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Obstetrics and Gynecology

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	DATE	
SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	MARITAL STATUS	
RACE/ETHNICITY	E-MAIL ADDRESS		MOTHERS MAIDEN NAME	
MAILING ADDRESS		CITY	STATE	ZIP
HOME #	CELL #	PRIMARY CARE PHYSICIAN OR REFERRING PHYSICIAN		
EMPLOYER NAME/ADDRESS		OCCUPATION	BUSINESS PH#	
SPOUSE NAME (PARENT, IF MINOR)	SOCIAL SECURITY NUMBER		CONTACT PH #	
EMERGENCY CONTACT	RELATIONSHIP TO PT	HOME PH #	CELL PH #	

PRIMARY INSURANCE INFORMATION

POLICY HOLDER'S NAME	DATE OF BIRTH		GROUP/POLICY #	SSN/ID #
PRIMARY INSURANCE COMPANY	RELATIONSHIP TO PT		EMPLOYER'S NAME/ADDRESS/PHONE #	
CLAIMS MAILING ADDRESS	CITY	STATE	ZIP	INSURANCE CO. PHONE #

I hereby authorize Tulsa Women's Health Care, Inc. to release any medical information necessary to process insurance claims relating to the medical care rendered by Tulsa Women's Health Care, Inc.

Signature _____ Date _____

I authorize payments of medical benefits to Tulsa Women's Health Care, Inc. for any medical care rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by my insurance. Accounts not paid within 60 days are subject to a 6% monthly finance charge.

Signature _____ Date _____

Name: _____DOB_____Ethnicity:_____Doctors Name: _____

Chief Complaint: _____ Height:_____ Weight:_____ Pharmacy/Location:_____

HISTORY OF PRESENT ILLNESS

__ Y __ N Contraception
__ Y No Symptoms
__ Y __ N Fatigue
__ Y __ N Headache
__ Y __ N Breast Symptoms
__ Y __ N Abdominal pain
__ Y __ N Female Genital Symptoms
__ Y __ N Hot Flashes
__ Y __ N Pelvic Pain

__ Y __N Menorrhagia (excessive/frequent periods)
__ Y __N Bleeding between periods
__ Y __N Dysmenorrhea (pain periods)
__ Y __N Metrorrhagia (bleeding unrelated to cycle)
__ Y __N Light bleeding between periods
__ Y __N Vaginal discharge
__ Y __N Anxiety
__ Y __ N Depression

Personal Medical History

__ Y __ N History of Cervical Dysplasia(abnormal cells)
__ Y __ N History of Human Papilloma Virus
__ Y __ N History of Menopause
__ Y __ N History of UTI (Urinary tract infection)

LMP, Contraception, and Sexual History

First day of last menstrual period:_____
__ Y __ N Contraception? What Kind?_____
__ Y __ N Sexually active
Date of last pap smear:_____

Social History

__ Y __ N Alcohol? If yes, how much:_____
__ Y __ N Tobacco? If yes, how much and for how many years? _____. If no, have you ever been a smoker and for how many years?_____.
__ Y __ N Recreational Drug use? If yes, how much and what kind_____

Pregnancy Summary

_____ Gravida (how many times pregnant)
_____ Para (how many live children)
_____ Aborta (miscarriages/elective abortions)

Family History

__ Y __ N Breast Cancer
__ Y __ N Diabetes Mellitus
__ Y __ N Down Syndrome
__ Y __ N High Blood pressure
__ Y __ N Tay-Sachs Gene
__ Y __ N Colon Cancer

Prev. Surgical Procedures & Dates:_____

Current Medications & Dosages:_____

Allergies (All Types): _____

Personal Medical History

__ Y __ N History of Allergic Rhinitis
__ Y __ N History of Asthma
__ Y __ N History of Acute Bronchitis
__ Y __ N History of CAD (heart disease)
__ Y __ N History of CHF (heart failure)
__ Y __ N History of COPD
__ Y __ N History of DM type II
__ Y __ N Esophagitis Chronic Reflux
__ Y __ N History of essential hypertension
__ Y __ N History of Hyperlipidemia (high cholesterol)
__ Y __ N History of hyperthyroidism
__ Y __ N History of osteoarthritis (joints)
__ Y __ N History of hypothyroidism
__ Y __ N History of Breast Cancer

__ Y __ N History of PYELO (inflammation of kidney)
__ Y __ N History of Renal Failure
__ Y __ N History of Stroke Syndrome (CVA)
__ Y __ N History of Obesity
__ Y __ N History of Lumbago (back pain)
__ Y __ N History of Hepatitis

Systemic Symptoms
__Y __N Weight Change
__Y __N Chills
__Y __N Fever
__Y __N Night Sweats
__Y __N Feeling tired or poorly
__Y __N Other Constitutional Symptoms

Head Symptoms
__Y __N Headache
__Y __N Facial Pain
__Y __N Sinus Pain
__Y __N Other Head related symptoms

Otolaryngeal Symptoms
__Y __N Ear ache
__Y __N Hearing Loss
__Y __N Ringing in the ears
__Y __N Nosebleeds
__Y __N Nasal Discharge
__Y __N Mouth Sores
__Y __N Bleeding gums
__Y __N Hoarseness
__Y __N Throat pain

Breast Symptoms
__Y __N Breast Pain
__Y __N Nipple Discharge
__Y __N Breast Lump
__Y __N Other Breast Symptoms

Cardiovascular Symptoms
__Y __N Chest pain or discomfort
__Y __N Fast heart Rate
__Y __N Palpitations
__Y __N Other Cardiovascular symptoms

Pulmonary Symptoms
__Y __N Shortness of breath
__Y __N Cough
__Y __N Coughing up blood
__Y __N Night sweats

May we leave a detailed voicemail: ___Y ___N

Gastrointestinal Symptoms
__Y __N Appetite
__Y __N Difficulty swallowing
__Y __N Heartburn
__Y __N Nausea
__Y __N Vomiting
__Y __N Abdominal pain
__Y __N Diarrhea
__Y __N Black or bloody stools
__Y __N Other Gastrointestinal symptoms

Genitourinary Symptoms
__Y __N Dysuria (painful Urination)
__Y __N Increased urinary frequency
__Y __N Hematuria (blood in urine)
__Y __N Genital Lesion

Skin Symptoms
__Y __N Pruritus (itching)
__Y __N skin lesions
__Y __N Rashes
__Y __N Other skin symptoms

Endocrine Symptoms
__Y __N Excessive sweating
__Y __N Excessive thirst
__Y __N Libido has changed (sex drive)
__Y __N Other endocrine symptoms

Neurological Symptoms
__Y __N Dizziness
__Y __N Vertigo
__Y __N Fainting
__Y __N Motor Disturbance
__Y __N Sensory Disturbance
__Y __N other neurological symptoms

Psychological Symptoms
__Y __N Sleep disturbance
__Y __N Anxiety
__Y __N Depression

Cancer Family History Questionnaire

Personal Information			
Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know.
The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, ovarian, or **pancreatic cancer** at any age	☐ Y ☐ N		
Colorectal or **uterine cancer** at 64 or younger	☐ Y ☐ N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Two **breast cancers** (bilateral) in one relative at any age	☐ Y ☐ N		☐ M ☐ P	
Three **breast cancers** in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Metastatic prostate cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Uterine cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with **breast cancer** at any age	☐ Y ☐ N		☐ M ☐ P	
Do you have a family history of **other cancers?**	☐ Y ☐ N	**List them here:**		
Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	**Who?**	**What gene(s)?**	**What was the result?**

TULSA WOMEN'S HEALTH CARE

OFFICE POLICIES

Thank you for choosing us as your health care provider. We are committed to providing you with the very best care and treatment possible. All our physicians are specialty trained in Obstetrics and Gynecology to provide the most contemporary treatment in female health. As we strive to provide quality health care, we recognize the benefits of insurance plans and the billing and collection of patient accounts can be confusing. The following is a statement of our Office Policies which we hope will help you understand the financial practice of medicine today. Please read and sign this prior to treatment.

INSURANCE
The physicians of Tulsa Women's Health Care participate in several PPO, HMO, and MANAGED CARE plans. Please present your insurance card at **all** visits to the office. We will submit all claims to your primary carrier, and as a courtesy, we will file your secondary insurance if applicable. If you have any questions about a particular insurance carrier, please contact our Billing Office.

SELF PAY
Payment is due and collected at the time of service.

SURGERY
Surgery usually involves a larger fee than office procedures. Prior to any surgery, we will provide you with a Financial Estimate of your responsibility. Therefore, a down payment may be required prior to surgery. Insurance payments are to be assigned to us. In the event of overpayment, a refund check in the amount of credit will be sent to you. Please remember that all Financial Estimates are solely based on information provided to us from your insurance plan. Therefore, it is not a guarantee of payment from them.

OBSTETRICAL
Our obstetrical global fee covers cost for routine obstetric care. This includes antepartum care, delivery and postpartum care. This does not include confirmation visit, laboratory, ultrasounds or additional services outside the routine obstetric care. These services will have separate fees. We will review your insurance benefits with you therefore, a down payment may be required to be paid by your 5th month of pregnancy, depending on your insurance benefits if any.

LABORATORY
Depending on your insurance carrier, lab work ordered by your physician will be billed by the laboratory providing the service.

PAYMENTS
All co-pays, deductibles and co-insurance are due and collected at the time of service.

We accept CASH, CHECK, OR VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN
I authorize payment of medical and surgical benefits to Tulsa Women's Health Care for services rendered. I understand I am financially responsible to the physician for charges not covered by insurance. Accounts not paid within terms of 60 days are subject to a 6% monthly finance charge.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____ _____
Print Name of Patient or Legal Guardian Relationship

_____ Basis of refusal, if refused: _____
Witness

TULSA WOMEN'S HEALTH CARE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Tulsa Women's Health Care may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and healthcare Operations (TPO). Please refer to Tulsa Women's Health Care's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Tulsa Women's Health Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Tulsa Women's Health Care HIPPA Officer at *10011 S Yale Ave; Suite 100, Tulsa Ok. 74137.*

With my consent, Tulsa Women's Health Care may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Tulsa Women's Health Care may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements and office documents as long as they are sealed with Tulsa Women's Health Care envelopes, or have our logo stamped on it.

With my consent, Tulsa Women's Health Care may e-mail and/or fax to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements and office document, as long as cover sheet is attached. I have the right to request that Tulsa Women's Health Care restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Tulsa Women's Health Care's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Tulsa Women's Health Care may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____ _____
Print Name of Patient or Legal Guardian Relationship

_____ Basis of refusal, if refused: _____
Witness

TULSA WOMEN'S HEALTH CARE
PATIENTS AGREEMENT ON ADMISSION

AUTHORIZATION FOR MEDICAL TREATMENT

Tulsa Womens Health Care and its staff are hereby authorized to administer any medical, diagnostic or therapeutic treatment, including blood transfusions, as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure to therapeutic course, absent emergency or extraordinary circumstances. I understand that in the event of an emergency, professional services shall be provided by a requested private physician.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by Tulsa Womens Health Care and are accessible to TWHC personnel and medical staff. TWHC personnel and physicians in attendance may use and disclose medical information for TWHC operations and functions and to any other physicians or health care personnel involved in my continuation of care for the admission. Safeguards are in place to discourage improper access. TWHC and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier or self insured employer group liable for any part of TWHC charges and to any health care provider who is or may become involved with my care. Oklahoma law requires that TWHC advise you that the information authorized for disclosure may include information which may be considered a communicable or verbal disease, including but not limited to Hepatitis, syphilis, gonorrhea, human immunodeficiency virus and acquired immune deficiency syndrome (AIDS). By signing this agreement, you are consenting to such disclosure.

RELEASE OF RESPONSIBILITY

Tulsa Womens Health Care is hereby released from any responsibility for any items of personal property and is not required to provide safekeeping. TWHC is held harmless from any injury, damages claims or actions which may arise out of my use of personal electric equipment.

ASSIGNMENTS OF INSURANCE BENEFITS

I agree that insurance benefits for TWHC charges payable to the insured are to be made payable to Tulsa Womens Health Care and that physician benefits otherwise payable to the physicians(s) responsible for my care. Any payment received for this period may be applied to any unpaid bills which I am liable subject to the rules of coordination of benefits.

PRECERTIFICATION POLICY

I understand that Tulsa Womens Health Care will assist with insurance precertification requirements which are the responsibility of the policy holder and/or physician, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY

As consideration for the services provided to me, payment is guaranteed for any amount due for such services provided by Tulsa Womens Health Care. TWHC charges services and goods shall be at TWHC's billed charged rates unless otherwise agreed to in writing by TWHC.

CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of this Patient Agreement if I shall request.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by this practice is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this agreement. You will receive this upon request.

_____ _____ _____

Patient or responsible party signature | Relationship | Date signed

_____ Basis of refusal, if refused:_____

Witness

Cole Nilson, D.O. Rob Sterling, M.D.
Nathan Rapp, D.O Hollie Black, D.O. Megan Mayhue-Sontag, PA-C

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Tulsa Women's Health Care to use and/or disclose protected health information (PHI) about me to or for the parties listed below.

Name/ Relationship	Phone Number
Name/ Relationship	Phone Number
Name/ Relationship	Phone Number

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Tulsa Women's Health Care has acted in reliance upon this authorization. My written revocation must be submitted to Tulsa Women's Health Care's Privacy Officer at 10011 S. Yale Ave., Suite 100 · Tulsa, OK 74137.

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Patient's Name — Date

_____
Print Name or Legal Guardian