Women's Health Associates of Richardson

Obstetrics and Gynecology

Charles Downey, MD / Meghan Drake, MD/ Jolaiya Faturoti, MD

Name:____ Preferred Name (if different):______________
(Last) (First) (M.I.)

Address:____ Apt/Condo #:______________

City:________________________ State:_______________________ Zip:_________________________

Cell Number:__________________Home Number:_________________Work Number:__________________

Primary Phone Number: ☐ Cell ☐ Home ☐ Work May we leave a message? ☐ Y ☐ N

Primary Care Physician:_________________________________ Phone #:_________________________

Patients Date of Birth:__________________ Age:_______ SS#:________________________

Email Address:____

Race: ☐Asian ☐Black/African American ☐Caucasian ☐Other:_____________________Sex:__________

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic ☐Decline to Provide Primary Language:________________

Preferred Pharmacy:______________________________ Phone:_________________________________

Address/Cross Streets:____ City:______________________

Emergency Contact:______________________________ Relation:__________ Phone:_________________

Name of Insured (if different):____________________________ DOB:____________ SS#:_____________

Relation: ☐Self ☐Spouse ☐Parent ☐Other Employer/Company:________________________

How did you hear about our office?____

If referred, by whom?____

REMINDER: Appointments may be rescheduled for the following reasons:

-If a patient is more than 15 minutes late.
-If a patient is unable to pay for the office visit
-If children that need supervision from the staff (except for newborns) are brought to the appointment.
The following must be provided at your appointment: insurance cards and driver's license or government issued id. This is necessary for our office to process your insurance claims more efficiently. Rescheduling may be necessary for the staff to manage the schedule and for the courtesy of patients.

Patient signature:____**Date:**_________________

HEALTH HISTORY

Name:____Age:______________

Reason for visit:____

____

Last Menstrual Cycle:_______________________

GYNECOLOGICAL HISTORY:

Date of last pap smear:______________ Normal Abnormal Where:______________________________

Have you ever had an abnormal pap smear? No Yes If yes, year:____________________________

Treatment for abnormal pap: Repeat Pap Colposcopy/Biopsy Cryotherapy LEEP/Cone Other

If still having cycles: Length of Cycles:__________________________ Days of flow:____________________

Hysterectomy (if yes, what year?)__________________________Menopause (if yes, what year?) ____________________

Date of last mammogram:___________ Normal Abnormal Where:______________________________

Sexually Active: Yes Not Currently Never **Sexual Partners are:** Male Female Both

Total number of *male* partners in your life: 0 1-4 5-10 11-20 >20

Birth Control: Not Necessary None Condoms Pill/Patch/Ring Injection Tubal IUD Vasectomy

Implant Other:____

List methods of birth control or hormones you have used in the past:_______________________________________

Infections: Do you currently have, or do you have a history of the following (please indicate year): ☐ N/A

Chlamydia___________Gonorrhea___________Warts________ HPV_________Trichomonas_________Syphilis_______

Herpes________number of outbreaks per year?_________

Are you interested in screening for sexually transmitted diseases (the charge for this test may apply to your insurance deductible)? Yes No

How old were you when you had your first menstrual cycle:___________

Any history of physical or sexual abuse/assault or concerns in your current relationships: Yes No

OBSTETRICAL HISTORY: ☐ N/A

Number of Pregnancies:______________ Number of Deliveries:_______________ Number of Living Children:__________

Date	Outcome: (vaginal delivery, c/section, miscarriage, termination, ectopic)

CURRENT MEDICATIONS: ☐ **None**

Medication	Dosage Instructions	Diagnosis

Vitamins: None Multivitamin / Prenatal Calcium Vit B Vit C Vit E Vit A Vit D Iron

Other: ____

Over the counter medications:____

Herbal/natural supplements:____

MEDICAL HISTORY: (Hypertension, Diabetes, Asthma, Injuries, Blood transfusion, etc.) ☐ **N/A**

Diagnosis	Onset Date	Treating MD

Drug Allergies: (Sulfa, Penicillin, Myacins, etc.) ☐ **None**

Drug	Reaction (Itching, Shortness of Breath, Hives, etc.)

Are you allergic to any of the following: Iodine/IV Dye Peanuts Latex

SURGICAL HISTORY: (Hysterectomy, Gallbladder, Appendix, etc.) ☐ **N/A**

Surgery	Date

FAMILY HISTORY:

Mother: Alive Deceased Present Health or Cause of Death:______________________________

Father: Alive Deceased Present Health or Cause of Death:______________________________

Condition:	**Maternal(Mother) /Paternal(Father)**		**Family Member:** ☐ **N/A**
Breast Cancer	M	P	________________
Uterine Cancer	M	P	________________
Ovarian Cancer	M	P	________________
Colon Cancer	M	P	________________
Osteoporosis	M	P	________________
Blood Clot/DVT	M	P	________________
Heart Attack	M	P	________________
High Blood Pressure	M	P	________________
High Cholesterol	M	P	________________
Stroke	M	P	________________
Diabetes	M	P	________________
Thyroid Disorder	M	P	________________
Depression	M	P	________________
Congenital/Birth Defects	M	P	________________

Other:____

SOCIAL HISTORY:

Smoker: No Yes Packs per day:________________How many years:__________

Past smoker: No Yes Packs per day:_____How many years:______Year quit:__________

Alcohol: No Yes Number of servings per week:____________________________

Drug Use: No Yes Type and frequency:________________________________

Occupation: ________________________

Education: High School College Graduate School Other:________________________

Marital status: Single Engaged Married Widowed Separated Divorced Significant Other

Live with: Alone Roommate Family Spouse Significant Other Fiancé Other:__________

Type of diet: Regular Low Fat/Carbohydrate/Cholesterol Diabetic Vegetarian Other:__________

Caffeine: No Yes Number of servings per day:______________________________

Exercise: No Yes Type: Cardio Weights Other:______________# of days a week:___

Are you currently having problems with any of the following (please circle all that apply):

General: Fatigue Weight Gain / Loss: Amount over the past year:______ lbs.

Respiratory: Cough Shortness of breath with light activity

Breast: Pain Masses Do you do a self-breast exam monthly? Yes No Sometimes

Heart: Palpitations Chest Pain

Gastrointestinal: Constipation Diarrhea Nausea Vomiting Rectal Bleeding

Menses:	Irregular Heavy flow Painful cycles Missed cycles Bleeding between periods
Menopause:	Hot Flashes Moodiness Night Sweats Vaginal Dryness
Genital:	Itching Burning Discharge Odor Pain or bleeding with intercourse
Urinary:	Frequency Urgency Burning Pain Incontinence
Musculoskeletal:	Joint Pain Muscle Pain If yes, where:_______________
Skin:	Acne Mole Bruising Rash If yes, where:_______________
Neurological:	Headaches Dizziness
Psychiatric:	PMS Depression Anxiety Mood Swings Insomnia

PREVENTATIVE EXAMS: (indicate date)

Immunizations: Tetanus: __________ HPV(Gardasil): ___________ Covid: _____________

Colonoscopy: __________________

Bone Density:__________________

Blood work:____________________

If a screening test is ordered and returns to us as "abnormal", further testing may be done and will likely apply to your insurance deductible. This includes testing ordered at Annual or Well Woman exams.

We routinely check for Chlamydia with the pap smear if you are 25 or younger per the American College of Obstetricians and Gynecologists (ACOG) recommendations.

We also routinely check for Human Papilloma Virus (HPV) with the pap smear if you are 30 or older at least every 3 years per ACOG and American Cancer Society recommendations. The charge for this test may be applied to your insurance deductible.

Signature:____ Date:____________________

Charles Downey, MD / Meghan Drake, MD /Jolaiya Faturoti, MD

GENERAL CONSENT FOR TREATMENT

***The following is a general consent for treatment for any services rendered here in the office, i.e. pap smear, breast exam, pelvic. If your plan of treatment requires further procedures, you will be consented on those specific procedures.*

*The consent you are about to read was written by the Texas Medical Association and requires that all physicians have patient consent for general treatment.***

"I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of the Physicians of Women's Health Associates, their assistants, or their designee as is necessary in their judgment.

I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examination by Women's Health Associates of Richardson.

--Texas Medical Association.

****

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Women's Health Associates of Richardson for services rendered by them in person or under their supervision. I understand that I am financially responsible for all of the fees or any balance not covered by my insurance.

Authorization to Release Information

I hereby authorize Women's Health Associates of Richardson to release any medical or incidental information that may be necessary for either medical care or in processing claims or applications for financial benefits.

Medicare/Medicaid

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf to Women's Health Associates of Richardson, Dr. Carol Norton, Dr. Charles Downey, Dr. Elayna Brooks or Dr. Charmaine Gibson.

A photocopy of these assignments shall be as valid as the original.

Print Patient Name Here: ________________________________ Date of Birth: ____________________

Print Parent or Guardian Name Here: ____

Signature: ____ Date: _________________________

WOMEN'S HEALTH ASSOCIATES of RICHARDSON
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FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about the following financial policy, please do not hesitate to discuss them with us.

For those insurance plans in which we participate, your predetermined portion of charges set by your insurance plan ***is due at the time of service.*** For your convenience we will accept Cash, American Express, VISA, MasterCard and Discover Card.

Your Insurance

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the authorized co-payment at the time of service. If you have insurance coverage under a plan with which we do not have a prior agreement, payment in full will be expected at time of service. You will be given the paperwork necessary to assist in filing your own claim. **Any balance due after your insurance(s) pay(s) is your responsibility and is due in full within 30 days.**

We make every effort to follow the guidelines required by your insurance company. However, every contract is unique. If you do not inform us of any special requirements in your plan and we subsequently perform a service or test that is denied, we have no choice but to bill you directly for those charges. Every effort is made to file claims on your behalf with your insurance plan. Unfortunately, if we are unable to collect payment from your insurance company after 60 days, you will be held financially responsible. Therefore, we encourage our patients to be pro-active in assuring that claims are paid.

If your insurance coverage changes, it is your responsibility to notify our office at least 48 hours before your next appointment. Failure to do so may result in rescheduling of your appointment.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient and the custodial parent or guardian for payment. We will not disclose any confidential information to the parent or guardian without written and verbal consent of the minor.

Missed Appointments

Please call us as early as possible if you know you will need to reschedule your appointment.

*****Please note: There is a $25 or $50 fee charged for any appointment missed without prior 24-hour notification*****

Should your account be reported to a collection agency for non-payment, you will be responsible for any/all fees incurred by such action.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_______________________________________ ___________________________
Signature of Patient or Responsible Party **Date**

____
Signature of Co-responsible Party

_______________________________________ ___________________________
Print Name of Patient Here **Date of Birth**

2821 E Pres George Bush Hwy, Suite 400 Richardson, TX 75082
Office: 972-231-9144 Fax: 972-231-9174
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WOMEN'S HEALTH ASSOCIATES
of RICHARDSON
Obstetrics and Gynecology

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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES
AND REVIEW OF
PATIENT RESTRICTION OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I have received and reviewed Women's Health Associates of Richardson **Notice of Privacy Practices**, which explains how my Individually Identifiable Health Information (IIHI) may be used or disclosed. IIHI is the same as my medical information. I have also received a copy of this **Acknowledgment of Review and Patient Restriction of Protected Health Information**. I can fill in the names of friends, relatives, spouse, immediate family, etc. below if I want them to be able to have access to my IIHI. I understand that my Primary Care Physician will be provided access to my IIHI via the Women's Health Associates of Richardson electronic portal unless otherwise noted below.

I am confirming receipt of this Acknowledgment of Review of Privacy Practices and identifying who has access to my IIHI, other than myself. Please check below.

☐ **Security question:** In what city were you born? ______________________________
(You or anyone who calls the office will be asked this security question. Please know, this is for patient privacy and assures the office that we may give personal information over the phone.)

☐ I do not want anyone to have access to my IIHI. I am the only one who should have access to my IIHI.

☐ It is agreed and acceptable for my "spouse only" to have access to my IIHI.

☐ Patient is under eighteen (18) years of age and understands that her legal representative has access to her IIHI and the legal representative is signing below.

☐ I want the person/s listed below to have access to my IIHI:

Name: ________________________________ Relationship: _______________

Name: ________________________________ Relationship: _______________

☐ I do not want my Primary Care Provider to have access to my IIHI.
☐ It is acceptable to leave a detailed, medical phone message for me at the following number:

(______) ______________________________ ☐ Home ☐ Work ☐ Cell

____
Printed Name of Patient

____
Signature of Patient **IF NOT A MINOR**

____
Signature of Personal/Legal Representative **IF PATIENT A MINOR**

____ ______________________
Personal/Legal Representative's Relationship to Patient Date

____ ______________________
Signature of Compliance Officer for Date
Women's Health Associates of Richardson

I authorize this office to have access to my prescription drug history.

____
Patient Name (Please Print) Date

____
Patient Signature

The remainder of this form is optional.
We are required to ask the following questions to meet
federal electronic medical records requirements.

PRIMARY LANGUAGE:____

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White

WOMEN'S HEALTH ASSOCIATES
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Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting Women's Health Associates of Richardson at 972-231-9144.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

______________________________	______________________________
Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
______________________________	______________________________
Witness Signature	Date