Highland OB/GYN
2301 Robeson Street Suite 201 * Fayetteville, NC 28305
(910) 485-1191 / (910) 485-6006 fax

Patient Registration Form

Personal Information:

Last Name:_____ **First Name:** _____ **Middle Initial:** _____

Address: _____
(City) (State) (Zip)

Date of Birth: Month_____ Date_____ Year_____ **Social Security Number:** _____-_____-_____

Home Number: (_____) _____-_____ **Cell Number:** (_____) _____-_____

Check One: Married □ Single □ Widow □ Divorced □ Separated □ Your Race: _____

You consent for us to leave a message for you on your:
Cell □ Home □ Work □ **Please indicate the number** (____) _____-_____ Patient Initials: _____

Emergency Contact: Name_____ Relationship_____ Phone Number: (____) _____-_____

E-mail address: _____

Pharmacy Information: _____ _____
Name of Pharmacy Address

Insurance Information:

Primary Policy Holder's Name: _____ DOB: _____ SSN: _____

Primary Insurance
Insurance Company: _____ Policy # _____ Group # _____

Secondary Insurance
Insurance Company: _____ Policy # _____ Group # _____

I have received and understand the Financial Policy of this practice _____
Patient Signature

Payment / Insurance Consent

I, _____ hereby authorize the designated physician to release any information acquired in the course of my treatment to my insurance company for the completion of claims. In consideration of the medical services to be rendered, I agree to pay Highland OB/GYN Clinic, PA the regular charges for said services. I understand that I am responsible for all charges not paid by insurance. I certify that I have read the above, or it has been explained to me, and I agree to all of its terms and as evidence of this fact, sign my name below.

_____ _____
Patient's Signature Date

Prescription Consent

ePrecribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the office. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include: **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan. **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events. **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled. By signing this consent form you are agreeing that Highland OB/GYN Clinic, PA can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. I Understand all of the above, I hereby provide informed consent to Highland OB/GYN Clinic, PA to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Patient's Signature Date

HIPPA Information
I have been given a copy of the Highland OB/GYN Clinic Notice of Privacy Practice. I consent to the uses and disclosures of my health information as outlined in the notice.

_____ _____
Patient's Signature Date

Highland OB/GYN
2301 Robeson Street Suite 201 * Fayetteville, NC 28305
(910) 485-1191 / (910) 485-6006 fax

Patient Medical History Form

Last Name:_____ **First Name:** _____ **Date of birth:** _____

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

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 ☐
Month / day / year
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) Or 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? _____

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? _____

Do you have a current sexual partner? Yes ☐ No ☐ Is your partner: Male ☐ Female ☐

Are there any concerns about your sexual activity which you may want to discuss with your Provider?

Yes ☐ No ☐ Explain: _____

PAST OBSTETRICAL / GYNECOLOGICAL SURGERIES Please check all that apply Or None ☐

	YEAR		YEAR
☐ D&C	_____	☐ ovarian surgery	_____
☐ hysteroscopy	_____	☐ L cyst(s) removed ovarian	_____
☐ infertility surgery	_____	☐ R cyst(s) removed ovarian	_____
☐ tuboplasty	_____	☐ L ovary removed	_____
☐ tubal ligation	_____	☐ R ovary removed	_____
☐ laparoscopy	_____	☐ vaginal or bladder repair	_____
☐ hysterectomy (vaginal)	_____	for ☐ prolapsed or ☐ incontinence	
☐ hysterectomy (abdominal)	_____	☐ cesarean section	_____
☐ myomectomy	_____	☐ other (specify) _____	_____

PAST SURGICAL HISTORY (Not OB/GYN)

Please list all surgeries and the year performed Or 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: Or None ☐

Cryotherapy Yes ☐ No ☐ Cone biopsy Yes ☐ No ☐

Colposcopy Yes ☐ No ☐ Loop excision (LEEP) Yes ☐ No ☐

Date of last mammogram: _____ (month) _____ (year) Location: _____

Have you had an abnormal mammogram? Yes ☐ No ☐ If yes, when _____

OTHER PAST GYNECOLOGICAL HISTORY Please check all that apply Or None ☐

		Year Treated			Year Treated
Venereal warts	Yes ☐ No ☐	_____	Endometriosis	Yes ☐ No ☐	_____
Herpes – genital	Yes ☐ No ☐	_____	Chlamydia	Yes ☐ No ☐	_____
Syphilis	Yes ☐ No ☐	_____	Gonorrhea	Yes ☐ No ☐	_____
Pelvic inflammatory disease	Yes ☐ No ☐	_____	Vaginal infections	Yes ☐ No ☐	_____
			Other _____		_____

PERSONAL MEDICAL HISTORY Please check all that apply

Or None ☐

Arthritis ☐
Diabetes: ☐
High blood pressure ☐
Heart disease ☐
Kidney Disease ☐
Gallstones ☐
Liver Disease ☐ (including hepatitis)
Epilepsy ☐
Blood Transfusions ☐
Thyroid disease ☐
Asthma ☐
Emphysema ☐
Bronchitis ☐
HIV+ ☐
Eating Disorder ☐
Other: _____

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

Medication	Dose	Frequency	Prescribed by

Pharmacy Information: _____ Name _____ Address

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

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_____ Last date used _____
Exercise: Type: 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

Or None ☐

Diabetes ☐
High Blood Pressure ☐
High Cholesterol ☐
Heart Disease ☐
Breast Cancer ☐
Ovarian Cancer ☐

Endometrial Cancer ☐ Osteoporosis ☐ Other _____
Colon Cancer ☐ Thyroid disease ☐
Bleeding Disorder ☐ Genetic disorder ☐

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

_____ _____

_____ _____

_____

OTHER SYMPTOMS Please check all that apply and list the year **Or None ☐**

Have you recently experienced:

weight loss ☐ weight gain ☐ breast discharge ☐
hair growth ☐ change in energy ☐ Other _____
hair loss ☐ change in urinary function ☐ Other _____
change in exercise tolerance ☐ hot flushes/flashing ☐

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:** _____

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____

Gender (M/F):_____ Today's Date(MM/DD/YY):_____ Health Care Provider:_____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	*------*	*---*	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Hereditary Breast and Ovarian Cancer Syndrome - Red Flags*

Personal and/or family history† of:

- ☐ Breast cancer diagnosed before age 50
- ☐ Ovarian cancer
- ☐ Two primary breast cancers
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer‡§
- ☐ Three or more HBOC-associated cancers at any age‡§
- ☐ A previously identified HBOC syndrome mutation in the family

†Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage
‡In the same individual or on the same side of the family
§HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer

Lynch Syndrome - Red Flags*

An individual with any of the following:

- ☐ Colorectal or endometrial cancer before age 50
- ☐ MSI High histology before age 60¶
- ☐ Abnormal MSI\IHC tumor test result (colorectal/endometrial)
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ Lynch syndrome cancer** with one or more relatives with a Lynch syndrome cancer^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family

An individual with any of the following family histories:

- ☐ A first- or second-degree relative with colorectal or endometrial cancer before age 50
- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50^
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family

¶MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern
***Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas*
^Cancer history should be on the same side of the family

**Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com*

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment:_____

Highland Ob / GYN Clinic, P.A.

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Phone: (910) 485-1191 / Fax: (910) 485-6006

Patient Financial Policy

Thank you for choosing Highland OB/Gyn as your health care provider. We are committed to providing our patients with first rate medical care and excellent service. The following is a statement of our Financial Policy which we require you to read and sign.

The patient or legal representative is ultimately responsible for all charges incurred. It is the patients' or legal representative's responsibility to keep this office informed of any changes in information that will affect the billing of your office visits to your insurance and or receiving payment for services rendered at Highland OB/GYN. It is our policy not to discuss patient account information, balance information or medical records with anyone other than the patient unless the patient gives prior written consent in accordance with HIPPA regulations.

Assignment of Benefits / Patient Responsibility

- Highland OB/GYN Clinic, PA will submit claims to insurance policies in which we are a contracted provider. This is being done as a courtesy to our patients but requires that the patient provides our office with the necessary insurance information, **for all active policies pertaining to the patient receiving services at our office**. Should the patient have more than one active insurance policy, the patient is required to make the staff at Highland OB/GYN aware of the order in which the policies should be submitted to the insurance companies. If the patient fails to provide us with the correct insurance information and/or the order in which to submit the claims to the insurances companies (primary insurance, secondary insurance and tertiary insurance, as applies to the patient) and the claims submitted are not paid by the insurance carrier, for any reason, the patient will be responsible to pay, in full, for the services rendered. The patient is also required to sign an assignment of benefits statement (located on the patient registration form) so that we may receive the payment from the insurance company for the service(s) provided to the patient. ***Your insurance contract is an agreement between you and your insurance carrier and any deductibles, co-payments and coinsurance amounts, that are the patients' responsibility, are due at the time of each visit.***
- Please be aware that some, and perhaps all, of the services provided at Highland OB/GYN may be non-covered services by your insurance policy and may not be considered reasonable and necessary under the Medicare program and/or other medical insurance policies. The patient is financially responsible for all services rendered at the time of each service.
- Once your insurance is filed (based upon the information the patient will provide to us before the service is rendered) and your claim(s) are not paid in a timely manner and /or a portion of your claim(s) have been put to the patients' responsibility to pay, that balance must be paid in full within sixty (60) days of the first statement sent to the patient. Balances that remain unpaid and without a payment arrangement will be sent to a collection agency and will incur an additional $35.00 late fee.
- ***All patients that wish to have insurance filed for their services must present a valid insurance card at the time of service. If you do not have your insurance card then you will be considered a self-pay patient and full payment will be due before services are rendered.***
- ***Medicaid for Pregnant Women will only cover visits related to maternity care. Patients seen for anything not relating to pregnancy will be responsible for the full costs of their services.***
- ***Family Planning Medicaid only covers limited services which will be explained to you upon check-in. Patients seen for anything not covered by Family Planning Medicaid will be responsible for the full costs of their services and must be paid before services are rendered.***
- Patients being seen for maternity care will have their benefits verified before their New OB visit and if necessary, a payment plan will be arranged to have the deductible and /or co-insurance amounts paid in full by the month before expected delivery.
- If you deliver a male child and wish to have him circumcised, you must provide us with a copy of valid insurance coverage so that we can file for the procedure. Benefits for this procedure will be verified and if an amount is due from the patient for the procedure that amount will be expected to be paid in full before the procedure is done. If you are not filing insurance for this procedure or if it is a non-covered service under your insurance policy benefits, you will be responsible for the circumcision fee of $300.00, which is due before the procedure is done. ***Medicaid does not cover circumcision.***

Missed Appointments – Unless our office staff (not including our on call service) is notified 48 hours before your scheduled appointment your failing to come to that scheduled appointment is considered a "no-show" and you will be subjected to a $25.00 missed appointment fee . If three or more appointments are missed, you may be required to obtain medical care from another provider. Please help us serve you by keeping scheduled appointments.

Payment Arrangements

If a patient is unable to pay their balance due in full a payment arrangement may be made on an individual basis and will be subjected to verification of financial hardship. Payment arrangements are offered on an individual basis and at the discretion of the management of Highland OB/GYN. A patient may be denied a payment arrangement for any reason deemed necessary by the management of Highland OB/GYN. If a payment arrangement is agreed upon and is broken in any way the arrangement will be cancelled and the balance will then be due in full. If it is not paid within thirty (30) days the account will be subjected to late fees based upon the balance, a $35.00 late fee and will be sent to a collection agency.

Statements

Monthly statements are sent detailing patient balances. If you have any questions about the balance please call the office during normal business hours and speak to the billing department. If your balance is not paid after two statements (60 days of first statement) then your account will be charged a $35.00 late fee and will be sent to a collection agency.

Payment Methods

We accept cash, check, money orders, Visa, MasterCard and Discover as forms of payment for all balances. If you have had a returned check with our office you may not write another check to us and cash, money order or credit card will be a required method of payment for all future payments.

Nonsufficient Funds (NSF)

If a check is returned for nonsufficient funds, you will be charged $25.00 fee for each NSF check in addition to the amount owed. Insurance companies will not cover this fee and it is the patient's responsibility to pay the fee and the balance due before another appointment can be made. If you have had a returned check with our office you may not write another check to us and cash, money order or credit card will be a required method of payment for all future payments. If the balance and fee is not paid within 30 days then your account will be charged a $35.00 late fee and will be sent to a collection agency.

Collection Agency referrals

Accounts which cannot be collected after normal in-house collection efforts have been exhausted may be referred to a collection agency, magistrate or attorney for further collection action. Those accounts will also incur an additional $35.00 late fee. All account balances and fees must be paid in full or the patient can not be seen for any additional appointments at Highland OB/GYN and could result in being discharged from our practice.

Refunds

Patients with credits on their accounts may request the refunds at any time. Refund checks will be written to the appropriate party, normally the insurance company or the patient. A patient's refunds will not be processed until all active or past due balances and all claims are paid in full. Once the account is in good standing the refund will be processed within 30 days. The patient needs to advise our office of the correct address to mail the refund check or may come to the office during normal business hours to pick it up.

If you have any questions regarding this policy or the contents herein, please contact our Practice Administrator for further clarification.

I have read and understand the financial policy of Highland OB/GYN. I agree to all the terms outlined above.

_____ _____

Printed Name of Patient or Responsible Party (Relationship to patient) Date

_____ _____

Signature of Patient or Responsible Party (Relationship to patient) Date

Updated September 2013

Highland Ob / GYN Clinic, P.A.

Out of Network Financial Policy

Thank you for choosing Highland OB/Gyn as your health care provider. We are committed to providing our patients with first rate medical care and excellent service. The following is a statement of our Policy which we require you to read and sign.

The patient or legal representative is ultimately responsible for all charges incurred. It is the patients' or legal representative's responsibility to keep this office informed of any changes in information that will affect the billing of your office visits to your insurance and or receiving payment for services rendered at Highland OB/GYN. It is our policy not to discuss patient account information, balance information or medical records with anyone other than the patient unless the patient gives prior written consent in accordance with HIPPA regulations.

Assignment of Benefits / Patient Responsibility

- Highland OB/GYN Clinic, PA will submit claims to insurance policies provided by the patient in which we **are not** a contracted provider. This is being done as a courtesy to our patients. ***Your insurance contract is an agreement between you and your insurance carrier and Highland OB/GYN is not privileged to the details of that contract agreement. It is not the policy of Highland OB/GYN to pre-verify benefits before services are rendered. Ultimately the patient is responsible to understand and follow all stipulations of their insurance policy for all services received.***
- You are being made aware that we are not a contracted provider with the insurance you have provided to our office. This means that you will be considered a self-pay patient for all services rendered. As a courtesy to you we will file a claim for your service to your insurance company and will refund to you only the amount paid by your insurance company.
- The patient is responsible for all charges which are not paid by the insurance company.
- Any balance must be paid in full within sixty (60) days of the first statement sent to you. Balances that remain unpaid and without a payment arrangement will be sent to a collection agency and will incur an additional $35.00 late fee.
- By signing this form you are acknowledging that you understand you are responsible for all costs associated with all services you receive that are deemed medically necessary by the Providers of Highland OB/GYN. You also understand that your treatment may not be interrupted to make you aware of each charge and you may receive a statement at a later date or be asked to pay for additional services received when you check-out.

If you have any questions regarding this policy or the contents herein, please contact our Practice Administrator for further clarification.

I have read and understand the out of network financial policy of Highland OB/GYN.
I agree to all the terms outlined above.

_____ _____

Printed Name of Patient or Responsible Party (Relationship to patient)

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Witness Date

Highland OB / GYN Clinic, PA
2301 Robeson Street Suite 201
Fayetteville, NC 28305
*Phone: (910) 485-1191 * Fax: (910) 485-6006*

Appointment Cancellation Policy

We strive to render excellent medical care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another sick patient.

Our policy is as follows:

We request that you please give our office a 48 hour notice in the event that you need to reschedule your appointment with the provider. If you do not contact our office within the 48 hour timeframe – you will be considered a No-show. Calling us ahead allows other sick patients to be scheduled into that appointment spot and it also makes it possible to reschedule your appointment more efficiently. A fee of **$25.00** will be charged to you for a missed appointment. Once you are charged this missed appointment fee you can not be seen by a provider again until the fee is paid.

If a patient accumulates a total of three (3) missed appointments, the patient may not be rescheduled for future appointments and will be discharged from the practice.

Additionally, if a patient is more than 15 minutes late to her appointment, the appointment may be cancelled requiring you to reschedule and counting as a no-show.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Highland Ob/Gyn Clinic, PA's Appointment Cancellation Policy.

_____ _____
Patient Signature Date

Highland
OB/GYN CLINIC, PA

E-Prescribing / Medication History Download Consent Form

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription direction to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in the E-Prescribing program. These include:

- Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – allows the prescriber to receive an electronic notice from the pharmacy telling them if a patients' prescription has been picked up, not picked up or partially filled.

By signing this consent form you are agreeing that Highland OB/GYN Clinic, PA and the staff can request and use your prescription medication history from other healthcare providers and / or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to the practice to enroll me in the E-prescribe program. I have read and had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____	_____
Printed Patient Name	**Date of Birth**
_____	_____
Patient Signature	**Date**