FAR HILLS ob/gyn

CAROLINE H. KENNEBECK, M.D. KELLY L. McCLUSKEY, M.D. SHANNON N. McAFEE, D.O. SAMANTHA E. HOUSER, D.O.
JENNIFER A . MITTLESTEAD, M.D. JOSEPH J. HANCOX, M.D. JENNIFER A. SMITH, M.D. MEGAN BONK, P.A.-C

Registration Form

Patient Information

Last Name:	First Name:	Middle Name:	Maiden Name:
Address:	City/State:		Zip:
DOB: / Age:	S.S. #:		Home Phone:
Employer Name:	Employment Status: ☐ Full time ☐ Part time ☐ Retired ☐ Not Employed		Work Phone: / Cell Phone:
Referring Physician:	Marital Status: ☐ M ☐ S ☐ D ☐ W		Pharmacy/Location:
Email:	Language:	Race:	Pharmacy Phone:
How did you hear about us? ☐ Other_____	☐ Insurance ☐ Yellow Pages	☐ Drive-By ☐ Internet	☐ Newspaper ☐ Family/Friend ☐ Special Events ☐ Magazine ☐ Hospital ☐ Physician Ref.

☐ Same as patient — Responsible Party Information (If different from patient)

Person who accompanies child to visit

Last Name:	First Name:	Birthdate:
Address:	S.S. #:	Relationship to patient:
Home Phone:	Cell Phone:	Work Phone:

Emergency Contact (spouse or nearest relative)

Emergency Contact Name:	Phone Number:
Is it OK to leave message with ER contact? ☐ Yes ☐ No	Relation to Patient:

Primary Insurance Information

Insurance Company:	Group # / Plan ID:	Member Number:
Subscriber Employer Name:	Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	Sex: ☐ M ☐ F
Subscriber Name:	Subscriber DOB:	Copay:

Secondary Insurance Information

Insurance Company:	Group # / Plan ID:	Member Number:
Subscriber Employer Name:	Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	Sex: ☐ M ☐ F
Subscriber Name:	Subscriber DOB:	Copay:

The undersigned patient or guardian certifies that the above facts are correct and agrees as follows:

1. Authority is granted to Far Hills OB/GYN, Inc. and Jennifer A. Smith OB/GYN LLC to render needed treatment and/or tests for the above named patient.
2. I authorize Far Hills OB/GYN, Inc. and Jennifer A. Smith OB/GYN LLC to release any information required for payment of claims.
3. I authorize my insurance or Medicare benefits to be paid directly to Far Hills OB/GYN, Inc. and Jennifer A. Smith OB/GYN LLC, realizing I am responsible to pay noncovered and unauthorized service.
4. If you are unable to keep your appointment, 24 hour cancellation notice is required. If you miss your appointment without notifying our office, you will be charged a $25.00 Cancellation/No Show Fee. This charge is not billable to your insurance.
   If you are more than ten minutes late for an appointment, you will need to reschedule. It is unfair to our other patients to make them wait when they have arrived on time.
5. Returned Check Fee: you are charged $35.00 if your check is returned from the bank.
6. 1.5% late fee is charged on unpaid balances over 90 days.

_____ _____

The above information is correct / Patient or Guardian Signature — Date

Far Hills OB/GYN, Inc. and Jennifer A. Smith OB/GYN LLC

(over)

Far Hills OB/GYN and Jennifer A. Smith OB/GYN LLC Fee Schedule 2026

Exhibit [A]

NEW PT			ESTAB. PT YEARLY			OFFICE PROCEDURES			B/C MAINTENANCE		
			Exam 12-17 Yrs	99394	$195.00	I&D Abscess Vulva/Perinea	56405	$525.00	Nexplanon Insert	11981	$300.00
O.V. Expanded	99202	$165.00	Exam 18-39 Yrs	99395	$195.00	I&D Bartholin Cyst	56420	$600.00	Nexplanon Removal	11982	$250.00
O.V. Detailed **New Pt. Problem or New Poss OB**	99203	$200.00	Exam 40-64 Yrs	99396	$195.00	Marsupialization	56440	$900.00	Insertion of IUD	58300	$140.00
O.V. Comp	99204	$210.00	Exam 65 + Yrs	99397	$195.00	Insertion of Pessary	57160	$130.00	Removal of IUD	58301	$160.00
O.V. Comp / Ext	99205	$235.00	**MEDICATION**			**MONA LISA**			**TESTING**		
ESTABLISHED PT			Depo-Provera 150 mg	J1055	$127.50	Mona Lisa (3) Laser Treatment Mona Lisa (3) Vulvar Treatment		$600.00 each or $1800.00 Series of (3)			
O.V. Brief	99211	$100.00	Gardasil	90649	$400.00	Mona Lisa (3) Combination Laser & Vulvar		$800.00 each or $2400.00 Series of (3)	Fetal Activity NST	59025	$150.00
O.V. Problem	99212	$125.00	Rhogam Tdap	90384	$210.00 $70.00	Touch-up (yearly) 4th Treatment		$600.00 $600.00	OB U/S < 14 wks	76801	$280.00
O.V. Expanded **Most gyn problems and OB f/u visits**	99213	$150.00	Administration Vac Administration not vac.	90471 96372	$30.00 $30.00				OB U/S > 14 wks	76805	$290.00
O.V. Detailed	99214	$175.00	**OFFICE PROCEDURES**			**LABORATORY**					
O.V. Complicated **gyn And Est. Poss OB**	99215	$185.00	Breast Aspiration	19000	$200.00	Urine Preg. Test	81025	$15.00	OB U/S - Limited	76815	$200.00
NEW PT YEARLY			Each additional	19001	$40.00	Wet / Dry Mount Slide	87210	$15.00	OB U/S - Repeat	76816	$200.00
Exam 12-17 Yrs	99384	$235.00	Colpo - Biopsy & ECC Colpo	57454 57455	$400.00 $300.00	*Other Labs billed out by Pathgroup			OB U/S - Vaginal	76817	$200.00
Exam 18-39 Yrs	99385	$235.00	Colpo - Diagnostic	57452	$325.00	Sneakpeak Gender 6 weeks		$175.00	Quick Scan	76815	$200.00
Exam 40-64 Yrs	99386	$235.00	Cryosurgery	57511	$300.00				Ultrasound - Vaginal	76830	$250.00
Exam 65 + Yrs	99387	$235.00	Dest. Of Condyloma (Simple)	56501	$200.00	**IUD DEVICES**			Ultrasound - Pelvic	76856	$250.00
			Vulvar Biopsy (1) Vulvar Biopsy (add)	56605 56606	$425.00 $150.00	Kyleena Liletta	J7296 J7297	$1500.00 $1300.00	U/S IUD Position	76857	$130.00
			LEEP Endometrial Biopsy (Emb) Hysteroscopy DX Hysteroscopy w/bx Hysteroscopy w/ Novasure Ablation	57522 58100 58555 58558 58563	$1200.00 $200.00 $700.00 $1500.00 $4500.00	Mirena Nexplanon Paragard	J7298 J7307 J7300	$1500.00 $1500.00 $1500.00	3d U/S 28 - 32 weeks 3d Gender U/S Can do at 15 weeks		$200.00 $175.00

Copy of Fee Schedule: *Failing to provide proper insurance information at time of service, and / or lack of information within 7 days of visit will forfeit filing a claim(s) and you agree to pay services rendered. _____ Sign / Date

Far Hills OB/GYN, Inc. and Jennifer A. Smith OB/GYN LLC

POS Reorder # 1808472

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Financial Policy

1. All co-pay / co-insurance amounts are due at each visit or procedure.
2. Charges not covered by insurance are due at the time of service.
3. Balances remaining after insurance payment are due within 30 days.
4. Any unpaid balance after 90 days will be charged a service charge / late fee of 1.5% per month until the account is paid in full.
5. We accept cash, check, Visa, Mastercard and Discover.
6. There is a returned check fee of $35.00 for any checks returned without payment from your bank.
7. Appointment Cancellation Notice required: You are to give a 24-hour cancellation notice for any and all appointments. Failure to cancel appointments without giving a 24-hour cancellation notice will be charged a $25.00 cancellation fee.
8. Failing to provide proper insurance information at time of service, and / or lack of information within 7 days of visit will forfeit filing a claim(s) and you agree to pay services rendered.
9. See Far Hills OB/GYN, Inc. and Jennifer A. Smith OB/GYN LLC In Office Fee Schedule. We are providing you a listing of our costs and if you do not see a procedure listed under Exhibit [A] we can provide this for you in advance.

Maternity Care / Surgery

1. Insurance benefits for maternity / surgery will be verified through your insurance carrier. For maternity, monthly payments will be established through the months of your prenatal care, so that your out-of-pocket expenses are credited two months prior to your due date.
2. For surgery, a prepay deposit may be requested, depending upon your out-of-pocket expenses as quoted by your insurance carrier.

Collection Accounts

1. **If you allow your account to go to collection, you are notifying our office that you are terminating the doctor / patient relationship.**
2. If your account has been sent to collection, after paying the entire balance plus late fees, you will be on a PAYMENT AT TIME OF SERVICE for one year. You then will be permitted to return to a normal pay structure.
3. If your account has been sent to collection TWICE, you may return to our office after clearing your collection balance and fees. You will be put on a permanent PAYMENT AT TIME OF SERVICE basis.
4. Accounts are sent to collection starting at 90 days unless payment arrangements have been made. You will be responsible for balance due and late fees of 1.5% / 18% annually.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES THAT ARE NOT COVERED BY MY INSURANCE. PAYMENT IS EXPECTED AT THE TIME OF MY VISIT. IF THIS CANNOT BE DONE, I AGREE TO MAKE OTHER ARRANGEMENTS WITH THE BILLING DEPARTMENT. I ALSO AGREE TO PAY ANY FEES FROM ANY PAST DUE AMOUNTS.

_____ _____

Patient Date

(over)

Patient Name: _____ Date of Birth: _____

Home Address: _____ Pref. Pharmacy: _____

_____
City State Zip Code

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Statement of Release

The purpose of this form is to give the physicians and staff of this office permission to release your medical information (such as lab or test results) to any person you designate when we are unable to reach you. This will also allow us to give your medical information to a friend or family member who may call on your behalf. This consent will remain in effect until updated by you. Please read carefully and sign below.

I hereby authorize the physicians and/or clinical staff of Far Hills OB/GYN, Inc. and Jennifer A. Smith, OB/GYN LLC to release information pertaining to my patient file to the following person(s):

_____ _____ _____
(Name) (Telephone) (Relationship)

_____ _____ _____
(Name) (Telephone) (Relationship)

_____ _____ _____
(Name) (Telephone) (Relationship)

_____ _____ _____
(Name) (Telephone) (Relationship)

_____ _____ _____
(Name) (Telephone) (Relationship)

☐ I DO NOT authorize the physicians and/or clinical staff of Far Hills OB/GYN, Inc. and Jennifer A. Smith OB/GYN LLC to release information pertaining to my patient file to any person(s).

PATIENT SIGNATURE _____ *DATE:* _____

Messages may be left on my answering machine / cell phone / voice mail:

☐ *YES* ☐ *NO*

Preferred method of contact:

☐ Home phone ☐ Cell phone ☐ Text message ☐ Email

☐ Other _____ _____
Email address

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Notice of Privacy 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.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information: The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician who we have requested to be involved in your care. *For example* - we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment. We will use and disclose your protected health information to obtain payment for the health care services we provide you. *For example* - we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We will use and disclose your protected health information to support the business activities of our practice. *For example* - we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information:

Appointment Reminders. We will use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives. We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care. We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care.

Research. We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law. We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Workers' Compensation. We will use and disclose your protected health information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Inmates. We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

(over)

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MEGAN BONK, P.A.-C

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, _____

have received a copy of this office's Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

Far Hills OB/GYN, Inc. and Jennifer A. Smith OB/GYN LLC

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowlegement could not be obtained because:

( ) Individual refused to sign
( ) Communication barriers prohibited obtaining the acknowlegement
( ) An emergency situation prevented us from obtaining acknowlegement
( ) Other (Please Specify)_____

_____

Your Health Information Rights: Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager, at 5701 Far Hills Avenue, Dayton, OH 45429. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if: 1. the information was not created by us, or the person who created it is no longer available to make the amendment; 2. the information is not part of the record which you are permitted to inspect and copy; 3. the information is not part of the designated record set kept by this practice; or 4. if it is the opinion of the health care provider that the information is accurate and complete.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. *For example* - you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information). Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. *For example* - you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice manager or directly to the Secretary of Health and Human Services.

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to 5701 Far Hills Avenue, Dayton, OH 45429. You should know that there would be no retaliation for your filing a complaint.

Uses or Disclosures Not Covered: Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information: If you have questions or would like additional information, you may contact our practice manager at 5701 Far Hills Avenue, Dayton, OH 45429.

Effective Date: 4/14/03

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Medical History

PLEASE ANSWER ALL QUESTIONS ON THIS FORM

Date _____

Patient's name _____ Birth date _____

Who referred you here? _____

What is your main problem for coming to the doctor today? _____

_____

_____

Are you taking any medicines, including birth control pills? Please list all medications: _____

_____

_____

Which type of birth control do you use, if any? _____

Are you allergic to any medications? If you have any allergies please list reaction you have had: _____

_____

When did your last period start? _____

When was your last Pap smear? _____

Have you ever had an abnormal Pap smear? If so, please list date with results: _____

Have you ever had herpes or any sexually transmitted diseases? Please list: _____

_____

Have you had previous surgery? _____

Dates & Types: 1. _____

2. _____

3. _____

4. _____

5. _____

If you have had any pregnancies, including miscarriages or others, please list all: _____

	Date	Length of Labor (Hours)	Sex	Birth Weight	Complications
1.					
2.					
3.					
4.					
5.					
6.					

(over)

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Health History Form

Have you or an immediate member (mother, father, sister, brother or grandparent) ever had any of the following conditions?

Check and detail positive findings including date and place of treatment. Precede findings by reference number.

		Patient	Family
1.	Congenital anomalies	_____	_____
2.	Genetic diseases	_____	_____
3.	Multiple births	_____	_____
4.	Diabetes mellitus	_____	_____
5.	Malignancies	_____	_____
6.	Ovarian cancer	_____	_____
7.	Breast cancer	_____	_____
8.	Hypertension	_____	_____
9.	Heart attack	_____	_____
10.	Stroke	_____	_____
11.	Rheumatic fever	_____	
12.	Pulmonary disease	_____	_____
13.	GI problems	_____	
14.	Renal disease	_____	_____
15.	Genitourinary tract problems	_____	
16.	Abnormal uterine bleeding	_____	
17.	Infertility	_____	
18.	Venereal disease	_____	_____
19.	Blood clots – leg or lung	_____	_____
20.	Phlebitis varicosities	_____	
21.	Emotional / psychological disorders	_____	
22.	Neurologic disorders	_____	_____
23.	Headaches / migraines	_____	
24.	Metabolic / endocrine disorders	_____	_____
25.	Anemia / hemoglobinopathy	_____	_____
26.	Blood disorders	_____	_____
27.	Infectious diseases	_____	
28.	Skin problems	_____	
29.	Operations / accidents	_____	
30.	Allergies / meds sensitivity	_____	
31.	Blood transfusions	_____	
32.	Other hospitalizations	_____	
33.	Thyroid disease	_____	_____
34.	Arthritis	_____	_____
35.	**No known diseases / problems**		

Do you drink alcohol? _____ If so, how many drinks per week? _____

Do you use recreational drugs? _____ If so, what do you use? _____

How much? _____ How often? _____ Would you like to quit? _____

Do you smoke? _____ How many per day? _____ Would you like to quit? _____

Name: _____