

PATIENT REGISTRATION PACKET

PLEASE FILL OUT COMPLETELY

PATIENT INFORMATION

PATIENT'S NAME (FIRST, MIDDLE, LAST) _____

ADDRESS _____ EMAIL _____

CITY _____ STATE _____ ZIP CODE _____ SOCIAL SECURITY NUMBER _____ - _____ - _____

DATE OF BIRTH ____/____/____ (MM/DD/YYYY) MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ LEGALLY SEPERATED

SPOUSE'S NAME (FIRST, LAST) _____ SPOUSE'S DATE OF BIRTH ____/____/____ (MM/DD/YYYY)

HOME NUMBER _____ - _____ - _____ WORK NUMBER _____ - _____ - _____ ext: _____ MOBILE NUMBER _____ - _____ - _____

WHICH IS THE BEST NUMBER TO LEAVE A CONFIDENTIAL VOICEMAIL? ☐ HOME ☐ WORK ☐ MOBILE/CELL

IT IS OK TO LEAVE A DETAILED MESSAGE WITH _____ / _____ IF I AM UNAVAILABLE.

NAME

RELATIONSHIP

RACE/ETHNICITY

- ☐ AFRICAN AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ LATINO ☐ MULTI-RACIAL ☐ NATIVE AMERICAN ☐ PACIFIC ISLANDER
☐ OTHER (PLEASE SPECIFY) _____

PHARMACY INFORMATION

PHARMACY NAME _____ PHONE NUMBER _____ - _____ - _____

PHARMACY ADDRESS _____

EMERGENCY CONTACT INFORMATION

NAME _____ RELATIONSHIP _____

BEST CONTACT NUMBER _____ - _____ - _____ ALTERNATE CONTACT NUMBER _____ - _____ - _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ POLICY/ID NUMBER _____

NAME OF POLICY HOLDER _____ RELATIONSHIP _____

POLICY HOLDER'S DATE OF BIRTH ____/____/____ (MM/DD/YYYY) *PLEASE NOTIFY STAFF OF ANY SECONDARY INSURANCE PLANS*

MEDICARE-----Is the Patient:

- Entitled to Benefits Under Medicare Hospital Insurance (Part A)? ☐ YES ☐ NO Effective date _____
- Entitled to Benefits Under Medicare Hospital Insurance (Part B)? ☐ YES ☐ NO Effective date _____
- Entitled to Benefits under Medicare due to a disability? ☐ YES ☐ NO
- Actively employed and has chosen Medicare as secondary coverage? ☐ YES ☐ NO

Patients Medicare Identification No (From Medicare ID card) _____

All charges payable at the time of service unless prior credit arranged

ASSIGNMENT OF BENEFITS:

I hereby 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, and Harms. This assignment will remain in effective until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNATURE OF PATIENT _____ TODAY'S DATE _____

Medical History

Today's Date ____/____/____

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

Social History

	Yes	No
Ever Smoked? If yes, packs per day: _____ Number of years: _____ Current Smoker? _____		
Alcohol? If yes, type: _____ Number per day: _____ Drinks per week: _____		
Drug use? If yes, type: _____ How often? _____		
Do you regularly use seat belts?		
Exercise? If yes, type: _____		
Do you take calcium supplements or have a regular dairy intake (3 or more servings a day)?		
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

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

Today's Date ____/____/____

Medical History

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

Pharmacy: _____ Pharmacy Phone #: _____

***** Please check the phone number at which you prefer to be reached or where a message may be left: home cell work *****

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 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			Diabetes					

Are you willing to accept blood products due to a life threatening situation? ____ Yes ____ No

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		

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. The 15-minute grace period does not apply to new patients.
- Established patients: we will honor a 15-minute grace period for scheduled appointments. However, there may be circumstances when it is necessary to reschedule late patients. This will be determined at the time of your visit.
- 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. This applies to patients, children, and guests.
- While we value family support, we ask that you limit the number of guests to 4 (this includes children) when you come to your office visits. This allows for adequate space accommodations within our waiting room and exam rooms.
- For safety concerns, children are not permitted in patient rooms during sterile procedures, sonogram visits or visits involving pelvic and/or breast examinations. Children present in these situations may interfere with our staff's ability to give good care. We ask that children accompanying patients to pre-natal visits be supervised and/or in their strollers for the duration of the visit.
- 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 may result in your dismissal from our practice. OB patients with more than 2 "no-shows" will be discharged for non-compliance.

_____ I have read and understand the office policies 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 cancelled without 24-hour notice. **Any surgeries that are canceled within 48 business hours of surgery, or patients that no-show for their pre-op appointment will be subject to a \$100 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, but 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
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
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 complaint. 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 Maggie Fuller 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.

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)



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