ObGyne
Birthing Center for
Natural Deliveries

167 Martin Luther King Jr. Drive, Forsyth Georgia 31029
www.centerfornaturaldeliveries.com
478-394-6061 phone | 478-992-9786 fax
info@centerfornaturaldeliveries.com

Thank you for choosing us for your healthcare needs. Our mission at Obgyne Birth Center for Natural Deliveries is to create a welcoming and supportive environment where holistic women's wellness and safety are the highest priority, providing comprehensive well-woman, prenatal, labor, birth and postpartum care to families served.

Dr. Bola Sogade is board certified in Family Practice and Obstetrics & Gynecology. Dr. Sogade manages all deliveries for obstetric patients and performs all surgeries.

Ashley Marshall is a Certified Nurse Midwife with over eight years of experience. Ashley is proud to provide current, evidence-based yet compassionate care for both obstetric and gynecological patients.

To provide the most efficient care possible to our patients, the Obgyne Birth Center providers consist of our physician, midwife and nurse practitioners who all provide collaborative care to our patients.

Payment is due at the time of service. Please make checks payable to: **Obgyne Birth Center for Natural Deliveries.**
(Returned checks will be assessed a NSF Fee.)

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Legal Last Name:	First:	Middle:	Marital Status (circle one) Single/ Mar/ Div/ Sep/ Wid
Email Address:		Race (circle one) American Indian/ Alaska Native / Asian / Hawaiian /	
Emergency Phone Number: ( )		Black or African American / White / Hispanic / Other	
Birth Date:	Sex (check one) ☐ M ☐ F		Social Security No:
Street Address:	Cell phone: ( )		Home Phone: ( )
PO Box:	City:	State:	Zip Code:
Occupation:	Employer:		Employer Phone: ( )
Spouse Name:	Spouse DOB:		Spouse SSN:
Primary MD:	Primary MD Phone:		Primary MD Address:
Referring Doctor or Patient:	Cardiologist:		Permission to obtain records? (Circle One) ☐ YES ☐ NO

HEALTH INFORMATION DISCLOSURE:

Name/relation 1. _____ / _____ 2. _____/ _____

3. _____ / _____ 4. _____ / _____

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist)

Name of Primary Insurance:				Subscriber's S.S. No. (If different form patient)
Subscriber's name (if different from patient):				Birth Date:
Group #:	Policy #:			
Patient's relationship to subscriber:	☐ Child	☐ Self	☐ Spouse	☐ Other
Name of Secondary Insurance (if Applicable)				Subscriber's S.S. no. (If different form patient)
Subscriber's Name (if different from patient's)	Birth Date:			Patient's relationship to subscriber (circle one
Group #:	Policy #:			
OTHER INSURANCE:	Policy no.:			Group no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to Patient:	Home phone:	Work Phone:

The above information is true to the best of my knowledge. I hereby authorize direct payment to my physicians from my insurance company when applicable. I am responsible for any balance due my physicians that is not paid by my insurance carrier. Said balance is to be paid in a timely manner. I also authorize the release of any medical information to a referring physician or insurance company.

Patient/Guardian Signature:	**Date:**

NEW PATIENT MEDICAL HISTORY FORM

The following information is very important to your health. Please completely fill out this important information.

Patient Name _____ Age ____ Birth Date_____

Date _____ Chief Complaint_____

List current medications/supplements (include birth control pills): _____

_____

List all medication allergies: _____

_____

Review of your body systems: Do you have now or have you ever had any of the following?

	NO	YES	Please Explain
Abdominal Pain			
Abnormal Pap Smear			
Anemia			
Angina			
Anxiety Disorder			
Arthritis			
Asthma			
Back Pain			
Bleeding between periods			
Bleeding Ulcers			
Blood in Urine			
Blood Transfusion			
Blurred			
Bowel Disorders			
Breast Disease			
Cancer			
Chest Pain			
Chicken Pox			
Depression			
DES Exposure			
Diabetes			
Dizziness			
Endometriosis			
Excessive Thirst			
Extreme Menstrual Pain			
Fibroids			
Frequent Urination			
Gall Bladder disease			

	NO	YES	Please Explain
GERD			
H. Hernia / Peptic Ulcer			
Headache/Migraine			
Heart Disease			
Hypertension			
Infertility			
Insomnia			
Irregular Heart Beat			
Jaundice/Hepatitis			
Kidney Disease			
Lack of Bladder Control			
Low Blood Pressure			
Lung Disease			
Mumps			
Nipple Discharge			
Osteoporosis			
Painful Urination			
Pelvic Pain			
Respiratory Disease			
Psych. Illness / Depression			
Seizure Disorder			
Skin Disease			
Thyroid Disease			
Urinary Infections			
Varicose Veins / Phlebitis			

Past Surgical History:

Date	Procedure

Illness History (Other than Surgical Procedures):

Date	Illness

Family History

Family		Cause of Death	Age
Your Father			
Your Mother			
# Siblings	#Living #Deceased		

Family	Yes/No	If Yes, Which Family Member	
Heart Disease			
High Blood Pressure			
Diabetes			
Stroke			
Cancer			
If Yes, Location			
Thyroid Disease			
Other Diseases			

Tests (Give Date Last Done):

Test	Year Performed	Not Sure	Never Done	Results
Pap Smear				
Breast Exam				
Mammogram				
Rectal Exam				
Sigmoidoscopy				
Colonoscopy				
Cholesterol				
Rubella				
Triglycerides				
Thyroid Profile				
Tetanus (DPT)				
Bone Density				
Other				

Gynecology History:

Age Onset_____ Problems with Breasts_____

Date of Last Period_____ Unusual Vaginal Discharge_____

Periods - Regular____Irregular_____ Difficulty with Periods_____

OB History:

# of Children Born Alive_____ # of Cesarean Sections _____

# of Premature Births_____ # of Stillborn _____

# of Miscarriages_____ # of Abortions _____

Describe any Complications:

_____

_____

Your Personal Habits: Do You…?

	Yes	No	Please Explain
Do you exercise regularly (3-4x a week)?			
Do you use illegal drugs?			
Do you use alcohol?			
Were you ever a heavy drinker?			
Do you smoke?			
If ever, when did you stop?			
Do you have an eating disorder? Anorexia / Bulimia			
Have you ever been physically abused?			
Are you currently being physically abused?			
Do you feel safe in your home?			
Do you have sex with: men women both			
Any concerns?			

My signature indicates that the above information is true and correct to the best of my knowledge.

Patient Signature_____ Date _____

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Dr. Bola Sogade, MD, FAAP & FACOG
Karolyn Rodgers, CNM

Consent to Release Information

Patient Name_____

Date of Birth_____

Information to be released from:

Name/Agency_____

Address_____

City/State/Zip_____

Phone/Fax_____

Send Requested Medical Information to:

Name/Agency_____

Address_____

City/State/Zip_____

Phone/Fax_____

CHECK INFORMATION NEEDED:

☐ Immunizations ☐ Progress Report ☐ Lab Reports ☐ Radiology Reports/X-ray ☐ ER/Hospital

☐ Other _____

Please state any items you DO NOT want to be released. If left blank, Obgyne Birth Center for Natural Deliveries will release this information.

_____

_____

_____

This information is required for:

☐ Transfer of Care ☐ Personal Copy ☐ Consultation/Referral

If dissatisfaction with the clinic. Please specify: _____

I give permission to release only the information I've selected on this form to the individual(s) or agency(s) I've named and only for the purposes that I've checked. I understand that this release is valid for 60 days and I may refuse to sign this authorization or revoke benefits. The revocation will take effect on the day a signed copy is received by Obgyne Birth Center for Natural Deliveries. I have the right to access my treatment records. Copies of my records may be obtained with reasonable notice. I understand if the person or entity that receives the release of information is not a health care organization covered by the federal privacy regulations or a business associate of that organization that my privacy may no longer be protected.

Patient Signature_____ **Date**_____

Signature of Representative_____ **Date**_____

Authority to represent Individual: Parent ☐ Guardian ☐ Power of Attorney ☐ Authorized Representative

OFFICE USE ONLY

I have verified the Identity of the patient and obtained a photo ID of the person to whom the authorized release is to be made.

Staff Signature_____ **Date**_____ **Office Contact number**_____

Permission to Create a *Health Exchange record* and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program *(Health Exchange).* This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in the document, and have had the opportunity to have my questions answered about the *Health Exchange and this* permission form.

☐ **Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record**

☐ **No, I do not agree to participate in the Central Georgia Health Exchange electronic medical record**

_____	_____	_____
Printed Name of Patient/Representative	Signature of Patient/ Representative	Date

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis (Relationship to Patient) _____ [A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical records system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with the paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug use abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to redisclosure. However, the *Health Exchange* system incorporates access control, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures; clinic care; obtaining reimbursement for health care services; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet, "A Guide to the Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your doctor's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Health Exchange, 777 Hemlock Street, Hospital Box 98, Macon, GA 31201. Any withdraw of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, the extent I have refused permission, I understand that my Health Information will not be available to other providers (including The Medical Center of Central Georgia) through the *Central Georgia Health Exchange.*

Laboratory and Testing Patient Responsibility Policy

Obgyne Birth Center for Natural Deliveries may only fulfill some of your laboratory testing at Obgyne Birth Center. As a result, some of the testing may be submitted to a reference laboratory to bill for their services and will not allow pass through billing by another facility. The customer may receive a bill from the reference laboratory if any work is referred.

Unfortunately, Obgyne Birth Center staff does not know the specifics of all contracts and the patient will need to notify the staff to receive maximum reimbursement from their insurance provider. All patients need to know specifics of their current provider plan and any specifications about contracts with national reference laboratories. You can obtain this information by contacting your provider.

NB: *It is your responsibility to inform the staff, if you have a lab preference based on your insurance plan. You would be responsible for uncovered charges.*

Choice of Reference Laboratory if needed: _____

I have read and I agree to the Laboratory and Testing Patient Responsibility Policy.

_____ _____

Patient or Responsible Party (Print) Reason Person Cannot Sign

_____ _____

Patient or Responsible Party Signature Date

_____

Relationship to Patient Address Phone

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Lab Result Office Policy

Patient Advisory

Attention Patient:

I the undersigned adhere to the following as a standard procedure in regard to how I, the patient, will receive any and all results that pertain to any and all labs that have been done per requested by my provider.

- All patients are required to have an In-office provider consultation within 10-14 days of lab testing to discuss all lab results, regardless of outcome of the results. These visits are considered normal office visits and, as a result, patients will be required to pay all regular fees/co-pays.
- If the patient is symptomatic at the time of the office visit, they will be empirically treated by the provider as per ACOG/AAFP protocol at that time, while awaiting lab results.
- Results will ordinarily not be given over the phone or by mail to patients.

By signing below, I am agreeing to all terms and conditions that have been provided to me in according to the above guidelines.

_____ _____

Print Name Date

_____

Signature

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Patient Agreement

_____ I understand that, in the opinion of **Obgyne Birth Center's providers (and any of its entities), the** services or items that I have requested to be provided may not be covered under the my insurance or the Georgia Department of Community Health as being reasonable and medically necessary for my care. I understand that my insurance or Peach State through its contract with the Department of Community Health determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

_____ I understand that there is a $75.00 processing fee for all paperwork requested by patients. A two (2) week processing period is required and the $75.00 fee is due upon receipt of materials.

_____ I understand that if I am a "Self-Pay Patient", (meaning I have no insurance coverage), that I will be charged $150.00 on my first visit and $100.00 on subsequent visits.

_____ I understand that if I am a "Self-Pay Patient", (meaning I have no insurance coverage), that I may be charged additional fees for any Labs such as blood work, swabs or cultures, and

_____ I understand that these fees are assessed PathGroup, Inc., and will not hold OBGYNE BIRTH CENTER responsible for these fees.

_____ I understand that if I am a "Self-Pay Patient", (meaning I have no insurance coverage), that it is my responsibility to make sure I understand any and all treatment costs charged by OBGYNE BIRTH CENTER and am responsible for any and all payment(s) associated with my office visit.

_____ I understand that I will be charged a $35.00 "NO SHOW" fee if I fail to come in for my appointment or reschedule 24 hours prior. I understand that my insurance will not cover this fee and it is my responsibility.

_____ I acknowledge that I have been given access to the Privacy Policy and I am aware that it is available on the practice website: www.centerfornaturaldeliveries.com

_____ _____
Printed Name of Patient/ Representative DOB

_____ _____
Signature of Patient/ Representative Date