

BLOSSOM GYNECOLOGY, WELLNESS & INFERTILITY

Marjorie A. Chorness, MD FACOG
420 The Parkway, Suite C, Greer, SC 29650
Phone: (864) 662-5000, Fax: (864) 662-5008
www.blossomobgyn.com

Dear _____ Appointment: _____

Thank you for choosing Blossom Gynecology, Wellness, & Infertility. Marjorie A. Chorness, M.D. is a Board-Certified specialist in OB/GYN & Infertility with over 20 years of experience in patient care. Our goal is for you to receive personalized, private, professional care during your office visits. We offer a full range of obstetric & gynecologic services. For more information, please visit our website at www.blossomobgyn.com, print the New Patient Packet from the Forms section, complete, and bring with you to your visit.

Important Information – In order to ensure that your visit goes as smoothly as possible, please review the following information.

- Bring a **list of your current medications and dosages** with you to all of your visits.
- Please arrange for childcare.
- In order to minimize interruptions during your visit, we ask that you **silence your cell phone**.
- As a courtesy to staff and patients with sensitivities to fragrance, **please refrain from wearing perfumes, body sprays, and/or scented lotions**.
- **Medical records policy** - To facilitate your first visit, please obtain your medical records from previous physicians/providers. You may have your records faxed to our office at 864-662-5008 prior to your first visit or bring them with you at that time. The enclosed form may be faxed to your previous providers or you may call the appropriate office and pick up your records. A Medical Records Release form is enclosed for your convenience.
- **Reschedule/Cancellation Policy** – If you are unable to keep your scheduled appointment, please call the office 24 hours in advance to notify us. **Failure to do so will result in a \$35.00 charge**. If you miss your appointment, we can re-schedule you once at your request. If we do not have your medical records at the time of your appointment, your appointment will be rescheduled.

Directions to our office:

From Greenville: Take I-85 to Pelham Road (Exit 54). Make a left off the exit and get immediately in the right lane. Go to the second light just over the bridge and turn right on to “The Parkway”. Go through the third light, pass Mountain View Family Practice and make your next right into our parking lot. We are the last building on the left.

From Spartanburg: Take I-85 to Pelham Road (Exit 54). Make a right off the exit and stay in the right lane. Make a right at the first light on to “The Parkway”. Go through the third light, pass Mountain View Family Practice and make your next right into our parking lot. We are the last building on the left.

We look forward to serving your obstetric and gynecology needs for many years to come. Please feel free to communicate with us via email at frontoffice@blossomobgyn.com for appointment scheduling and at patientaccounts@blossomobgyn.com for billing questions.

Marjorie A. Chorness, MD FACOG & The Staff of Blossom Gynecology, Wellness, & Infertility.

BLOSSOM

GYNECOLOGY, WELLNESS & INFERTILITY, P.A.

MARJORIE A. CHORNESS, MD FACOG

Today's date	Social Security #	DOB: / /	
PATIENT INFORMATION			
PATIENT'S Last Name	First	MI	Address
City/State		Zip Code	Home # Cell #
Employer	Employer Address	Work #	Pharmacy #
Email Address		Primary Care Physician	
Marital Status <input type="checkbox"/> S- Single <input type="checkbox"/> M- Married <input type="checkbox"/> D-Divorced <input type="checkbox"/> X- Separated <input type="checkbox"/> W- Widow		Employed <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> R-Retired <input type="checkbox"/> Self <input type="checkbox"/> N- None	
		Student <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> N- None	

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	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Subscriber's Employer		Employer Address		Employer Phone #	

INSURANCE AUTHORIZATION AND ASSIGNMENT	
<p>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.</p>	
_____ <i>Patient/Guardian signature</i>	_____ <i>Date</i>

MC/as 10/12/2015

(Please fill out information on reverse side)

MC/as 10/12/2015

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

CHILDREN			
NAME	AGE	NAME	AGE

PERSONAL INTERESTS

LEVEL OF EDUCATION
<input type="checkbox"/> High School <input type="checkbox"/> College 1 2 3 4 <input type="checkbox"/> Post Graduate <input type="checkbox"/> Other

EMERGENCY CONTACT				
Name	Relationship	Home #	Cell #	Work #

Other information pertinent to your medical care:

MC/as 10/12/2015

MC/as 10/12/2015

PATIENT INFORMATION

Date: _____

Name (First, Middle Initial, Last):	Age:	DOB (MM/DD/YYYY):
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What brings you to the office today?

Referred by?

Background information pertaining to current problem, if applicable:

History of Gynecologic Problems/Issues:

- | | | | | |
|----------------------------------------|----------------------------------------------|--------------------------------------|----------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Abnormal Paps | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Herpes | <input type="checkbox"/> Frequent UTI's |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Menopausal Problems | <input type="checkbox"/> Menorrhagia | <input type="checkbox"/> Overactive Bladder | <input type="checkbox"/> Pelvic Infections |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Prolapse | <input type="checkbox"/> Pelvic Pain | <input type="checkbox"/> Stress Incontinence | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Dysmenorrhea | <input type="checkbox"/> Genital Warts | <input type="checkbox"/> PMS | <input type="checkbox"/> HPV | |
- Other Gynecological History: _____

Pregnancies

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

Last Menstrual Period (Date): _____ **How many days is your cycle?** _____ **Frequency of periods:** _____

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

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

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

Please list all Illnesses:

PATIENT INFORMATION

Please list all Surgeries:

Please list all medications. Including over the counter (list dosage and frequency also):

Allergies:

Family History

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

Social History

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

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

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

BLOSSOM GYNECOLOGY, WELLNESS & INFERTILITY, P.A.
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. The following is a statement of our Financial Policy.

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 insurance carrier, will be due at the time of service.

Non-Covered Services: Any services that are not covered under the 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 to verify coverage.

Annual Exams: Annual exams are preventive care services. Any problems or concerns addressed during an annual exam are considered a separate service and may be a separate charge.

Collection Policy: Should your account become past due, the patient/guarantor of the account is responsible for resolving all outstanding balances in a timely manner. Any questions regarding balances can be directed to the front office receptionist or 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 and may affect your credit. The patient/guarantor of the account will assume all costs of collection, including but not limited to, collection agency fees (up to an additional 50% of the balance), 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 on your account.

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 each set of forms or administrative 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.

By signing below, I acknowledge I have understood, agreed to and given a copy of the financial policy as outlined above.

Patient/Guardian Signature

Date

Patient/Guardian Printed Name

E-mail Address

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PATIENT INSURANCE WAIVER FOR THE DIGENE HIGH-RISK HPV TEST

The Digene® High-Risk HPV Test is a new, highly sensitive test used in cervical cancer screening to detect the high risk strain of HPV (human papillomavirus). HPV is a very common virus that most sexually active women are exposed to at some point in their lives. Fortunately, for most women HPV infection will resolve on its own after 1-2 years. However, if the virus is not eliminated by your body, it may cause abnormal changes to the cells of your cervix. HPV testing is not advised for women under the age of 30 due to the very high percentage of positive result in this group.

Unlike the Pap test alone, these two tests used together inform your doctor if you are at risk for cervical disease. If either test is abnormal, your doctor will suggest the best course of follow up. Studies have also shown that for women who are HPV and Pap test negative, there is virtually no risk of developing cervical cancer before the next annual visit.

You have the option to Accept or Decline HPV testing by signing this waiver below. If you accept, you are agreeing to pay for the test if your insurance company does not.

I have read the information above about The Digene® High-Risk HPV Test, and based on this information,

I **AGREE** to have the HPV testing I **DO NOT** want to have the HPV testing.

Signed: _____

Date: _____

Printed Name: _____

IMPORTANT INFORMATION REGARDING QUEST BILLING/SERVICES

Lab services at Blossom Gynecology, Wellness & Infertility, such as pap smears, blood work and urine testing, are provided by Quest. Financial aspects of these services are handled directly by the billing department at Quest. This information is not shared with Blossom Gynecology, Wellness & Infertility, therefore, we are not equipped to assist you in these matters. **If you have concerns or questions regarding your lab charges, please refer to the toll free number on your Quest bill.**

It is your responsibility to notify us at the time of your visit if another lab must be used. If we do not receive this information from you at the time your labs are processed, any amount not paid by your insurance company is your responsibility.

Signed: _____

Date: _____

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NEW PATIENT MEDICAL RECORDS RELEASE

Please complete the following form and send it to your previous OB/GYN physician. In order to provide you with the best care, we need to have all of your medical records transferred to our office prior to your first appointment.

Patient Name: _____

SS#: _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip _____

Phone number: _____

I authorize the release of my medical records to:

Blossom Gynecology, Wellness & Infertility
420 The Parkway, Suite C
Greer, SC 29650
Phone: 662-5000; Fax: 662-5008

From the following physician:

Name

Address

City

State

Zip

Phone

Fax

ALL OB/GYN MEDICAL RECORDS MUST BE RECEIVED PRIOR TO THE DAY OF YOUR APPOINTMENT. If you are unable to retrieve your records by your appointment time, unfortunately we will have to reschedule. We apologize for any inconvenience this may cause; however, this benefits you by allowing our office to give you the absolute best medical care.

Patient Signature: _____ Date: _____

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