORIE A. CHORNESS, MD FACOG

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

PATIENT INFORMATION

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		

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/lh 7/2/18

BLOSSOM
GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

children

NAME	AGE	NAME	AGE

PERSONAL INTERESTS

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

PATIENT CONTACT PREFERENCES			
I give Blossom Gynecology, Wellness & Infertility, P.A. permission to contact me in the following way:			
Home Phone	❒ Yes ❒ No	Cell Phone	❒ Yes ❒ No
Work Phone	❒ Yes ❒ No	E-Mail	❒ Yes ❒ No
		E-Mail Address: _____	

With the following information:			
Appointment Information	❒ Yes ❒ No	Prescription Information	❒ Yes ❒ No
Lab Results	❒ Yes ❒ No	Insurance/Billing	❒ Yes ❒ No

EMERGENCY CONTACT				
Name	Relationship	Home #	Cell #	Work #

BLOSSOM GYNECOLOGY, WELLNESS & INFERTILITY, P.A.
MARJORIE A. CHORNESS, MD FACOG
420 C THE PARKWAY • GREER, SC 29650 864.662.5000 FAX 864.662.5008

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.

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 policy, are due at time of service.

Non-Covered Services: Any services that are not covered under your 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.

Well Woman Exams: These exams include preventive care only. Any problem or concern addressed during an annual exam is considered a separate service and may be a separate charge.

Collection Policy: Should your account become past due, the guarantor of the account is responsible for resolving all outstanding balances in a timely manner. Any questions regarding balances 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. The patient/guarantor of the account will assume all costs of collection, including but not limited to, 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.

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 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.

Lab Services: Effective June 1st, 2018, LabCorp provides the lab services in our office. Charges for these services are handled directly by LabCorp's billing department therefore; we are unable to assist you in these matters. Any questions regarding lab charges should be directed to the billing number on your LabCorp bill.

By signing below, I acknowledge I understood and agreed to the financial policy as outlined above. I consent to receiving emails and phone contact regarding financial matters.

_____ _____
Patient/Guardian Signature Date

_____ _____
Patient/Guardian Printed Name E-mail Address

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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

_____ _____
Parent/Guardian Signature* Date

**Parent/Guardian's signature is not required if the patient is 16 years old or above and the procedure does not involve an operation in accordance with S.C. Code Ann. § 63-5-340.*

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MARJORIE A. CHORNESS, MD FACOG
420 C THE PARKWAY • GREER, SC 29650 864.662.5000 FAX 864.662.5008

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ______________________________________ **Patient ID #:** ______________________

I hereby acknowledge that I have received a copy of Blossom Gynecology, Wellness & Infertility, P.A.s Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____ _______________________________

Signature of Patient or Legal Representative **Date**

____

Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

- -

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____________________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____
____
____
____
____

- ☐ Other (Specify)

____
____
____
____
____

BLOSSOM GYNECOLOGY, WELLNESS & INFERTILITY, P.A.
MARJORIE A. CHORNESS, MD FACOG

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Blossom Gynecology, Wellness & Infertility, P.A. to use and/or disclose my protected health information as described below to

(name and address of recipient)_____

_____

for the following purposes: **(describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)**

_____

_____

I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying Blossom Gynecology, Wellness & Infertility, P.A. in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) Blossom Gynecology, Wellness & Infertility, P.A. agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Marketing:

☐ If this box has been checked by the practice, I understand that the practice will receive compensation for using or disclosing my information for marketing purposes.

Type of Information to Be Disclosed

☐ Entire Medical Record	☐ Most Recent 5 Year History	☐ Radiology Reports
☐ Office Chart Notes	☐ All Hospital Records	☐ Operative Reports
☐ Billing Statements	☐ Transcribed Hospital Reports	
☐ Dental Records	☐ History and Physical Exam	☐ Other _____
☐ Laboratory Reports	☐ Emergency and Urgent Care Records	
☐ Pathology Reports	☐ Medical Records for Continuity of Care	_____
☐ Consultation	☐ Diagnostic Imaging Reports	
☐ Discharge Summary	☐ Emergency Room Reports	_____

In addition, I authorize that this will include health information relating to (check if applicable):

☐ HIV/AIDS infection ☐ Drug/Alcohol abuse ☐ Genetic Testing

Patient Name: _____ **Patient ID #:** _____

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Printed Name of Patient's Representative (if applicable)

Relationship to Patient (*if applicable*)
0 Parent or guardian of unemancipated minor
0 Court appointed guardian
0 Executor or administrator of decedent's estate
0 Power of Attorney

_____

Printed Name of Patient's Representative (*if applicable*)

_____ _____

Signature of Witness **Date**