Obstetrics & Gynecology Associates

Dear Patient,

Women today are busier than ever juggling a family, commitments and career obligations so in an effort to adhere to your appointment time we are sending you this paperwork in advance.

Please bring the completed forms to the office on the day of your appointment along with the following information and documents

- **Arrive 30 minutes prior to your scheduled appointment time**
- **Current driver's license or other government issued picture identification**
- **Insurance card**
- **Medical records from other physicians.**
- **Referral; if required by your insurance company**

Be prepared to pay co-payments or deductibles at the time of your visit. Our office will verify your insurance benefits prior to your scheduled appointment but the staff **will not** call employers, human resource departments, spouses or parents to obtain your insurance information. **If you do not provide the office with current insurance information you will be asked to pay for services, in full, at the time of your appointment.** Please direct any questions you may have regarding your benefits to your insurance company. We accept cash, checks, Master Card, Visa, American Express and Discover.

Thank you for taking the time to complete this information. We look forward to serving you.

Sincerely,

The Staff of Obstetrics and Gynecology Associates

Please complete the attached forms and bring them to your office visit

4001 Long Prairie Rd. Suite 150
Flower Mound, TX 75028
972-420-1470 (phone)
972-420-1465 (fax)

Obstetrics & Gynecology Associates

PATIENT REGISTRATION

PATIENT INFORMATION:

Patient Name _____ Date of Birth

Address _____City/ST/Zip

Home Phone _____ Cell Phone _____ Work Phone_

Preferred Contact Phone Number _____ ☐ Cell ☐ Home ☐ Work

Email _____Social Security

Driver's License Number & State of Issue: _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employed: ☐ Full-time ☐ Part-time ☐ Student ☐ Not Employed

Employer: _____Employer Address:_____

Nearest relative not living with _____Phone#

Emergency contact _____Phone #_____

Assignment of Health Insurance Benefits and Consent to Treat

I hereby consent to treatment at Lewisville Obstetrics & Gynecology Associates, P.A.
I request payment of authorized benefits for medical services provided to me be paid by my insurance carrier to Lewisville Obstetrics & Gynecology Associates, P.A. I authorize the release of any medical information necessary to determine benefits due. I understand I am financially responsible for any charges not covered by my healthcare benefits. Co-payments and deductibles are due at the time services are rendered. I am responsible for the entire bill if the claim is denied by my insurance carrier. I understand by signing this form I am accepting financial responsibility as explained above for all services rendered.

Patient Name (PRINT)_____ **Date of Birth:**_____

Patient Signature:_____ **Date** _____

Obstetrics & Gynecology Associates

You are required to disclose all of your insurance information to our office including insurance through your employer, spouse's employer, parent, guardian, school, Medicaid or Medicare. If you are seeking treatment for a condition not covered by your health insurance plan you are still required to disclose other insurance information to our practice.

Are you insured through an ACA insurance plan purchased on the Healthcare Market Place: ☐ Yes ☐ No

Are you insured through your employer, your spouse's employer, parent or guardian: ☐ Yes ☐ No

Are you insured through Texas Medicaid or Medicare ☐ Yes ☐ No

Are you insured through a school: ☐ Yes ☐ No

PRIMARY INSURANCE INFORMATION

Insurance Co _____ Phone _____

Address _____ City/ST/Zip _____

Policyholder _____ Policyholder Social _____ Policyholder DOB _____

Policyholder ID _____ Group _____ Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer _____ Address/City/St _____

SECONDARY INSURANCE INFORMATION

Insurance Co _____ Phone _____

Address _____ City/ST/Zip _____

Policyholder _____ Policyholder Social _____ Policyholder DOB _____

Policyholder ID _____ Group _____ Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer _____ Address/City/St _____

I certify the above information is correct and I have disclosed all of my insurance information to Obstetrics & Gynecology Associates. I understand if I falsified or fail to disclose insurance information to Obstetrics & Gynecology Associate, now or at any time during my treatment, I will assume financial responsibility for all charges billed by my doctor.

Patient Name (PRINT) _____ **Date of Birth** _____

Patient, Parent, Guardian Signature: _____ **Date:** _____

Obstetrics & Gynecology Associates

THIS AUTHORIZATION REMAINS IN EFFECT UNTIL REVOKED IN WRITING

Notice of Privacy Practice Receipt

I was provided a copy of Obstetrics & Gynecology Associates Notice of Privacy Practices.

Print Patient Name DOB Relationship to Patient

Signature of Patient or Patient Representative Date

READ THE INFORMATION BELOW CAREFULLY

Obstetrics & Gynecology Associates will only release your appointment, billing, medical information, etc. to the person(s) listed below. We will not return or accept phone calls from anyone other you or the person(s) listed below.

May we release information to anyone other than you? ☐ Yes ☐ No

Name of the person(s) we may release your information to:

Name: _____Relationship_____

Name: _____Relationship_____

COMMUNICATION

What is the best way to contact you with test results & medical information?

Phone Number _____

☐ Leave a detailed message that includes test results, medical conditions, prescription refills, etc.

Phone Number _____

☐ Only leave a message to call the office.

I authorize Obstetrics & Gynecology Associates to release periodic status reports to physicians or facilities participating in my care. I understand my medical records are confidential and cannot be disclosed without my written authorization except where otherwise provided by law. Records pertaining to the diagnosis and/or treatment of HIV/AIDS, psychiatric illness and alcohol or chemical abuse dependency will not be released without consent. A photocopy or facsimile of this consent is as valid as the original. Obstetrics & Gynecology Associates may release medical information to my insurance company needed to process my claim.

I agree to be responsible for all lawful debts incurred for medical services received from Obstetrics & Gynecology Associates.

Patient Name (PRINT)_____Date of Birth:_____
Patient Signature: _____ Date: _____

Obstetrics & Gynecology Associates

Patient Name (PRINT):_____ **Date of Birth:**_____

The government, in an effort to promote transparency of investments to consumers or potential consumers, believes that hospitals should disclose at the time of admission or registration, whether there are physician investors/owners of the facility. This disclosure includes whether any of the physicians have immediate family members who are also investor/owners.

A physician-owned hospital is defined as "any Medicare participating hospital in which a physician(s) have an ownership or investment interest. The ownership or investment interest may be through equity, debt or other means and includes an interest in an entity that holds an ownership interest in the hospital."

Texas Health Presbyterian Flower Mound and Assure Fertility Partners of Dallas, LLC have physician investors and a list of the physician investors in this practice is as follows:

Andrea Galusha, M.D., Lauren Banks, M.D., Janice Mitchell, M.D. and Ashley Birmingham-Presbyterian Flower Mound

Janice Mitchell, MD-Assure Fertility Partners of Dallas, LLC

Patient Signature: _____ **Date:** _____

Patient Name (PRINT):_____ Date of Birth:_____

NOTICE OF PRIVACY POLICY AND PROCEDURES

Obstetrics & Gynecology Associates will strive to make your experience with our office pleasant. We are here to serve you. If at any time you are unhappy with our office, please contact our office manager 972-420-1470 Ext. 127. Your comments are always appreciated.

On your first visit to our office you will be asked to complete several forms, these will be kept as part of your medical record. Complete these forms carefully.

OFFICE HOURS: ☐ **Patient initials**

- General office hours are from 9am-5pm on Monday-Thursday and 7:30am-3:00pm on Friday. Visits are by appointment only. Our main telephone number is 972-420-1470. We ask 24 hours advance notice of appointment cancellations.

APPOINTMENTS: ☐ **Patient initials**

- If you fail to keep an appointment with one of the physicians without calling to cancel you will be charged a $25.00 fee that is non-refundable and is not charged to your insurance company. You will be asked to pay the fee at your next appointment.

INSURANCE: ☐ **Patient initials**

- Whether you are insured through an individual/family policy purchased from the Healthcare Market Place, an employer's group health insurance plan or a government sponsored program, our Billing Department must be able to verify you are eligible for healthcare benefits and, if applicable, your premiums are paid through the date you are seeing the physician. If we are unable to verify either of these criteria, you will be asked to pay for medical services in full or reschedule the appointment until a time insurance coverage can be verified.
- If at any time during your treatment your insurance information changes or terminates you must notify the Billing Department immediately or you may be financially responsible for services rendered.
- We participate in most major insurance plans. Please contact your insurance company to verify our participation in your plan. You will be asked to provide our office with your most current insurance information each time you call and schedule an appointment. Our office will verify your benefits prior to your appointment. You must bring your insurance card to your office visit. Without the card we will not file your insurance and will ask for payment in full.

LAB and PATHOLOGY: ☐ **Patient Initials**

- You may receive a separate bill from Quest, Lab Corp or Path Advantage for labs, pathology, etc., performed in our office. The office bills for the professional service provided by the physician and any device or medication administered.

PAYMENTS: ☐ **Patient Initials**

- Payment is expected at the time of service, including but not limited to co-payments, co- insurance, deductibles and non-covered services. Payment options available include: cash, check, Visa, Master Card, American Express and Discover. Payment arrangements must be made with the Billing Department in advance of the service being performed.
- If at any time during your care you apply for and are approved for any Government sponsored program (Medicaid) it is your responsibility to notify our Billing Department immediately. This Practice is not liable for any financial penalty a patient may suffer because our Billing Department was not informed of your insurance status. A copy of your Medicaid card must be given to our office as soon as it is received.

Patient Name (PRINT):_____ **Date of Birth:**_____

- Obstetrics & Gynecology Associates offers a 30% discount to uninsured patients who pay for services in full at the time of service.
- Payments for services rendered and not paid in full at the time of service are due at 100% of our billed charges; the uninsured discount will not apply.
- Payment plans are only made for patients with an established payment history and are made at the discretion of Practice Management. Payment plans are not made for new patients.
- Payment plans must be made with our Billing Department in advance of the service being rendered.
- All co-payments, deductibles and copayments are due at the time services are rendered.

MEDICAL RECORDS: ☐ **Patient Initials**

- **Electronic copy**: $25.00 first 500 pages and $50.00 for over 500 pages.
- **Paper copy**: $25.00 for the first 20 pages of records and .50 for each page thereafter plus postage and handling.

FORMS: ☐ **Patient Initials**

- $15.00 charge for completing disability or FMLA forms

EMERGENCY CARE: ☐ **Patient Initials**

- **If you judge any problem to be life threatening, go to the nearest emergency room.** Phones are answered 24/7. After office hours emergencies only call 972-420-1470 to have the on-call physician paged. If your call is judged by the on-call physician to be non-urgent your account will be charged $25.00 which must be paid prior to your next visit to the office. **Please do not call after hours for test results or medication refills. The on-call physician will not return these calls after business hours.**

PRESCRIPTION REFILLS: ☐ Patient Initials

- Please allow two business days for all non-emergency prescription refills. We ask our patients to contact the pharmacy where the medication was initially filled to request a refill. Your pharmacy will contact our office for refill approval. **Refill requests must be called in before 2pm. Requests received after 2pm may not be processed until the next business day.**

I have read and understand Obstetrics & Gynecology Associates Payment and Insurance Policy and received a copy of the Notice of Privacy Practices.

Signature: _____ **Date:** _____

Hereditary Cancer Screening

If it has been more than one month since you last completed this form, please complete it again.

Patient Name(Print): _____ **Date of Birth:** _____

Physician: _____ **Date Completed:** _____

Instructions: Please circle "Y" for any of the diagnosis or conditions that apply to YOU and/or YOUR FAMILY. Please list the relationship of each of the individuals diagnosed (Self, Aunt, Uncle, Grandmother) and their age at diagnosis. This is a screening tool for Hereditary Cancer Syndromes. If you circle "Y" to any of the statements below you may be a candidate for genetic testing.

BREAST & OVARIAN CANCER (BRCA)			Relationship	Mother's Side	Father's Side	Age Diagnosed
Y	N	Breast Cancer		Y	Y	
Y	N	Ovarian Cancer		Y	Y	
Y	N	Breast Cancer in both breasts or multiple		Y	Y	
Y	N	Male Breast Cancer		Y	Y	
Y	N	Pancreatic Cancer		Y	Y	
Y	N	Prostate Cancer		Y	Y	
Y	N	Triple Negative Breast Cancer		Y	Y	
Y	N	Are you of Jewish descent		Y	Y	
Y	N	Family member with known BRCA Mutation		Y	Y	
COLON & UTERINE CANCER (COLARIS)			**Relationship**			
Y	N	Colon Cancer		Y	Y	
Y	N	Uterine Cancer		Y	Y	
Y	N	Ovarian, Stomach, Kidney/Urinary Tract, Brain or other cancers		Y	Y	

____ Information given to patient to review

____ Candidate for further risk assessment and/or genetic testing

____ Patient offered genetic testing

____ Follow up appointment scheduled ☐ Accepted ☐ Rejected

Patient Signature: _____ Date _____

Physician Signature: _____

Date: _____ Page 1

Dr. _____

Patient Name:(PRINT) _____Date of Birth_____

FIRST DAY OF YOUR LAST MENSTRUAL PERIOD:	

Are you having an medical problems today:

Please list any recent changes in medical history:

Social History		
	Y/N	**How much per day**
Smoker		
Alcohol		
Drug Use		
Martial status: (circle one) **Married Single Divorced Widowed**		
Work history:(circle one) **Full time Part time Student Work/Home**		
Sexually active: (circle one) **Yes or No**		
Are you sexually active with (circle all that apply) **Men Women Both Decline to answer**		

Have you had any surgery since your last visit to our office
_____
_____
_____

Pharmacy	
Pharmacy Name:	
Pharmacy Street & City:	
Pharmacy Phone Number:	

Are you currently taking any medication:			
Name of the Medication		**Dosage**	**Allergies**

Date: _____ Page 2

Dr. _____

Patient Name(PRINT): _____ Date of Birth_____

Please check any of the symptoms you are currently having			
Systemic		**Urinary**	
Weight change > 5 lbs	☐	Pain with urination	☐
Chills	☐	Increased frequency of urination	☐
Fever	☐	Bloody urine	☐
Night sweats	☐	**Female Reproductive**	
Fatigue	☐	Genital lesion or growth	☐
Neck		Abnormal vaginal bleeding	☐
Neck pain	☐	Painful periods	☐
Lump in neck	☐	Heavy periods	☐
Difficulty swallowing	☐	Premenstrual syndrome (PMS)	☐
Breasts		Painful intercourse	☐
Breast pain	☐	Abnormal vaginal discharge	☐
Nipple discharge	☐	Pelvic pain	☐
Breast lump	☐	**Skin**	
Cardiovascular		Skin lesions or moles	☐
Chest pain	☐	Rash	☐
Palpitations	☐	**Endocrine**	
Respiratory		Hot flashes	☐
Shortness of breath	☐	Excessive thirst	☐
Persistent cough	☐	Cold intolerance	☐
Wheezing	☐	**Neurologic**	
Gastrointestinal		Dizziness	☐
Heartburn/reflux	☐	Fainting	☐
Nausea	☐		
Vomiting	☐	**Psychological**	
Abdominal pain	☐	Sleep disturbances	☐
Diarrhea	☐	Anxiety	☐
Chronic constipation	☐	Depression	☐
Black or bloody stools	☐		

Patient Name(PRINT):_____
Date of Birth:_____

In an effort to provide the best experience during your office visit today, please take a few minutes to complete the following questions. It will help us keep current on very important health issues affecting you and it will allow the most efficient use of time with the doctor.

Contraception:

1. Are you currently using hormonal contraception (birth control)? Yes_____No_____

2. What specific form of birth control are you using?_____

3. Are you planning another child or more children?

Within next year___Within next 5 years_____Within next 10 years____My family is complete___

Menstrual Periods

1. How long does your average monthly period last? ____days

2. Do you ever feel as though your periods impact your quality of life? Yes_____No_____

3. Do you ever experience irregular or inconsistent bleeding patterns? Yes_____No_____

Urinary Health

1. Do you ever leak urine when you cough, laugh or sneeze? Yes_____No_____

2. Do you ever feel as though you have to urinate urgently? Yes_____No_____

3. Do you feel like you have to urinate too frequently? Yes_____No_____

4. Do you ever experience painful urination? Yes_____No_____

5. Is your sleep ever interrupted by the need to urinate? Yes_____No_____

Obstetrics & Gynecology Associates

RETAIN THIS COPY FOR YOUR RECORDS

NOTICE OF PRIVACY PRACTICES

When it comes to your health information, you have certain rights.

YOUR CHOICES:

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why, in writing, within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask who we shared information with and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another accounting within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting our Privacy Officer:

Patty Turner
4001 Long Prairie Rd. Suite 150
Flower Mound, TX 75028
972-420-1470 Ext. 127

- You can file a complaint:

U.S. Department of Health and Human Services Office for Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
1-877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints

WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT

RETAIN THIS COPY
FOR YOUR RECORDS

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information if the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

YOUR CHOICES:

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information with a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Sharing of psychotherapy notes

How do we typically use or share your health information? We typically use or share your health information in the following ways

OUR USES AND DISCLOSURES:

Treat you

- We can use your health information and share it with other professionals who are treating you.

Run our organization

- We can use and share your health information to run our practice, improve your care and contact you when necessary.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information? We are allowed or required to share your information in other ways- usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information: ***www.hhs.gov.oc/privacy/hipaa/understanding/consumers/index.html***

OTHER USES AND DISCLOSURES:

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone's health and safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donations requests

- We can share health information about you with organ procurement organizations.

RETAIN THIS COPY
FOR YOUR RECORDS

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address wo rkers'comp en sa tion , law enforcement, and other government requests

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government function such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order or in response to a subpoena.

OUR RESPONSIBLITIES:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can, in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the terms of this notice

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

This Notice of Privacy Practices applies to the following organization:
Lewisville Obstetrics & Gynecology Associates, P.A. d.b.a. Obstetrics & Gynecology Associates
4001 Long Prairie Rd. Suite 150
Flower Mound, TX 75028
972-420-1470

Please retain this copy for your records

NOTICE OF PRIVACY POLICY AND PROCEDURES

Obstetrics & Gynecology Associates will strive to make your experience with our office pleasant. We are here to serve you. If at any time you are unhappy with our office, please contact our office manager 972-420-1470 Ext. 127. Your comments are always appreciated.

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-

APPOINTMENTS:

- If you fail to keep an appointment with one of the physicians without calling to cancel you will be charged a $25.00 fee that is non-refundable and is not charged to your insurance company. You will be asked to pay the fee at your next appointment.
-

INSURANCE:

- Whether you are insured through an individual/family policy purchased from the Healthcare Market Place, an employer's group health insurance plan or a government sponsored program, our Billing Department must be able to verify you are eligible for healthcare benefits and, if applicable, your premiums are paid through the date you are seeing the physician. If we are unable to verify either of these criteria, you will be asked to pay for medical services in full or reschedule the appointment until a time insurance coverage can be verified.
- If at any time during your treatment your insurance information changes or terminates you must notify the Billing Department immediately or you may be financially responsible for services rendered.
- We participate in most major insurance plans. Please contact your insurance company to verify our participation in your plan. You will be asked to provide our office with your most current insurance information each time you call and schedule an appointment. Our office will verify your benefits prior to your appointment. You must bring your insurance card to your office visit. Without the card we will not file your insurance and will ask for payment in full.

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- If at any time during your care you apply for and are approved for any Government sponsored program (Medicaid) it is your responsibility to notify our Billing Department immediately. This Practice is not liable for any financial penalty a patient may suffer because our Billing Department was not informed of your insurance status. A copy of your Medicaid card must be given to our office as soon as it is received.

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MEDICAL RECORDS:

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FORMS:

- $15.00 charge for completing forms

EMERGENCY CARE

- **If you judge any problem to be life threatening, go to the nearest emergency room.** Phones are answered 24/7. After office hours emergencies only call 972-420-1470 to have the on-call physician paged. If your call is judged by the on-call physician to be non-urgent your account will be charged $25.00 which must be paid prior to your next visit to the office. **Please do not call after hours for test results or medication refills. The on-call physician will not return these calls after business hours.**

PRESCRIPTION REFILLS:

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