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Obstetrics & Gynecology

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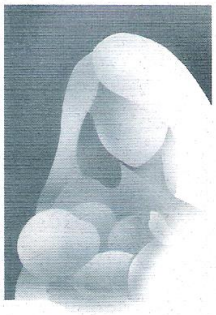

Welcome To Our Office

We are happy that you have chosen us as your OB/GYN Practice. We will make every effort to make you feel comfortable and to service your needs in this field of medicine. You will find the following information helpful as you become acquainted with our office.

We have five physicians in our Practice and each has been trained specifically in the field of Obstetrics and Gynecology and are certified and qualified in this field. They have an excellent support staff of Registered Nurses and Medical Assistants as well as our Business Office Staff who will cheerfully help you in any way that they can be of service.

We have three locations to serve you:

Union Rd/Williamsville	Delaware Ave/Kenmore	Broadway/Alden
716-633-6363	**716-259-8220**	**716-259-9026**
Mon-Thurs 8-7:30 pm	Mon-Thurs 11-4:00 pm	Fridays only 8-2:30 pm
Fridays 8-2:30 pm	Closed Fridays	

Making and Canceling Appointments

We have ample time each day for scheduling visits; however, regular checkups such as yearly visits are often filled to capacity and are best scheduled several weeks in advance. If you are unable to keep your scheduled appointment, 24 hour notice of cancellation would be appreciated. Rest assured that we make every effort to see our scheduled patients on time; however, emergencies do occur that will sometimes affect our schedule. We will let you know when that happens and we apologize if you are caused any delay. We thank you for your patience.

What To Expect on Your Initial Office Visit

Your initial office visit is more detailed than your follow up and yearly visits. The receptionist will need to copy your insurance card and take your photo for identification purposes. You will then be interviewed by our nursing staff who will obtain your medical history. Next you will consult with the Physician to gather any additional information about you and your medical needs. You will then be prepared by the nursing staff to be examined by the Physician.

What To Do In An Emergency After Hours

Please call the office during business hours with any health concerns you may have as most emergencies can be satisfied through our office. The receptionist will take your information and return your call as soon as possible, depending on the urgency. Please allow 24 hours for all prescription refills. Please remember that your call is important to us and we will do all we can to help you. After office hours, please call our answering service at (716) 827-1625 and they will have a doctor return your call.

Please restrict non-emergency calls to regular office hours.

Medical Insurance Claims

Depending on your insurance coverage, all or part of your expenses will be covered. Our office currently participates with many different insurance companies, too numerous to be mentioned individually. Please feel free to call us and discuss your insurance with our Billing Office. She can make you aware of any special requests from the insurance companies, such as copays, referrals, deductibles, etc. **All copays are expected at the time of service.**

If you participate with insurance plans that are considered "private pay" plans or "high deductible" plans, we will ask for payment at the time of service. For your convenience, we do take cash, checks and credit cards.

An Explanation of Fees and Payments

We make every effort to keep your medical costs as affordable as possible. One way to accomplish this is by asking that you pay at the time of service. This saves us postage and clerical costs that would otherwise be reflected in your bill. Any account that needs to be billed 30 days past due will reflect a finance charge. Any account placed with our collection service will be held responsible for all collection fees incurred. Questions regarding charges, payments or insurance can be answered by calling our Billing Office at (716) 633-6363 from 8:30 am to 5:00 pm daily.

We have enclosed a short questionnaire for you to fill out and return to us before your appointment. This will help the receptionist in completing your chart as quickly and efficiently as possible as not to delay your appointment time. It would also be helpful for you to arrive approximately 15 minutes prior to your scheduled appointment. This form is confidential, as is all your medical information, and will become part of your permanent record.

A stamped, return envelope has been enclosed for your convenience. Thank you for allowing us to service your medical needs.

If you have any questions or concerns, please do not hesitate to call us at (716) 633-6363.

Sincerely,

LouAnne Phillips
Office Manager

PATIENT QUESTIONNAIRE

Name _____ Date of Birth _____ Age _____

Address _____

City/Town _____ Zip _____ Marital Status _____

Home # _____ Work # _____ Spouse/Parent Name _____

Employer _____ Spouse/Parent DOB _____

Occupation _____ Spouse/Parent SS # _____

Spouse/Parent Employer _____ Employer Telephone # _____

INSURANCE INFORMATION

Primary Ins. _____ Secondary Ins. _____

Address _____ Address _____

Policy ID # _____ Policy ID # _____

Effective Date of Insurance _____ Effective Date of Insurance _____

Name of Subscriber _____ Name of Subscriber _____

Relationship & DOB _____ Relationship & DOB _____

For confidentiality reasons, please list family members or other persons, if any, whom we may inform about your medical condition and diagnosis in case of an emergency.

Name _____ Relationship _____ Telephone _____

Name _____ Relationship _____ Telephone _____

For confidentiality reasons, please print the telephone number where we can call you regarding your appointments, test results or other health care information.

Home _____ Work _____ Other _____

If there is no answer at this number(s), can we leave a message? Yes No

PAYMENT AUTHORIZATION

Insurance Companies require your signature on file for us to submit claims and release information to medical providers. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered. I will be held responsible for all finance charges of 1-1/2% added to my account after 30 days, and will be responsible for any and all collection fees should I become delinquent. I have completed this questionnaire and I certify that this information is to be true to the best of my knowledge. I certify that any medical information may be released to my health insurance carrier for processing medical claims.

PATIENT SIGNATURE _____ DATE _____

GENERAL MEDICAL INFORMATION

Describe the current medical problem/reason for today's visit: _____

_____

Present Medications: _____

Allergies to Medication: _____

Other Physicians Currently Treating You: _____

Previous or Other Medical Problems: _____

List Any Previous Surgeries or Hospitalizations (include number of miscarriages and live births):

_____

Are You Pregnant, Planning a Pregnancy or Nursing a Child? □ Yes □ No

Do You Smoke? □ Yes □ No □ Cigarettes □ Other No. of Years _____

How Much Do You Smoke? _____ Interested in Stopping? □ Yes □ No

Do You Regularly Drink Alcohol? □ Yes □ No How Much Per Day? _____

Do You Drink Coffee? □ Yes □ No How Many Cups Per Day? _____

Are You Under A Lot Of Pressure At Work? □ Yes □ No Please Describe _____

_____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following (check *all that apply*):

□ Chest pain/pressure_____
□ Hypertension _____
□ Heart Attack _____
□ Stroke _____
□Headaches _____
□ Difficulty Hearing _____
□ Allergies or Eczema _____
□ Depression _____
□ Frequent Urinary Infections _____

□ Asthma _____
□ Dizzy Spells _____
□ Cancer _____
□ Diabetes _____
□ Arthritis _____
□ Glaucoma _____
□ Cataracts _____
□ Hemorrhoids ____

□ Kidney Disease_____
□ Shortness of Breath _____
□ TB/Lung Disorder _____
□ Ulcers _____
□ Skin Disorders _____
□ Hepatitis _____
□ Memory Loss _____
□ Blood in Stool _____
□ Other _____

FAMILY HISTORY

	Father	Mother	Fathers Parents	Mothers Parents	Siblings	Children
High Blood Pressure	□	□	□	□	□	□
Cancer	□	□	□	□	□	□
Heart Attack/Stroke	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□
Asthma	□	□	□	□	□	□

Immunizations: (Add year, if known):

□ Smallpox ____ □ Tetanus ____ □ Typhoid ____ □ Polio ____
□ Influenza ____ □ Pneumonia _____ □ Rubella _____ □ Hepatitis _____