Cole Nilson, DO · Rob Sterling, MD
Nathan Rapp, DO - Hollie Black, DO
Megan Sontag, PA-C
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 _____

Tulsa Women's Health Care

Name:_____ Doctor: _____

DOB: _____ Ethnicity:_____

May we leave a detailed message on voicemail? **YES/NO**

What was your baseline weight? (right before you got pregnant)_____ lbs.
What is your current height?_____ Feet _____ Inches

What was the first day of your last menstrual period? (if unknown, give your best guess) _____/_____/_____

How old were you when you first started your period? _____ years old.

Are your periods regular? _____

If so, how many days does your cycle normally run? _____days

How long do you normally bleed with your periods? _____ days

How much did you weigh at birth? _____ lbs _____oz
How much did your partner weigh at birth? _____ lbs_____oz

Do you have any history of traumatic births in your family? _____

If so, please describe: _____

Please list all previous pregnancies, including any miscarriages and elective abortions:

DOB	Miscarriage or abortion	Gestational age	Vaginal or cesarean	Length or labor (hrs)	Hospital	Sex and weight of baby	Child's name

Were there any complications with any of your previous pregnancies or deliveries? If so, please describe:_____

_____

_____

Have you ever had surgeries or hospitalizations (other than childbirth?)

Surgery or Hospitalization	When? (year)	Comment

Does anyone in your family or your partner's family have any history of any genetic abnormalities?

____ Neural Tube Defect (Spina Bifida, Anencephaly)
____Trisomy 21 (Downs Syndrome)
____ Congenital Heart Defect
____ Cystic Fibrosis
____ Tay-Sachs (Jewish, Cajun, French Canadian)
____ Thalassemia (Italian, Greek, Mediterranean, Asian)
____ Canavan Syndrome
____ Hemophilia Or Hematologic Disease
____ Huntington's Chorea
____ Autism
- if so was this person tested for Fragile X? _____
____ Mental Retardation
- if so was this person tested for Fragile X? _____
____ Muscular Dystrophy
____ Sickle Cell Disease or Trait (African)
____ Other Inherited Genetic or Chromosomal Disorder
____ Maternal Metabolic Disorder (type 1 diabetes, PKU)
____ Recurrent Pregnancy Loss, or a Stillbirth
____ Other Birth Defects
____ Other Genetic Screening

If you answered yes to any of the above, please explain who has the disorder: _____
_____

Have you or your partner ever had:
____ HIV or AIDS
____ Genital Herpes
____ Any other STDs

If yes, please explain who had the disease and if treatment was received. _____
_____

Please indicate if you have or have had any of the following medical conditions.

_____ allergic rhinitis
_____ anemia or other blood disorders
_____ asthma or other pulmonary disorders
_____ autoimmune disorder
_____ breast disorder
_____ infertility
_____ liver disease
_____ neurologic disorder
_____ renal disease
_____ (Rh) Sensitized
_____ thyroid disorder
_____ depression
_____ psychiatric disorder
_____ diabetes
_____ heart disease
_____ hypertension (high blood pressure)
_____ trauma history
_____ uterine abnormalities
_____ varicosities/ DVT (blood clots)
_____ anesthetic complications
_____ other family history
_____ other

If you checked yes to any of the above, please explain:_____
_____

Have you ever had a blood transfusion? YES/NO
If so, when? _____
When was your last pap smear? _____
Have you ever had an abnormal pap smear? YES/NO
If so, when? _____
Have you ever had any surgeries on your cervix, or have you every had to have any part of your cervix frozen?
YES/NO _____

Since finding out you were pregnant, have you used any:
Alcohol YES/NO
if so, how many drinks per day? _____

Tobacco YES/NO
if so, how many per day? _____

Drugs YES/NO
if so, what kind? _____
if so, how much per day? _____

Have you ever been exposed to TB (tuberculosis)? _____
If so, please explain if you had negative test, or received treatment _____

Have you had any kind of rash or viral illness since your last menstrual period? _____
If so, please explain _____

Have you ever had chicken pox? _____
Or have you received the vaccine? _____

Have you had any other significant exposure or history of infection? _____
If so, please explain_____

Do you feel safe at home? YES/NO

Please list any and all medication you are currently taking.

Medication	Dosage

Please list all medication that you are allergic to

Medication	Reaction

Preferred pharmacy name and location _____

For all medical care and deliveries, please go to St Francis Main Hospital:

6161 S Yale Ave Tulsa, OK 74136

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

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