awh
advanced women's healthcare

PLEASE FILL OUT COMPLETELY

| **PATIENT INFORMATION** | | | | |
|---|---|---|---|---|
| Full Legal Name (First, Middle, Last) | | | | |
| How do you wish to be addressed (nickname)? | | | | |
| Date of Birth: | | SS#: | | |
| Address: | | City, State, Zip: | | |
| Cell: | Home: | | Work: | |
| Email Address: | | | | |
| Marital Status: | □ Single | □Married | □Divorced | □Widowed □Legally Seperated |
| Spouse Name: | | Spouse DOB: | | |
| Race/Ethnicity: | □ African American | □Asian | □ Caucasian | □ Hispanic □Latino |
| □Multi-Racial | □Native American | □Pacific Islander | □Other (Please Specify) | |

| | | | |
|---|---|---|---|
| Which is the best number to leave a confidential voicemail? | □Cell | □Home | □Work |
| If I am unavailable, it is ok to leave a message with: | | | |

| **EMERGENCY CONTACT** | |
|---|---|
| Name: | Relationship: |
| Best Contact #: | Alternate Contact #: |

| **INSURANCE INFORMATION** | |
|---|---|
| Insurance Carrier: | Phone: |
| Policyholder: | Date of Birth: |
| Social Security Number: | Relationship to patient: |
| Member ID#: | Group #: |
| ** PLEASE NOTIFY STAFF OF ANY SECONDARY INSURANCE PLANS ** | |

| **PHARMACY INFORMATION** | |
|---|---|
| Pharmacy Name: | Phone Number: |
| Pharmacy Address: | |

**ASSIGNMENT OF BENEFITS:**

I here by assign all medical and/ or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plans to Drs. Sigman, Napier, Heintges, Harms, and Reyes. This assigment will remain in effective until revoked by me in writing. A photocopy of this assignment is to be considered as a valid as an original. I understand that I am financially responsibl efor all charges whether or not paid by said insurance. I hereby authoize said assignee to release all information necessary to secure payment.

| | |
|---|---|
| Signature of Patient: | Today's Date: |

12201 Merit Drive, Suite 350 Dallas, TX 75251| ph 214-238-7888 | fax 972-573-0500

**Please describe any medical concerns you would like to address today:**

| |
|---|
| |

## Social History

| | YES | NO | |
|---|---|---|---|
| **Caffeine Use?** | | | If yes, what do you drink & how often per day/week? |
| **Ever Smoked?** | | | If yes, what type? ☐ tobacco cigarettes ☐ cannabis/marijuana ☐ E-cigarette/vape |
| | | | Number of years: Current Smoker? ☐ YES or ☐ NO |
| **Drink Alcohol?** | | | If yes, what do you drink & how often per day/week? |
| **Drug Use?** | | | If yes, type: How often? |
| | | | Number of years: Current User? ☐ YES or ☐ NO |
| **Glasses/Contacts?** | | | If yes, which one? |
| **Tattoos?** | | | If yes, how many & when????? |
| **Do you regularly use seat belts?** | | | If no, please buckle up! 😊 |
| **Exercise? If yes, type and how often?** | | | |
| **Do you feel safe in your home environment?** | | | |

## Gynecologic History

| | |
|---|---|
| **Age periods began:** | **Are you in a sexual relationship? _____yes _____no** |
| **Date of last menstrual period: / /** | **Sexual preference: male _____ female _____ both_____** |
| **Duration** (usual number of days of bleeding): | **Current method of birth Control:** |
| **Interval** (usual number of days between periods): | |
| **Cramps?** _____ mild _____ moderate _____ severe | **Date of last pap smear: / /** |
| **Do you do monthly self-breast exams?** _____ yes _____ no | Have you ever had an abnormal pap smear? |
| | Have you ever had treatment for dysplasia? |
| **Please mark if you have had any of the following:** | **Date of last mammogram: / /** |
| _____ Fibroids | Have you had an abnormal mammogram: |
| _____ Endometriosis | Have you had a breast biopsy? |
| _____ Herpes | **Date of last bone density evaluation: / /** |
| _____Gonorrhea or Chlamydia | Do you have Osteoporosis or Osteopenia? |
| _____ Genital Warts | **Date of last colonoscopy: / /** |
| _____ Other gynecologic problems – please describe: | |
| | |

## Obstetric History

| | Number | | Number | | Number |
|---|---|---|---|---|---|
| **Pregnancies** | | **Live Births** | | **Abortions** | |
| **Preterm birth (< 37 weeks)** | | **Miscarriages** | | **Living Children** | |

| No. | Date of Birth | Birth weight | Gender | # weeks pregnant | Type of Delivery (vaginal, C-section, abortion, or miscarriage) | Complications (during pregnancy or delivery) | Child's name |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Name: _____ Date of Birth _____/_____/_____ Age: _____

## Personal Profile

| |
|---|
| **Marital Status** ___ married ___ single ___ divorced ___ widowed ___ living with partner |
| **Highest level of school completed:** ___ high school ___ college ___graduate degree |
| **Current Occupation:** |
| **Number of children:** |
| **Number of peoples living in household:** |
| **Name of your Primary Care Physician:** |
| **Who referred you to our practice?** |
| **Are you registered on our patient portal? ___** yes ___ no *** Please attempt to access your portal account while you are here<br>If yes, have you sent us a secured message since your last visit? ___ yes ___ no today and let us know if you need your password reset *** |

## Current Medications

**(Please include vitamins, hormones, over the counter and non-prescription medications)**

| Drug/Medication | Dose/Strength | Drug/Medication | Dose/Strength |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Allergies

**(Please include allergies/sensitivities to medications and food)**

| Drug/Allergy | Reaction | Drug/Allergy | Reaction |
|---|---|---|---|
| | | | |
| | | | |

## Medical History

| Illness | Yes | No | Illness | Yes | No | Illness | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Asthma | | | High Cholesterol | | | Arthritis | | |
| Chronic lung disease | | | Blood clot in lung or legs | | | Epilepsy | | |
| High blood pressure | | | Stroke | | | Anorexia or Bulimia | | |
| Heart Murmur | | | Lupus | | | Cancer | | |
| Heart attack | | | Liver disease or hepatitis | | | Migraine headaches | | |
| Rheumatic fever | | | Gallbladder disease or gallstones | | | Latex Allergy | | |
| Chronic anemia | | | Chronic heartburn or ulcers | | | Other | | |
| Kidney infection or stones | | | Chronic constipation or diarrhea | | | | | |
| Thyroid disease<br>Hypo, Hyper or Hashimotos? | | | Diabetes | | | | | |
| **Are you willing to accept blood products due to a life-threatening situation? _____ Yes _____ No** | | | | | | | | |
| **Have you received the HPV/Gardasil vaccine? _____Yes _____No If so, how many doses? _____1st _____2nd _____3rd** | | | | | | | | |

## Operations & Hospitalizations

**(Please include biopsies, oral surgery and cosmetic procedures)**

| Surgery type or reason | Date | Surgery type or reason | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Family History

| **Mother: age ___ living ___ deceased- cause** | | **Father: age ___ living ___ deceased- cause** |
|---|---|---|
| **Illness** | **Yes** | **Which relative and age at onset** |
| Cardiovascular disease (heart attack or stroke) | | |
| High Cholesterol | | |
| High Blood Pressure | | |
| Diabetes | | |
| Breast, Ovarian or Uterine Cancer | | |
| Colon Cancer | | |
| Other | | |

Name: _____ Date of Birth _____/_____/_____ Age: _____

Pharmacy: _____Pharmacy Phone #:_____.

Mail Order Pharmacy: _____.

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## Office Policies

- New patients must arrive 20 minutes prior to your appointment time with completed paperwork, photo ID and their insurance card. New patients arriving after their appointment time will be rescheduled and a $50 "no-show" fee will be applied. The 15-minute grace period does not apply to new patients.
- Established patients: Our office will do everything we can to honor a grace period no longer then 15 minutes.This does not mean we can guarantee you will be seen, circumstances such as the doctors schedule and emergencies may affect whether we can honor such grace period.
- Unfortunately, we cannot allow food or drinks in our lobby due to numerous spills. We appreciate you putting your food/drinks away while you are here for your visit.
- While we value family support, we hope you understand that guests will not be permitted in our office.
- We request that patients call 24 hours in advance to cancel or reschedule your appointment. Failing to contact the office will be considered a "no-show" and will result in a $50 fee and may result in your dismissal from our practice. OB patients with more than 2 "no-shows" will be discharged from our care for non-compliance.
- If you are a patient that requires a service animal you MUST notify our office before coming in so we can accommodate all patients.

_____ I have read and understand the financial policies and my responsibilities listed above.
(initials)

## Financial Policy

Payment for services not covered by your insurance plan and any out of pocket expenses are ***due at the time of service***. Self-pay patients are expected to pay in full at the time of their visit (see Self Pay Agreement). Our office collection policy supersedes any other contract language or statements in managed care contracts or other insurance policies. We accept checks, cash, debit cards: Master Card, Visa, Discover, and American Express. Returned checks and balances older than 60 days may be subjected to an additional collection fees and interest charges of 1-2% per month. Charges may also be made for appointments canceled without 24-hour notice. **Any surgeries that are canceled within 10 days of surgery, or patients that no-show for their pre-op appointment will be subject to a $250 cancellation fee.**

AWH files insurance claims for all members within one of our managed care plans. We do not file claims on insurance plans that we do not participate with or on new insurance that we have not had an opportunity to verify in advanced of your appointment. Patients with insurance should understand that:

- Your insurance is a contract between *you, your employer* and *the insurance company.* We are not a party to that contract.
- We will file your insurance for plans in which we participate, only if we have the necessary information to verify your benefits 48 hours prior to your appointment and you present your actual card upon arrival. ***We do not verify insurance benefits on the same day as your appointment, so you will be asked to self-pay or reschedule.***
- Our fees are generally considered to fall within the acceptable range of usual and customary by most companies and therefore, are covered up to the maximum allowable determined by each carrier.
- Not all services are a covered benefit in your contract. Some insurance companies arbitrarily select certain services they will not cover or may set maximum limits. Such services include laboratory charges, sonograms, injections, and in office procedures, etc. You will receive a separate bill for these services as they are the patient's responsibility. Our billing team is happy to answer any questions you have about a bill and can be reached at 214.238.7808.

*We must emphasize that as a medical care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. It is understood that temporary financial problems may affect timely payments of your account. If you have any questions regarding the above information, please do not hesitate to ask.*

_____ *I have read and understand the financial policies and my responsibilities listed above.*
(initials)

## Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and accountability Act of 1996 **(HIPAA).**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, buy we must provide you with the following important information:

**Use and disclosure of your health information in certain special circumstances**

The following circumstances may require us to use or disclose your health information:

1. To the public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order
3. If required to do so by a law enforcement official

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities
6. To federal officials for intelligence and national security activities authorized by law
7. To correctional institutions or law enforcement officials you are an inmate or under the custody of a law enforcement official
8. For Workers Compensation and similar programs

**Your rights regarding your health information**

1. Communications. You can request that our practice communication with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request: however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit a signed and dated request to:
   Dr. Sigman, Napier, Heintges, Harms, Reyes & Eye
   12201 Merit Dr #350
   Dallas, Texas 75251
4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. To request an amendment, it must be made in writing and provide us with a reason that supports your request for amendment and submitted to:
   Dr. Sigman, Napier, Heintges, Harms, Reyes & Eye
   12201 Merit Dr #350
   Dallas, Texas 75251
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Private Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact out front desk receptionist.
6. Right to file compliant. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Angela Brennan at 214-238-7809.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

_____ *I understand I have a right to review the AWH's Notice of Privacy Practices prior to signing this document. The practice's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the clinic. The Notice of Privacy Practices also describes my right and the practice's duties with respect to my protected health information.*

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## Consent for Purposes of Treatment and Assignment of Benefits

- I hereby consent and authorize AWH to diagnose and treat me based on their professional, medical opinion. I have the right to revoke this consent, in writing, at any time, except to the extent that the practice has taken action in reliance on this consent.
- I consent to the use or disclosure of my protected health information by Drs. Sigman, Napier, Heintges, Harms & Reyes (AWH) for diagnosing or providing treatment to me, obtaining payment from insurance companies or to conduct health care operations of the practice.
- I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of AWH.
- I understand that AWH office charges do not include any lab work. I am responsible for any lab charges, including biopsies, sonograms, pap smears, etc.
- My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.
- I hereby authorize and assign all payment and/or insurance benefits for medical services and/or surgical procedures to AWH. I understand that I am responsible for all charges not covered by my insurance plan.

_____ *I have read and understand the above consents regarding my medical treatment.*
(initials)

**My signature below indicates that I have read and understand all the information above and a copy is available to me upon request.**

**PATIENT NAME (PLEASE PRINT) _____DATE OF BIRTH _____/_____/_____ (MM/DD/YYYY)**

**SIGNATURE OF PATIENT_____TODAY'S DATE_____/_____/_____ (MM/DD/YYYY)**

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Today's date___/____/_____

Re: Well Woman lab work

Please be aware that most insurance companies limit coverage of “wellness” labs. Typically, the only labs that will be covered by your insurance company are: a complete blood count (CBC), a complete metabolic panel (CMP) and a lipid panel to check cholesterol. Pap tests and HPV testing will be determined by your physician and will be in accordance of ACOG guidelines.

Urine analyses, vaginal cultures, thyroid testing, hormone testing, etc. would generally go towards your deductible or could possibly not be covered if drawn during a preventative care visit.

Any additional lab testing recommended by the physician or requested by the patient may incur separate charges that will be the responsibility of the patient.

We apologize for any inconvenience this may cause.

By signing, I understand that I am financially responsible for any lab work ordered during my wellness visit.

_____
Patient Printed Name

_____
Patient Signature

Amy G. Sigman, MD - Amie Napier, MD - Michelle Heintges, MD - Heidi Harms, MD - Maria Reyes, MD - Emily Eye, MD
12201 Merit Drive, Suite 350 | Dallas, TX 75251 | ph 214-238-7888 fax 972-573-0500