Women's Health Associates of Richardson
Obstetrics and Gynecology

Charles Downey, MD / Carol Norton, MD / Elayna Brooks, MD / Charmaine Gibson, MD

Name: _____ Today's Date: _____
(Last) (First) (Middle)

If you go by something other than your legal name, please indicate here: _____

Address: _____ Apt./Condo #: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____Home Phone: _____ Work Phone: _____

Which number would like to be primary? _____ May we leave messages at this number? ☐Y ☐N

Preferred contact method: ☐ PHONE ☐EMAIL ☐TEXT

Email Address: _____

Date of Birth: _____ Age: _____ SS#: _____ Sex: _____

Race_____ Ethnicity_____ Primary Language_____

Who are you seeing today?
☐ Dr. Charles Downey ☐ Dr. Carol Norton ☐ Dr. Elayna Brooks ☐ Dr. Charmaine Gibson
☐ Cori Poovey, NP ☐ Shirley Tran, NP

Insured (Name of Insurance Card Holder – Self, Spouse, Parent, etc.): _____

Insured's Date of Birth: _____ Insured's SS#: _____

Insured's Employer: _____Phone: _____

In case of an emergency notify: _____ Phone: _____

Relationship to patient: _____ Other Contact Phone: _____

Prescription Pharmacy Name:_____ Phone : _____

Pharmacy address or closest intersection: _____City_____

How did you hear about our office? _____

If referred to our office, by whom? _____

Your current Primary Care or Family Physician: _____ Phone: _____

Do you have a living will or advance directive: ☐ Yes ☐ No

The following information must be provided at your appointment: insurance cards, Driver's License or picture ID, and a major credit card. This information is necessary in order for our office to process your insurance claims more efficiently.

REMINDER: *Appointments may be rescheduled* for the following reasons:

- If a patient is more than 15 minutes late for an appointment.
- If a patient is unable pay for the office visit.
- If children that need supervision from the staff (except for newborns) are brought to the appointment.
- Rescheduling may be necessary in order for our staff to manage the schedule and for the courtesy of patients.

2821 E Pres George Bush Hwy, Suite 400 Richardson, TX 75082
Office: 972-231-9144 Fax: 972-231-9174
www.WHARichardson.com

WOMEN'S HEALTH ASSOCIATES of RICHARDSON
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Patient Signature_____ **Date**_____

Name_____ **Age**_____ **Last Menstrual Cycle**_____

Reason for visit _____

Are you <u>currently</u> having problems with any of the following (please circle all that apply):
Skin: *Acne* *Mole* *Bruising* *Rash* *If yes, where*: _____
Vision: *Unaided* *Glasses* *Contacts* *Lasik*
Hearing: *Aided* *Unaided* *Hearing deficit*
Menopause: *Hot Flashes* *Moodiness* *Night Sweats* *Vaginal Dryness*
Breast: *Pain* *Masses* Do you do a self-breast exam every month? *Yes* *No* *Sometimes*
Heart: *Palpitations* *Chest pain*
Lungs: *Cough* *Shortness of breath with light activity*
GI: *Constipation* *Diarrhea* *Nausea* *Vomiting* *Rectal Bleeding*
Urinary:*Frequency* *Urgency* *BurningPain* *Incontinence*
Vaginal: *Itching* *BurningDischarge* *Odor*
Weight: *Stable* *Increased* *Decreased* Amount over the past year? _____*lbs*
Psychiatric: *PMS* *Depression* *Anxiety* *Mood Swings* *Insomnia*
Neurological: *Headaches* *Dizziness*
Musculoskeletal: *Joint Pain* *Muscle Pain* If yes, where? _____

Menstrual History: *Hysterectomy* *Menopause*
If still having cycles: How many days apart? _____ How many days do they last?_____
Current Menstrual Problems: *Heavy bleeding* *Pain* *Clots* *Bleeding between periods*

Date of last pap smear: _____ *Normal* *Abnormal*

Date of last mammogram (if applicable): _____ **Where?** _____

Sexually Active: *Yes* *Not currently* *Never* Any concerns? *Pain* *Bleeding* *Dryness*
Sexual partners are: *Male* *Female* *Both*

Birth Control: *Not necessary* *None* *Condoms* *Pill/Patch/Ring* *Injection* *Tubal* *IUD* *Vasectomy* *Other* _____

Primary Care Provider or Family Physician: _____
May we exchange medical information with your PCP? *Yes* *No*

Obstetrical History:
Number of Pregnancies: _____ Number of Deliveries: _____
Number of living children: _____
Type of Delivery: C-Section – How many _____ Vaginal – How many _____ Largest baby: ___#___oz
Have you ever had any of the following (if yes, please specify the number of times):
Miscarriage: _____ Ectopic Pregnancy: _____ Termination: _____

Gynecological History
Please indicate if you have had any of the following procedures and the year performed.
Hysterectomy: __*Abdominal* __*Vaginal* __*Ovaries also removed* Year_____
Laparoscopy for: __*Ovary* __*Pelvic Pain* __*Endometriosis* __*Other* Year_____
Tubal Ligation: __*Laparoscopic* __ *Hysteroscopic* __*Post Partum* Year_____
Breast: __*Implants* (*under* or *over* muscle) __*Reduction* __*Biospy* Year_____

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Uterus/Cervix: __*LEEP* __*Cervical Cone* __*Cryotherapy (freezing)* __*D&C* Year_____
Other gynecological procedures (please list):
_____
_____

Have you ever had an abnormal pap smear? *No* *Yes*
Year of abnormal pap?_____
Treatment: __*Repeat pap* __*Colposcopy / biopsy* __*Cryotherapy* __*LEEP / Cone* __*Other*

How old were you when you had your first period? _____

If menopausal, at what age did you have your last period? _____

List methods of birth control or hormone replacement therapy you have used in the past:
_____

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

INFECTIONS: Do you currently have or do you have a history of the following (please indicate year)
____*Chlamydia* ____*Gonorrhea* ____*Warts* ____*HPV* ____*Trichomonas* ____*Syphilis*
____*Herpes* (number of outbreaks per year? ____)
Any history of physical or sexual abuse / assault or concerns in your current relationship? *Yes* *No*

Past Medical History: (Hypertension, Diabetes, Asthma, Injuries, Blood transfusion, etc.)

Diagnosis	Date	Treating MD
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

Non-Gynecological Surgeries: (Colonoscopy, Gallbladder, Appendix, etc)

Surgery	Date	Diagnosis
	/ /	
	/ /	
	/ /	
	/ /	

Immunizations: (indicate the date)
Tetanus _____ Hepatitis B _____ HPV(Gardasil) _____

Drug Allergies: (Sulfa, Penicillin, Myacins, etc)

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

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

Current Medications:

Medication	Date	Dosage Instructions	Diagnosis
	/ /		
	/ /		
	/ /		

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Medication	Date	Dosage Instructions	Diagnosis
	/ /		
	/ /		
	/ /		

Vitamins: *None Calcium Multivitamin Vit B Vit C Vit E Vit A Iron Others:*_____
Over-the-counter medications: _____
Herbal / Natural Supplements: _____

Social History:
Occupation: _____
Education (circle or complete): *High School College Graduate school Other*_____
Marital Status: *Single Engaged Married Widowed Separated Divorced Significant Other*
Live with: *Alone Roommate Family Spouse Fiancé Significant Other*
Type of Diet: *Regular Low Fat / Carbohydrate / Cholesterol Diabetic Vegetarian Other*
Exercise: *No Yes*
Type: *Cardio Weights Other* _____ # of days/week _____
Smoke:*No Yes* _____pack(s) per day for _____ years
Past Smoker: *No Yes* _____pack(s) per day for _____ years. Year quit _____
Alcohol: *No Yes* _____servings every: *day week month year*
Caffeine: *No Yes* Number of servings per day: _____
Drug Use: *No Yes* Type and frequency: _____
Do you have a living will (advanced directive)? *Yes No*

Family History:
Mother: *Alive Deceased* (from_____)
Father: *Alive Deceased* (from_____)

Condition:	**Maternal/Paternal**		**Family Member**
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_____

Preventative	Date	Ordering Physician
Blood Work		
Bone Density		

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If a screening test is ordered and returns to us as "abnormal", further testing may be done and will likely be applied 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 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.***

Are you interested in screening for sexually transmitted diseases? (You will want to check insurance coverage before blood is drawn) _____ *Yes* _____ *No*

Signature: _____ Date: _____

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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: _____

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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**

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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 Women's Health Associates of Richardson Date

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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

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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

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