



Welcome to Our Practice

At South Shore Women's Health we provide comprehensive Gynecologic and Obstetric services on Boston's South Shore. Our practice consists of seven Obstetrician Gynecologists, four Nurse Practitioners and two Physician Assistants. We are affiliated with South Shore Hospital in Weymouth, Massachusetts.

We provide a full range of gynecologic care including routine exams, preconception counseling, Pap smear evaluation, STD screening, birth control counseling, the evaluation of abnormal menstrual cycles, PMS treatment, and menopause care. We care for pregnant patients. We also care for high risk pregnant patients with the help of South Shore Health Maternal Fetal Medicine.

Our philosophy is one of patient education and provider-patient teamwork to reach our common goal - your good health! All patients may choose to see a physician, a nurse practitioner, or a physician assistant as their primary provider. Please visit our web site at www.southshorewomenshealth.com for more information about our providers and our services.

Administrative Policies

- We promise to inform you at check-in if your doctor is running late or has been called to surgery.
- We promise to treat you with respect & dignity in a professional and caring manner. In return we expect you to refrain from using verbally abusive language, threatening any employee or provider, or otherwise hostile behavior. Using such is cause for immediate termination from this practice.
- Many appointments require collection of a urine sample so please check with the front desk upon arrival before going to the bathroom.
- To respect other patients, we ask that cell phones be turned on vibrate mode while in our office.
- Missing or no-showing your appointment creates an undue burden and increases the cost of care to other patients. Missing three appointments without notice may result in dismissal from this practice.

Pre-registration

We have enclosed our patient registration and medical history forms. It would be greatly appreciated if you would take the time to complete them prior to your visit. You may either fax them to our office or fill them out online and submit. You may also bring them with you to your appointment.

Appointments

Office visits are by appointment only. The scheduler may ask you about your illness or the reason for your visit in order to adequately schedule the physician's time. If you feel that you need to be seen on an urgent basis, you will be connected with our triage nurse.

As a new patient, please arrive 15 minutes early for your appointment so that we can process your information into our system. Be sure and bring your insurance card and a photo ID for identification purposes. We will request your co-payment during the registration process.



Insurance

South Shore Women's Health participates with the following insurance plans. It is the responsibility of patients to know their individual benefits, so please consult your plan directly if you have questions regarding coverage of specific services.

Aetna	Harvard Pilgrim Health Care
Blue Shield	Humana / Choice Care
BMC Healthnet	Medicare
CIGNA	Neighborhood Health Plan
Fallon Community Plan	Private Health Care System
MassHealth	Tufts Commercial Plans
TriCare	Tufts Health Public
First Health	United Health Care
Great Western Health Care	Unicare

*Not all products within these insurance carriers are accepted; please check your benefits carefully.
You may require a referral for some or all of your services from your PCP. Check with your insurance carrier for information about their policies for referrals.

We appreciate the opportunity to serve you and pledge to provide you our best medical care, with compassion, in a safe environment. In order to make our relationship with you the best it can possibly be, please be familiar with the following policies:

Insurance & Billing Policies

- If you have insurance, please bring your card to every appointment; without it we cannot bill your carrier. We are required to collect co-payments and co-insurance and reserve the right to re-schedule or cancel appointments to comply with insurance company agreements.
- Your health insurance policy is an agreement between you and your insurance carrier. You are responsible for understanding your own coverage. Your insurance company makes the determination of your eligibility. You authorize your insurance benefits to be transferred directly to the rendering provider and acknowledge you are financially responsible for paying any co-insurance amounts. You agree to pay for services rendered within the limits of this care provisions policy.
- Many insurance companies have lists of approved drugs they cover. Your provider will prescribe the medication they feel will best address your needs. We will do our best to respond to prior-authorization requests from your insurance company, but this process may delay your prescription. You are responsible for contacting your insurance provider with any questions or requests concerning approved medications.
- We accept cash, check, and credit card. Payment in full is due within 30 days of your first statement unless other arrangements have been made. We send 3(three) statements at 28 (twenty-eight)-day intervals. You understand and agree that if we are forced to send your account to collections, you may be charged an administrative fee. You will be unable to book any future appointments until your balance is paid in full.



- If you need a surgical procedure, our surgical coordinators will assist you in scheduling. Although we seek prior authorizations, insurance carriers state they are not a guarantee of payment. You must call your insurance carrier to verify they will cover your procedure.
- If you get lab or imaging tests as part of your appointment which includes pregnancy and genetic tests remember some tests/labs are performed by outside parties; in such cases they bill separately. If you know your insurance carrier only covers certain labs or facilities, please notify our office in advance.
- Prior to your visit, if you have any questions regarding are policies or the enclosed forms please do not hesitate to call us for assistance.

By signing below you agree to the terms of service provided herein.

Signature (patient or guardian)

Date



90 Libbey Parkway, Suite #105
Weymouth, MA 02189
339-201-4120

689 Bedford Street
Whitman, MA 02382
781-447-4001

118 Long Pond Road, Suite 200
Plymouth, MA 02360
774-773-9976

PATIENT MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____

Primary Care Physician: _____ Phone #: (____) _____

Reason for referral / appointment: _____

MENSTRUAL HISTORY (Complete even if post-menopausal or no longer having periods)

Age at first period: _____

If your menstrual periods are regular; periods start every: _____ days

If your menstrual periods are irregular; periods start every: _____ to _____ days (e.g., 12 to 60)

Duration of bleeding: _____ days

Does bleeding or spotting occur between periods? Yes No

Does bleeding or spotting occur after intercourse? Yes No

First day of last menstrual period _____ Menopause: Yes No

Do you have pain associated with periods? Yes No Occasionally

If yes, is the pain before? Yes No During? Yes No

PREGNANCY HISTORY (Please list ALL pregnancies) Never been pregnant

OBSTETRICAL HISTORY INCLUDING ABORTIONS & ECTOPIC (TUBAL) PREGNANCIES

Year	Place of Delivery	Duration of Pregnancy	Hours of Labor	Type of Delivery	Complications Mother/Infant	Infant Sex	Infant Weight	Present Health of child

PREGNANCY RISK FACTORS: *Fill out this Section only if you are pregnant or planning to become pregnant in the near future*

Have you or the baby's father or anyone in your families ever had any of the following:

Down Syndrome (Mongolism)? If yes, who? _____

Other Chromosomal abnormality? If yes, specify and who? _____

Neural tube defect (spina bifida, anencephaly)? If yes, specify and who? _____

Hemophilia or other coagulation abnormality? If yes, specify and who? _____

Muscular Dystrophy? If yes, who? _____

Cystic Fibrosis? If yes, who? _____



Patient Name: _____ **DOB:** _____

BIRTH CONTROL HISTORY

What birth control method(s) do you currently use? _____
 What birth control method(s) have you used in the past? _____

SEXUAL HISTORY

Have you ever had a sexual partner? Yes No Age you became sexually active? _____

HEALTH HISTORY

- | | | |
|--|--|--|
| <input type="checkbox"/> Liver Disease (including hepatitis) | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV + |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Other: _____ | | |

CURRENT MEDICATIONS (Please list ALL medications. Please use back of form if more room is needed.)

Medication	Dose	Frequency	Prescribed By

Pharmacy Information:

Name: _____ **Address:** _____
Phone: _____

OVER THE COUNTER MEDICATIONS / VITAMINS / SUPPLEMENTS – Please List ALL

Name	Dose	Frequency	Taken for

ALLERGIES: Please list ALL known allergies -or- None

Allergy	Reaction / Symptoms



Patient Name: _____ **DOB:** _____

SOCIAL HISTORY:

Do you smoke: Yes No Packs per day: _____ / cigarettes per day: _____ How many years: _____
Drink alcohol: Yes No Wine (glasses/day): _____ Beer (bottles/day): _____ Hard Liquor (oz. /day): _____
Use street drugs: Yes No Type: _____ Amount: _____ How often: _____
Exercise: Yes No Type: _____ How often: _____

Your occupation: _____ Employer: _____

Marital Status: Married Single Widow Divorced Separated

Do you feel threatened or unsafe in your current relationship? _____

Do you have a history of: Emotional abuse: Yes No Sexual abuse: Yes No
Physical abuse: Yes No Verbal abuse: Yes No

FAMILY HISTORY Please check all that apply

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Endometrial Cancer | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Genetic Disorder |

Other: _____

If "yes" to any, please list affected relatives and which disease applies:

OTHER SYMPTOMS Please check all that apply and list the year

None

Have you recently experienced:

- | | | |
|---|---|---|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Breast Discharge |
| <input type="checkbox"/> Hair Growth | <input type="checkbox"/> Change in energy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Change in urinary function | _____ |
| <input type="checkbox"/> Change in exercise tolerance | <input type="checkbox"/> Hot Flashes / Flashing | _____ |



Patient Name: _____ **DOB:** _____

PAST OBSTETRICAL / GYNECOLOGICAL SURGERIES Please check all that apply

<p style="text-align: center;">YEAR</p> <p><input type="checkbox"/> D&C _____</p> <p><input type="checkbox"/> Hysteroscopy _____</p> <p><input type="checkbox"/> Infertility Surgery _____</p> <p><input type="checkbox"/> Tuboplasty _____</p> <p><input type="checkbox"/> Tubal Ligation _____</p> <p><input type="checkbox"/> Laparoscopy _____</p> <p><input type="checkbox"/> Hysterectomy _____</p> <p style="padding-left: 20px;">Abdominal or Vaginal</p> <p><input type="checkbox"/> Myomectomy _____</p>	<p style="text-align: center;">YEAR</p> <p><input type="checkbox"/> Ovarian Surgery _____</p> <p><input type="checkbox"/> L cyst(s) removed ovarian _____</p> <p><input type="checkbox"/> R cyst(s) removed ovarian _____</p> <p><input type="checkbox"/> L ovary removed _____</p> <p><input type="checkbox"/> R ovary removed _____</p> <p><input type="checkbox"/> Vaginal or bladder repair _____</p> <p style="padding-left: 20px;">for: Prolapsed or incontinence</p> <p><input type="checkbox"/> Cesarean Section _____</p> <p><input type="checkbox"/> Other (Specify): _____</p>
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PAST SURGICAL HISTORY (Not OB/GYN)

Please list all surgeries and the year performed NONE

Surgery:	Year

PAP SMEAR / MAMMOGRAM HISTORY

Date of last PAP smear? _____ Date of last Annual Wellness Exam: _____

Have you ever had an abnormal PAP smear? Yes No

Have you ever had treatment for an abnormal pap smear? Yes No

If yes, what type(s) of treatment have you had?

Check all that apply:

Cryotherapy Yes No

Cone Biopsy Yes No

Colposcopy Yes No

Loop Excision (LEEP) Yes No

OTHER PAST GYNECOLOGICAL HISTORY Please check all that apply or None

<p>Venereal Warts <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Year Treated</p> <p>Herpes – Genital <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Syphilis <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Pelvic Inflammatory disease <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Other: _____</p>	<p>Endometriosis <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Year Treated</p> <p>Chlamydia <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p> <p>Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No _____</p>
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Patient Name: _____ DOB: _____

PERSONAL MEDICAL HISTORY Please check all that apply None

- | | | |
|------------------------------------|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Gallstones |

OTHER SCREENING EXAMINATIONS:

Date of last Colonoscopy: _____ Performed by: _____

Date of last Bone Density Scan (DEXA): _____ Location: _____

ADDITIONAL COMMENTS / CONCERNS: Please list any additional comments, concerns or questions you would like to be addressed by your provider.

Patient Signature: _____ Date: _____

STAFF REVIEW:

Comments:

Nurse Signature: _____ Date: _____

PATIENT REGISTRATION

Name: _____ Maiden Name: _____ DOB: _____
Last First MI

Mailing Address: _____ Marital Status: _____ SS#: _____
Street Town State Zip

Cell Phone: _____ Home Phone: _____ Email: _____

Employer: _____ Occupation: _____

Address: _____ Work Phone #: _____
Street Town State Zip

Primary Care Physician/Referring Physician: _____

Preferred Pharmacy Name/Address: _____ Phone #: _____

Race		Ethnicity
____ American Indian or Alaska Native	____ White	____ Hispanic or Latino
____ Asia	____ Black or African American	____ Not Hispanic or Latino
____ More than one race	____ Native Hawaiian	Primary Language: _____
____ Other Pacific Islander	____ Other	

Insurance Information

Insurance Coverage: Yes ____ No ____

Name of Insurance: _____

Type of Plan: HMO ____ PPO ____ Other ____

Company Name if Group Policy: _____

Subscriber: _____

Subscriber Date of Birth: _____

Subscriber Soc. Sec. #: _____

Relationship: Self ____ Spouse ____ Child ____ Other ____

Policy Number: _____ Member Number: _____

Group Number: _____

If MassHealth: Recipient ID Number: _____

Managed Care Org: _____

If you have a second insurance, indicate below:

Name of Insurance: _____

Subscriber: _____

Subscriber Date of Birth: _____

Relationship: Self ____ Spouse ____ Child ____ Other ____

Policy Number: _____ Member Number: _____

Group Number: _____

Guarantor (Person who has financial responsibility) Same as Subscriber? Yes ____ No ____

Name: _____

Address: _____ Relationship: _____ Home Phone #: _____

Employer: _____ Employer Phone#: _____

Name of nearest relative not living with you

Name: _____ Relationship: _____

Address: _____ Home Phone #: _____

Medical Information and Payment Authorization

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor group indicated on the claim. I understand I am financially responsible for any balance not covered by my carrier. A copy of this signature is as valid as the original.

Signature: _____ Date: _____

How did you hear about our office?
 Friend/Family Referral Health Fair Newspaper Magazine Website Other _____

Which newspaper / magazine? _____



ACKNOWLEDGEMENT / RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form I acknowledge the receipt / reading of South Shore Women's Health, PC, Notice of Privacy Practices (Reception Room plaque or brochure) which provides me with detailed information about how South Shore Women's Health, PC may use and disclose my protected health information for the purposes of treatment, payment and health care operations.

In addition, by signing below, I understand that I hereby authorize the Practice to disclose my medical information so that the Practice may treat, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations.

Patient's Signature: _____ Date: _____

Patient's Name: _____ DOB: _____
(Printed Name)

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS AND / OR OTHER REPRESENTATIVES

NAME	RELATIONSHIP	TELEPHONE #

Patient's Signature: _____ Date: _____