If you choose to sign an authorization to allow disclosure of your PHI (Personal Health Information), you can later revoke that authorization to stop any further uses and disclosures (other than for treatment, payment and health care operations).

We may chance our policies at any time. Before we make a significant change in our policies, we will change our notice and send the new notice to you. You can also request a copy of our notice at any time.

Individual Rights
In most cases, you have the right to view or get a copy of your PHI. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your PHI for treatment, payment and health care operations except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means or at alternative locations, if you clearly state that disclosure of all or part of your PHI could endanger you.

Complaints
If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our Legal Duty
We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints or concerns, please contact:

Metro OBGYN
17 W. Exchange St. Suite 622
St. Paul, MN 55102
(651) 227-9141

NOTICE OF PRIVACY INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Metropolitan Obstetrics & Gynecology, P.A. understands that medical information about you and your health is personal, and we are committed to protecting your medical information. Individually identifiable information about your past, present and future health or condition, the provision of health care to you, or payment for such health care is considered "Protected Health Information" ("PHI").

Our Permitted Uses and Disclosures of Your Protected Health Information.

We use and disclose PHI about you for treatment, payment and health care operations.

Treatment: We may disclose PHI to your doctor for treatment purposes. For example, your doctor may wish to provide a medical service to you but first seek information as to whether the service has been previously provided.

Payment: We may disclose your PHI in order to fulfill our duty to provide your coverage, determine your benefits, and make payment for services provided to you. For example, we use your PHI in order to process your claims.

Health Care Operations: We disclose your PHI as part of certain operations, such as quality improvement. For example, we may use your PHI to evaluate the quality of medical services that were performed.

We may be asked by the sponsor of your health plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law from doing so.

We may use or disclose your PHI without your authorization for several other reasons. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings. In any other situation, we will ask for your written authorization before using or disclosing your PHI.

Metro OBGYN Health History Form

Office Patient ID #____________

Please fill in all information on front and back of form

Today's Date________________

Name____ Date of Birth _____/_____/_________

Referred by ___________________________________ Primary Care Doctor __________________________________

Reason for today's visit ____

Menstrual History

First day of last period ______/______/______ Age at first period _______

Your periods occur every ______________days and last for __________days

Any problems with your periods? ☐ No ☐ Yes

☐ Heavy flow ☐ Clots ☐ Pain/Cramping ☐ Irregular periods ☐ Discharge

☐ Bleeding between periods ☐ Other_________________________________

If menopausal

Age/year began_____________ Any Postmenopausal bleeding? ☐ No ☐ Yes

Gynecological History

Have you had any of the following? (Check all that apply)

☐ Abnormal Pap Smear ☐ Breast Pain ☐ Chronic Pelvic Pain

☐ DES Exposure ☐ Endometriosis ☐ Genital Warts

☐ Infertility ☐ Ovarian Cysts ☐ Pain with Intercourse

☐ PID ☐ PMS ☐ Recurrent Miscarriage

☐ Recurrent Vaginitis ☐ STD _______________________________

☐ Urinary Incontinence ☐ UTI (chronic) ☐ Uterine Fibroids

☐ **None of the above** *(additional medical history on the back of form)*

Contraceptive History

Are you currently sexually active? ☐ Yes ☐ No ☐ Never been

How many life time partners? _________ How many in the last year?______

Current method of birth control (Include tubal or vasectomy) _______________

Any problems with current method? ☐ No ☐ Yes ____________________

Previously used methods (Check all that apply)

☐ Birth Control Pill ☐ Condoms ☐ Diaphragm ☐ Depo Provera ☐ IUD

☐ NuvaRing ☐ Implanon ☐ Nexplanon ☐ Spermicide ☐ Sponge ☐ Other

☐ No previous birth control

Preventive Care History

Last Pap Smear Date:_____________________ ☐ Normal ☐ Abnormal

Last Mammogram Date: ___________________ ☐ Normal ☐ Abnormal

Last Colonoscopy Date:___________________ ☐ Normal ☐ Abnormal

Last DEXA (Bone Scan) Date: ______________ ☐ Normal ☐ Abnormal

Last Cholesterol Test Date:________________ ☐ Normal ☐ Abnormal

Vaccinations (year) Gardasil __________ Flu ___________

Herpes Zoster (Shingles) __________ TDAP (Tetanus) __________

Total Pregnancies	Full Term Deliveries	Premature Deliveries	Elective Terminations	Miscarriages	Ectopics	Multiples	Living

Date MM/DD/YYYY	Gestation Age #Wks@Delivery	Hours in Labor	Birth Weight	Sex	Type of Delivery	Type of Anesthesia	Early Labor	Comments/Complications Gestational Diabetes	Hospital

Surgical History (Please list all surgical procedures) ☐ **None**

Surgery____________________________________ Date_______________

Surgery____________________________________ Date_______________

Surgery____________________________________ Date_______________

Surgery____________________________________ Date_______________

Surgery____________________________________ Date_______________

Allergy History (List all medication allergies and reaction) ☐ **None**

Allergy___________________________ Reaction___________________

Allergy___________________________ Reaction___________________

Allergy___________________________ Reaction___________________

Allergy___________________________ Reaction___________________

Allergy___________________________ Reaction___________________

Current Medication History

(Please include current prescriptions and medications ONLY) ☐ **None**

Drug name________________________________ Dose______________

Drug name________________________________ Dose______________

Drug name________________________________ Dose______________

Drug name________________________________ Dose______________

Drug name________________________________ Dose______________

Drug name________________________________ Dose______________

Social & Lifestyle History

Marital Status ________________ Occupation_________________________

Tobacco Smoker ☐ Never ☐ Former ☐ Current - Amt/Day________________

Alcohol Use ☐ No ☐ Yes If yes, Amt/Wk______________

Caffeine Use ☐ No ☐ Yes Street Drugs/Marijuana use ☐ No ☐ Yes

Domestic Abuse ☐ No ☐ Yes If yes, ☐ Current or ☐ Past

Regular Exercise ☐ No ☐ Yes Type________________ Amt/Wk________

Monthly Breast Exam ☐ No ☐ Yes Have you had Chicken Pox ☐ No ☐ Yes

Do you have a Health Care Directive (living will) ☐ No ☐ Yes

Past Medical History

Indicate Relationship

Condition	Self	Family	
Anemia	☐ Self	☐ Family	->
Anxiety	☐ Self	☐ Family	->
Asthma	☐ Self	☐ Family	->
Blood Clotting Disorder	☐ Self	☐ Family	->
Cancer; Breast	☐ Self	☐ Family	->
Cancer; Cervical	☐ Self	☐ Family	->
Cancer; Colon	☐ Self	☐ Family	->
Cancer; Ovarian	☐ Self	☐ Family	->
Cancer; Skin-type:________________	☐ Self	☐ Family	->
Cancer; Uterine	☐ Self	☐ Family	->
Cancer; Other ->	☐ Self	☐ Family	->
Cardiac Arrhythmia	☐ Self	☐ Family	->
Coronary Artery Disease	☐ Self	☐ Family	->
Crohn's Disease	☐ Self	☐ Family	->
Cystic Fibrosis	☐ Self	☐ Family	->
Deep Vein Thrombosis (DVT)	☐ Self	☐ Family	->
Depression	☐ Self	☐ Family	->
Diabetes-type:____________________	☐ Self	☐ Family	->
Eating Disorder-type:_______________	☐ Self	☐ Family	->
Gastric Ulcer	☐ Self	☐ Family	->
Gastroesophageal Reflux Disease	☐ Self	☐ Family	->
Gestational Diabetes	☐ Self	☐ Family	->
Hepatitis-type:____________________	☐ Self	☐ Family	->
Hyperlipidemia (High Cholesterol)	☐ Self	☐ Family	->
Hypertension (High Blood Pressure)	☐ Self	☐ Family	->
Irritable Bowel Syndrome	☐ Self	☐ Family	->
Kidney Stones	☐ Self	☐ Family	->
Lupus	☐ Self	☐ Family	->
Migraines	☐ Self	☐ Family	->
Multiple Sclerosis	☐ Self	☐ Family	->
Osteoporosis	☐ Self	☐ Family	->
Parkinson's Disease	☐ Self	☐ Family	->
Pulmonary Embolism	☐ Self	☐ Family	->
Rheumatoid Arthritis	☐ Self	☐ Family	->
Scoliosis	☐ Self	☐ Family	->
Seizures	☐ Self	☐ Family	->
Sickle - Cell Disease	☐ Self	☐ Family	->
Sleep Apnea/Disorder	☐ Self	☐ Family	->
Stroke	☐ Self	☐ Family	->
Thyroid Disorder-type:_____________	☐ Self	☐ Family	->
Tuberculosis	☐ Self	☐ Family	->
Ulcerative Colitis	☐ Self	☐ Family	->

Other Medical History we should know about ->

Are there any other problems that are important to you today?

☐ No ☐ Yes ____

____

____

Patient Signature:________________________________

Experiencing Today / Recently

Review of Systems - You are currently having any of the following:

System	Symptom	Yes	No
Constitutional	Fever	☐ Yes	☐ No
	Chills	☐ Yes	☐ No
	Sweats	☐ Yes	☐ No
	Weight loss	☐ Yes	☐ No
	Weight gain	☐ Yes	☐ No
	Fatigue	☐ Yes	☐ No
Eyes	Impaired Vision	☐ Yes	☐ No
Head, Ears, Nose, & Throat	Headaches	☐ Yes	☐ No
	Sinus Congestion	☐ Yes	☐ No
Breast	Lumps	☐ Yes	☐ No
	Tenderness	☐ Yes	☐ No
	Swelling	☐ Yes	☐ No
	Nipple Discharge	☐ Yes	☐ No
Cardiovascular	Chest pain	☐ Yes	☐ No
	Loss of Consciousness	☐ Yes	☐ No
Respiratory	Shortness of breath	☐ Yes	☐ No
	Wheezing	☐ Yes	☐ No
	Cough	☐ Yes	☐ No
Gastrointestinal	Nausea	☐ Yes	☐ No
	Vomiting	☐ Yes	☐ No
	Diarrhea	☐ Yes	☐ No
	Constipation	☐ Yes	☐ No
	Blood in stools	☐ Yes	☐ No
Genitourinary	Urinary urgency	☐ Yes	☐ No
	Urinary frequency	☐ Yes	☐ No
	Urinary Incontinence	☐ Yes	☐ No
	Blood in urine	☐ Yes	☐ No
Integument (Skin)	Rash	☐ Yes	☐ No
	Change in moles, lesions	☐ Yes	☐ No
	Change in hair growth/loss	☐ Yes	☐ No
Neurologic	Muscular weakness	☐ Yes	☐ No
	Incoordination	☐ Yes	☐ No
	Tingling or numbness	☐ Yes	☐ No
Musculoskeletal	Joint pain	☐ Yes	☐ No
	Muscle pain	☐ Yes	☐ No
Endocrine	Excessive thirst	☐ Yes	☐ No
	Excessive urination	☐ Yes	☐ No
	Temperature intolerance	☐ Yes	☐ No
Psychiatric	Anxiety	☐ Yes	☐ No
	Depression	☐ Yes	☐ No
	Feeling Confused	☐ Yes	☐ No
	Difficulty Sleeping	☐ Yes	☐ No
	Excessive Anger	☐ Yes	☐ No
Heme-Lymph	Easy bleeding	☐ Yes	☐ No
	Easy bruising	☐ Yes	☐ No
	Swollen lymph glands	☐ Yes	☐ No
Allergic-Immunologic	Sinus allergy symptoms	☐ Yes	☐ No
	Frequent illnesses	☐ Yes	☐ No

Reviewed by:________________________________

Patient Name ______________________________________ **Account #**__________________

Authorization for Release of Information

Initial ________ I authorize the release of any information, including medical and billing information, by Metropolitan Obstetrics & Gynecology to my referring doctor or insurance company.

Initial ________ My insurer may share my past, current and future health and account records with Metro OBGYN about services I've received from Metro OBGYN and other care providers unrelated to Metro OBGYN. These records may be used by Metro OBGYN as needed to manage or coordinate my care and to improve the quality of that care. If I do not agree to this, I will initial below.

OR ***Initial*** ________ My insurer may not release any of my identifiable health records from providers unrelated to Metro OBGYN for the purposes described above.

Initial ________ I agree that Metro OBGYN may e-prescribe my prescriptions and may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes

YOUR PRIMARY PHARMACY ______________________________ ____________________
Pharmacy Name Pharmacy Address/Street Name Pharmacy City

Initial_________ I authorize payment of Medical Benefits, including Medicare and Medicaid benefits, be paid to Metropolitan Obstetrics & Gynecology, PA. for services rendered to myself.

Financial Policy of Metropolitan Obstetrics & Gynecology, P.A.

Charges are due and payable within 30 days upon receipt of statement. If no insurance coverage, please contact our business office to make arrangements for payment 651-265-6750.

Initial ________ I agree to pay for all services provided to me by Metropolitan Obstetrics & Gynecology PA, including those not covered by insurance.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Initial ________ I am aware of Metropolitan Obstetrics & Gynecology's Notice of Privacy Practices (a copy is available upon request and is posted in the reception room).

Request for family member to have access to protected health information.

The name(s) listed below are family members and/or friends to whom I wish to grant access to my healthcare information. I hereby authorize Metro OBGYN. to disclose my Protected Health Information (PHI) including appointment and billing information to the following:

NAME	RELATIONSHIP
1. ______________________________	______________________________
2. ______________________________	______________________________

□ **NONE**

Initial ________ I understand this consent will be considered valid until such time I revoke it. I may revoke this authorization by sending a written request for revocation to Metro Ob/Gyn, PA. I understand the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information. I understand and agree to these terms.

I have read each section above and initialed each appropriate section.

____ ________________________ ***Effective for 1 year / or specified dates***
SIGNATURE DATE

Updated 3/29/17

OB INFORMATION FORM

DOWNTOWN_______________ WOODBURY______________

MAPLEWOOD______________ APPLE VALLEY_____________

PATIENT NAME:____

DOB:____

ACCOUNT NUMBER:_____________________________

METRO OB/GYN PHYSICIAN NAME:__________________________________

DATE OF LAST MENSTRUAL PERIOD:_________________________________

DUE DATE:____________________________________

NUMBER OF PREGNANCIES(INCLUDING THIS ONE):_____________________

PREVIOUS C-SECTION YES_________ NO_________

INSURANCE COMPANY:____

REFERRING PHYSICIAN:____

PRIMARY CARE CLINIC:____

WHAT HOSPITAL WILL YOU DELIVER AT?

UNITED_______ST JOHNS_______WOODWINDS_______RIVER FALLS______

PLEASE ROUTE TO THE CODING DEPARTMENT.

FOR BILLING USE ONLY

HOSP ADM DATE:_____________ DELIVERY DATE:____________ D/C DATE:______________

HOSPITAL: UHI—NE—WW—RF PHYSICIAN: ___________ DELIVERING PHYSICIAN:_____________

CPT:_____________ DIAGNOSIS: _____________

_____________ _____________

_____________ _____________

_____________ BMI @ FIRST OB_________ _____________

Updated 6/7/2018

GLOBAL OB PACKAGE

Metro OB/GYN bills under the Global OB Package. The package includes the following services:

All Uncomplicated office visits
Urinalysis
Delivery of infant
Six week post partum check

Fee for vaginal delivery and OB care: $5698.00
Fee for Caesarean Section and OB care: $6324.00

At the end of your pregnancy we will bill one fee to either you or your insurance company for this package.

There are some services that may be performed during your pregnancy that **are not included** in the global package. They are the following:

The Initial OB visit
Ultrasounds
Non Stress Tests
AFP/Triple screen
Glucose Tolerance Test
Any lab work other than a urinalysis
Pap Smear

If you have any questions regarding this please contact our business office at 651-265-6750.

Signature Date

Prices are subject to change effective the 15th of each new year. This will affect those patients signing in one year and delivering in another.

Updated 5/24/19

GENETIC AND FAMILY HISTORY

Patient Name _________________________________ DOB ____________ Date __________

Attitude towards Pregnancy: ☐ Planned ☐ Unplanned ☐ Plan to parent/keep ☐ Adoption

Drug use: (Past/Current):

Tobacco	☐Y	☐No	Prepregnancy amt. _________	Pregnancy amt. _________	Yrs. total use _______
Alcohol	☐Y	☐No	Prepregnancy amt. _________	Pregnancy amt. _________	Yrs. total use _______
Caffeine	☐Y	☐No	Prepregnancy amt. _________	Pregnancy amt. _________	Yrs. total use _______
Street Drugs	☐Y	☐No	Prepregnancy amt. _________	Pregnancy amt. _________	Yrs. total use _______

Herbal Supplements Current/Past ____

Have you or any members of your family been born with or affected by any known genetic problem, retardation, birth defects, or major medical problems?

	Patient	*Father of Baby*	*Family*
1. Patient's age • 35 yrs or over	☐		
Father of baby • 50 years or over		☐	
2. Italian, Greek Mediterranean or Asian background (thalassemia): …….......	☐	☐	
3. Ashkenazi, Jewish, Cajun, Fr. Canadian background (Tay Sachs)? …….........	☐	☐	
4. African or Latin American background (sickle cell)?	☐	☐	
5. Down syndrome or other chromosomal problem?	☐	☐	☐
6. Hemophilia or other bleeding disorder?	☐	☐	☐
7. Muscular dystrophy or anyone in family in a wheelchair?	☐	☐	☐
8. Cystic fibrosis or any other metabolic disorder?	☐	☐	☐
9. Huntington's Chorea?	☐	☐	☐
10. Mental retardation or autism?	☐	☐	☐
11. Maternal medical problems? (diabetes, lupus, epilepsy, PKU, etc.) ………..	☐		
12. Other inherited genetic or chromosomal disorder?	☐	☐	☐
13. Child with birth defects not listed above? ………………………………………	☐	☐	☐
14. Patient or Father of Baby with birth defect? ……………………...................	☐	☐	
15. More than 3 first trimester spontaneous abortions or a stillbirth?	☐		☐

Infection History	Yes	No
Do you live with someone that has or ever been exposed to TB?	☐	☐
Have you ever had chicken pox?	☐	☐
Have you received chicken pox (Varicella) Vaccine?	☐	☐
Have you had a rash or any viral illness since LMP?	☐	☐
Have you ever been diagnosed with an STD?	☐	☐
Do you have cats in your home?	☐	☐
Do you have close contact with young children on a regular basis?	☐	☐