

Complete Women's Care

Patient Check In

Please review the information below that we currently have in our records. Mark out any incorrect information or changes and fill in any blanks. Notify our staff so that we may make these changes in our system. Thank you.

Full Name: _____ **DOB:** _____ **SSN:** _____
Billing Address: _____
Mailing Address: _____
Home Phone: _____ **Work Phone:** _____
Current Medications: _____
Drug Allergies: _____

Provide the following if person responsible for payment is different than patient:

Insured's name/Name of Person Responsible for Payment: _____
Their Address: _____ **City** _____ **State** _____
Zip Code: _____ **SSN:** _____ **DOB:** _____

Primary Insurance: (please circle one) PPO HMO Other Unsure
Name of Insured: _____ **Group Number:** _____
I.D./Policy Number _____
Patient's relationship to insured: _____
Insurance Address: _____

Secondary Insurance: (please circle one) PPO HMO Other Unsure
Name of Subscriber: _____ **Group Number:** _____
Policy Number: _____ **Patient's relationship to insured:** _____
Insurance address: _____

Name of Physician that referred you to our office: _____

Name of Physician that is your PCP or primary care physician: _____

Has any member(s) of your family been treated at this office? YES NO UNSURE

If so, who? _____

Emergency Contact (Name and phone number): _____

I plan to make payment of my medical expenses as follows (please circle one or more):

CASH/CHECK MC/VISA AMER EXPRESS DISCOVER

I authorize Complete Women's Care to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I understand that I am responsible for all medical fees during my treatment at Complete Women's Care.

If surgery is required, I assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, to Complete Women's Care.

I also certify that the above information is correct to the best of my knowledge.

Patient/Guarantor/Guardian Signature

Date

Complete Women's Care
Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____
Social Security No.: _____ Phone Number: _____

Information Release TO: **G. DeAn Strobel, MD**
230 E. Evergreen St.
Sherman, TX 75090
Phone: (903) 957-0275 Fax: (903) 957-0279

Information Release FROM: _____

Please release the following:

- | | |
|--|--|
| <input type="checkbox"/> Problem List | <input type="checkbox"/> X-ray/CT/MRI reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-ray/CT/MRI films |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> EKG Reports |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Other Diagnostic Reports _____ |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Pap Smears or Pathology Reports |

Please include information (if applicable) pertaining to: mental health, drug/alcohol use, HIV/AIDS, communicable disease treatment.

Purpose or need for disclosure of medical information:

- | | |
|---|--|
| <input type="checkbox"/> Continued patient care | <input type="checkbox"/> Personal use |
| <input type="checkbox"/> Attorney/Legal reasons | <input type="checkbox"/> Insurance Claim/Application |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Other _____ |

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

Signature of Patient or Legal Representative Date

Relationship to Patient Witness

COMPLETE THIS SECTION ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT

I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold G. DeAn Strobel, MD, or Complete Women's Care, PA, liable for any misinterpretation of the information in my medical record as a result of my not consulting the physician for the correct interpretation.

Signature of Patient or Legal Representative Date

Relationship to Patient Witness
Date request completed _____ # of pages copied _____ Initials _____

Financial Policy

TO OUR VALUED PATIENTS:

Thank you for choosing Complete Women's Care. We are committed to providing you with the best medical care possible. Please review a brief explanation of our policies & procedures below. If you have any questions, please ask one of our staff to assist you with an explanation. If you require further explanation, the billing administrator may be contacted. After you have read this document in its entirety, please sign below. Your signature constitutes an agreement to the procedures and policies of our practice.

Thank you,

Providers and Staff of Complete Women's Care

OFFICE HOURS

We are open Mondays through Thursdays 8:30 A.M. to 4:30 P.M and Fridays 8:30 A.M. to 12:00 P.M. We are closed Memorial Day, Labor Day, Good Friday, Thanksgiving Day, Christmas Day and New Year's Day.

DEFINITIONS

IN NETWORK: We refer to "in network" as the insurance companies with whom we have a contractual agreement. If we are in network, we have agreed upon a pay scale with the insurance company. In other words, we have agreed to a discounted rate for members of the insurance carrier with whom we are contracted.

OUT OF NETWORK/ NON-PARTICIPATING INSURANCE: If we are not in network with your insurance carrier, we will bill your carrier as a courtesy. If payment is not received within 60 days, the balance becomes your responsibility. You, the patient, will have to contact your insurance company to determine why payment has not been made. Please be aware, you may incur more out of pocket expenses for seeing a doctor out of network. It is your responsibility to check with your insurance company for benefits.

ACCEPT ASSIGNMENT DEFINITION: Accept assignment means that we agree to accept check payment from the insurance company for services rendered.

FINANCIAL POLICIES AND PROCEDURES

At Complete Women's Care, we believe that all patients who come to this office deserve the best medical care that can be provided. In order for us to provide you with the highest quality medical care and current technology, we must insure that we are able to meet the expenses necessary to operate this facility. To ensure that these expenses are met, we provide you with this agreement to acquaint you with our financial policy.

PAYMENT AT TIME OF SERVICE

As a courtesy, we will bill your insurance for all office visits. However, we ask that you pay any portion not covered by your insurance due to deductibles or co-payments on the day of service, unless otherwise specified in specific policies of Complete Women's Care.

Complete Women's Care

SUBMISSION OF CLAIMS

We will submit your insurance claims. However, it is important to remember that your insurance is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays.

BALANCES DUE AFTER INSURANCE PAYS

If there is a remaining balance due after your insurance carrier pays, you have 30 days to make payment on the invoice. Payment arrangements can be made for special circumstances by contacting the billing administrator within 30 days of the receipt of the invoice. It is your responsibility to make contact with our office to make special arrangements.

OUTSTANDING BALANCES

We urge you to keep your account current to avoid any misunderstandings with our office. All account balances past due over 90 days will be sent to an outside agency for collections. At that point, the account is out of our hands. If you need to make special arrangements, it is your responsibility to contact the billing administrator at our office before your account is sent to an outside agency.

PAYMENT ARRANGEMENTS

Under special circumstances, payment arrangements can be made. These arrangements are made with the "check out" receptionist or with the billing administrator. Our office can set this up for you as a courtesy. You will be sent a monthly statement. However, it is your responsibility to know your monthly due date, which will be determined at the time your payment arrangement is set up. After one missed payment, the account will be due immediately in its entirety or will be sent to an outside agency for collections.

PAYMENT OPTIONS

Our office accepts Visa and MasterCard. Our office also accepts money orders, checks or cash. There will be a \$30 fee for all returned checks.

MEDICARE PATIENTS

If you have Medicare as your primary insurance carrier, but you do not have a secondary insurance, you are responsible for the 20 percent at the time of service. Payment plans can be set up for special circumstances.

CASH PAYMENT

If you pay cash, please ask for a receipt so that you will have a record of your payment.

Complete Women's Care

BILLING PROCEDURE

You will receive a statement with your remainder balance once a reply is received from your insurance company. If you are self-pay or have not met your insurance plan's deductible, you should be prepared to pay for your visit before leaving the office. If you have an outstanding bill, you will be required to pay your account in full before being seen for subsequent appointments. If necessary, our billing office personnel will help you set up a budget plan. This will allow you to remain in good standing while you pay off your balance over a period of time.

Surgery

We require 100% prepayment prior to the scheduling of any elective surgery. If you wish, our office will be glad to process your insurance claim for surgical procedures. Please be sure that we have your correct insurance information.

Special Forms

Any disability, insurance, or other forms will have a \$20.00 processing fee.

Financial Policy

I, _____ verify by signing this document that I have received, read and understand Complete Women's Care Financial Policy. I understand that payment is due in full at time of service. If my insurance is no longer in effect I understand that I am responsible for my balance in full.

Signature

Date

Complete Women's Care
Complete Women's Care

G. DeAn Strobel, MD, FACOG Sandra Bollier, RN, MSN, ANP Brooke Norch, PA-C
230 East Evergreen Street * Sherman, TX 75090 * Phone: (903) 957-0275 * Fax: (903) 957-0279

Privacy Practice Notification

The Health Insurance Portability & Accountability of 1996 (HIPPA) is a federal program that requires all medical records and other identifiable health information used or disclosed by Complete Women's Care, in any form, whether electronically, on paper, or oral are kept properly confidential. This ACT gives you significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA we have prepared this explanation of how we are required to maintain the privacy of your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer services.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related issues and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorizations. You may revoke such authorization in writing, and we are required to honor and abide by your written request except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you may exercise by presenting a written request to our "Privacy Officer."

- ❖ The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction we must abide by it unless you agree in writing to remove it.
- ❖ The right to reasonable requests to receive confidential communications of protected health information from us by alternative locations.
- ❖ The right to inspect and copy your protected health information. There is a charge of \$25 for the first 20 pages and the \$.25 per page thereafter for copies.
- ❖ The right to amend your protected health information. You must make your request in writing to the privacy manager.
- ❖ The right to receive an accounting of disclosure of protected health information. You may request once annually with no charge. There is a \$25 charge for all subsequent requests.
- ❖ The right to receive a paper copy of this notice upon request.

To file a complaint please notify: "The Department of Health & Human Services Office of Civil Rights", 200 Independence Ave. S.W., Washington, D.C. 20201 or call 1-877-696-6775.

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Consent Form

1. I understand that under the Health Insurance Portability and Accountability Act I have certain rights to privacy regarding health information. I have read the Privacy Practice notification provided. **Initials:**_____
2. I authorize Complete Women's Care office to leave messages via my answering machine for appointments, reminders, general medical information, test results, billing, and/or referral information. **Initials:**_____
3. I authorize Complete Women's Care to communicate verbally with _____
_____ regarding my appointments, test results, general medical information, or referral information. For information for identification _____'s SS# is _____ . **Initials:**_____
4. I authorize Complete Women's Care to release any medical information needed to determine payment for my services. **Initials:**_____
5. I authorize Complete Women's Care to release protected health information to only HIPPA covered entities (health plans, providers, and healthcare clearinghouses) on my behalf. **Initials:**_____
6. I authorize my insurance carrier to make direct payments on my behalf to Complete Women's Care for medical services furnished. **Initials:**_____
7. I am aware I am responsible for co-payments, co-insurance, or any deductible at the time of services. **Initials:**_____
8. Authorization is valid until rescinded by me in writing. **Initials:**_____

Patient's Name:_____ SS#:_____

Signature:_____ Date_____

Relationship to patient (if pt is a minor or unable to sign):_____

Complete Women's Care

Review of Systems

Please circle YES or NO as related to the following problems which you are **CURRENTLY** experiencing.

CONSTITUTIONAL SYMPTOMS

Chills YES NO
 Fatigue YES NO
 Fever YES NO
 Headache YES NO
 Weight Gain YES NO
 Weight Loss YES NO

RESPIRATORY

Coughing up blood YES NO
 Frequent cough YES NO
 Poor exercise tolerance YES NO
 Shortness of breath YES NO
 Wheezing YES NO

GASTROINTESTINAL

Abdominal pain YES NO
 Blood in stool YES NO
 Constipation YES NO
 Diarrhea YES NO
 Indigestion/heartburn YES NO
 Jaundice YES NO
 Leakage of stool YES NO
 Nausea/vomiting YES NO

GENITOURINARY

Heavy periods YES NO
 Irregular periods YES NO
 Painful periods YES NO
 Vaginal bleeding YES NO
 Sores on vulva YES NO
 Incomplete emptying of bladder YES NO
 Painful urination or urgency YES NO
 Urinary frequency (day or night) YES NO
 Leakage of urine YES NO
 Blood in urine YES NO
 Cysts or lumps in breast(s) YES NO
 Dimpling in breast(s) YES NO
 Discharge or drainage from breast(s) YES NO

ALLERGY/IMMUNOLOGY

Hay fever/seasonal allergies YES NO
 Drug allergies YES NO
 Hives YES NO

MUSCULOSKELETAL

Back pain YES NO
 Joint pain YES NO
 Neck pain YES NO

EYES

Blurred vision YES NO
 Double vision YES NO
 Pain YES NO

EAR/NOSE/THROAT/MOUTH

Ear infection YES NO
 Hoarseness YES NO
 Ringing in ears YES NO
 Sore throat YES NO
 Sinus problems YES NO

CARDIAC

Ankle swelling YES NO
 Chest pain YES NO
 High blood pressure YES NO
 Varicose veins YES NO

NEUROLOGIC

Dizzy spells YES NO
 Headaches YES NO
 Numbness/tingling YES NO
 Passing out YES NO
 Seizures YES NO
 Tremors YES NO
 Weakness YES NO

SKIN

Boils YES NO
 Persistent itch YES NO
 Skin rash YES NO

HEME/LYMPH

Blood clotting disorder YES NO
 Swollen glands YES NO

ENDOCRINE

Excessive thirst YES NO
 Nipple or breast discharge YES NO
 Tired/sluggish YES NO
 Too hot/cold YES NO

PSYCHOLOGICAL

Are you satisfied with your life? YES NO
 Do you feel severely depressed? YES NO
 Have you considered suicide? YES NO
 Do you ever hear voices or see things? YES NO
 Depressed mood YES NO
 Do you limit your social activities? YES NO
 Are you being treated for this? YES NO

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