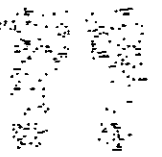
Scott P. Striplin, M.D.
Obstetrics & Gynecology



Last Name:_____First:_____ Middle Initial:____

Address:_____ City:_____ State:_____

Zip Code:_____ Age:_____

Home Phone: _____ Cell Phone: _____

Work or Other: _____ Email: _____

Birthdate: _____ Social Security Number: _____

Marital Status: **(Circle One)** Single Married Divorced Other

Occupation:_____ Employer:_____

In Case Of Emergeny Contact:

Name: _____ Phone Number: _____

Relationship:_____

Pharmacy used: _____

If you are NOT the primary insured, please supply the information below:

Insured Name:_____ Date of Birth:_____

Social Security Number:_____ Insurance ID # _____

Carrier:_____ Group # _____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed:_____ **Date:**_____

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to the physicians of Total Woman Care for services provided. I agree to pay all co-pays, deductibles, and co-insurance not paid by the insurance company. If medicaid coverage is obtained after the first or subsequent visit, this office will NOT bill medecaid retroactively, and any balances will have to be paid to Total Woman Care. I will seek reimbursement from the medicaid office directly.

Signed:_____ **Date:**_____

FINANCIAL POLICY

WE WILL ACCEPT MEDICAID IF:

1. **If you lose coverage from your present healthcare insurer:** We will accept Medicaid if it becomes the only means of medical coverage.

2. **If Medicaid is used as a secondary insurer:**
Medicaid will be accepted as a secondary coverage to your private insurance company if you present it to our staff at your first visit, **BUT NO LATER THAN YOUR SECOND VISIT WITH THE DOCTOR.** If at a later date you get Medicaid as your secondary medical insurance, this office reserves the right to refuse and will bot accept it. **Medicaid WILL NOT BE BILLED.** Patients will be responsible for all bills that you primary insurance company states are the patient's responsibility. If MEDICAID coverage is obtained after the first or subsequent visits as stipulated above, this office will not bill Medicaid retroactively, and balance will have to be paid by the patient. Reimbursement will have to be obtained from the medicaid office directly.

3. **IF YOU FAIL TO GIVE PRIMARY INSURANCE AT FIRST VISIT AND YOU ONLY PRESENT YOUR MEDICAID. YOU WILL BE RESPONSIBLE FOR THE FULL AMOUNT OF ANY AND ALL VISITS.**

4. **If you are a cash patient:**
Medicaid coverage will not be accepted after the second visit to this office, If a patient switches from cash to Medicaid. If you decided to get Medicaid coverage, this should be done either before your first visit to this office or immediately after your first visit and you must notify our staff that you **ARE APPLYING FOR Medicaid** as this process may take over 30days. You will remain a cash patient and you will be responsible for making the **$500 deposit** ob your second maternity visit and the balance will be due by the end of your 6th month of pregnancy. We will only accept Medicaid after a temporary card or your letter from the medicaid office stating that you have been approved, **NOT PENDING** or the actual card has been presented and verified by our staff.

ROUTINE CIRCUMCISIONS

Circumcisions are only covered by Pediatrician. If DR. Striplin is to perform the circumcision on your newborn, a **$250.00 payment** is expected to be paid in full one month prior to delivery date.

Ultrasounds

Medicaid only pays for two ultrasound, unless medically necessary. If you have more than three, you could be held financially responsible for the cost of the ultrasound. We will provide the necessary information for the billing, however, that does not mean that Medicaid will pay for the ultrasound. **Ultrasound to determine the sex of your baby is not an expense that is covered by Medicaid nor is it a free service that is provided by the office.** Please note that you could be financially liable for the ultrasound performed in this office as well as outside this office when sent to other facilities.

Payment is expected to be paid at time services are rendered. If you change your insurance and do not inform this office in a timely manner, this could result in claims being processed incorrectly and you could be responsible for any balances, co-insurances, deductibles, etc.

BY SIGNING THIS FORM YOU ARE ACKNOWLEDGING THAT YOU ARE AWARE OF WHAT IS EXPECTED OF YOU AND THAT YOU ARE RESPONSIBLE FOR ANY CHARGES AND UNDERSTAND THE POLICIES LISTED ABOVE.

SIGN: _____ DATE:_____

Dr. Scott Striplin

Patient History Questionnaire

Name: _____ Age: _____

Marital Status **(Circle One):**

Single Married Separated Divorced

Other

Number of Pregnancies: _____ Number of Full-Term babies: _____

Number of Premature babies: _____ Number of abortions: _____

Number of Miscarriages: _____

Number of Ectopic (Tubal) Pregnancies: _____ Number of Living Children: _____

When was your last baby born? _____

How big was your biggest baby? _____

How did you deliver your babies? **Circle below:**

Vaginal C-Section If both, did you have a vaginal birth after C-Section? _____

Please list any complications you have had with pregnancy, labor, or delivery: _____

_____

Have you ever had an abnormal pap smear? _____

If so, how were you treated? _____

Do you have history of herpes? _____

What method do you use for contraception (birth control)? _____

If you are menopausal, do you use any hormone replacement therapy? _____

If you use hormones, please list the type and dose: _____ _____

_____ _____ _____

_____ _____ _____

Do you have any medical problems? **Circle all that apply:**

Diabetes High Blood Pressure Heart Disease

Cancer (what type?) _____ Thyroid Disease

Other _____

Please list any surgery you have had and date of surgery: _____

_____

_____

Please list the names and dosages of all medication that you take on a regular basis: _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any medication allergies that you have and indicate the type of effect this medication has had on you: _____ _____

_____ _____ _____

Do you smoke? If so, please indicate how many packs of cigarettes per day: _____

Do you drink alcohol? If so, please indicate a daily amount or if it is social use only: _____

Do you use any other drugs? _____

Do any diseases run in your family? Please indicate the **relationship of the person** who has any of the following:

Diabetes _____ High Blood Pressure _____ Heart Disease _____

Cancer (what type?) _____ Birth Defects _____

Other _____

PATIENT QUESTIONNAIRE

Dr. Scott Striplin, MD
77 Starbrush Circle
Covington, LA 70433
(985) 893-0995

PATIENT INFORMATION RELEASE AUTHORIZATION

Full Patient Name: _____ Date of Birth: _____

I hereby authorize Dr. Scott Striplin, MD. To release/provide protected health information and/or financial/billing information to the following individuals:

DATE AUTHORIZED	NAME	RELATIONSHIP	PHONE NUMBER	PATIENT'S INITIALS

I understand that I may rescind all or some of the above authorization(s); however, in order to implement the change, I must personally visit the clinic, provide the above-requested information and enter my initials.

I authorize Dr. Scott Striplin, MD. To release my protected health information to other healthcare providers, healthcare payors, government agencies, and other healthcare organizations as reasonably necessary for continuity of care, reimbursement, audit, and/or quality of care-related purposes.

_____ _____ _____

Patient's Printed Name Signature Date