

Modern Obstetrics & Gynecology of North Atlanta, P.C.

Emory Johns Creek Physicians Plaza
6335 Hospital Pkwy, Suite 204
Johns Creek, GA · 30097 · (404) 446-2496

Patient Demographic Information and Communication of Information Consent

Name _____ Maiden Name _____
(First) (Middle) (Last)

Marital Status _____ Age _____ Date of Birth ___/___/___ SS# _____

Address _____

Email: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Your Occupation _____ Employer _____

Spouse's Name _____ Spouse's Age _____

Spouse's Occupation _____ Employer _____

Name of your Family Doctor _____ How Were You Referred to us? _____

How did you hear about us? _____

Emergency Contact (not spouse) _____ Relationship _____

Emergency Contact Home Phone Number _____ Cell _____

Who to Contact:

I hereby authorize and give permission to Modern Obstetrics & Gynecology of North Atlanta, P.C. to disclose and discuss any information related to my medical condition(s) to/with the following persons:

Name _____ Relationship _____

Name _____ Relationship _____

OR: **Do not share my information with anyone.**

I wish to be contacted in the following manner:

- Home/Work Telephone: _____
- Ok to leave message with detailed information
- Leave message with call-back number only

Written Communication:

- Ok to mail to my home address
- Ok to mail to my work/office address
- Ok to fax to this number _____

By my signature below, I authorize the release of any medical or other information deemed necessary by Modern Obstetrics & Gynecology of North Atlanta, P.c., including transferring of any medical records to support medically necessary referrals to other health care providers. I also authorize payment of medical benefits to Modern Obstetrics & Gynecology of North Atlanta, P.C.

Signature of Patient _____ Date _____

Modern Obstetrics & Gynecology of North Atlanta, P.C.

John C. Reyes, M.D.
 Ingrid V. Reyes, M.D.
 6335 Hospital Pkwy, Suite 204
 Johns Creek, GA 30097
 (404) 446-2496

NEW PATIENT MEDICAL HISTORY FORM

The following information is very important to your health. Please take the time to fully and completely fill out this important information. We are counting on you.

Patient Name _____ Age _____ Height _____ Birth Date _____ Date _____

Chief Complaint: _____

List present medications/supplements: _____

List all medication allergies: _____

Pharmacy Name _____ Phone# _____ Location _____

Family History

		<u>Cause of Death</u>	<u>Age</u>
Your Father	Living / Deceased		
Your Mother	Living / Deceased		
# of Your Siblings	#Living ____ / #Deceased ____		

Do you have a **Family History** of:

	<u>NO</u>	<u>YES</u>	<u>Please Explain</u>
Anemia			
Arthritis			
Blood Transfusions			
Bowel Disorders			
Breast Disease			
Cancer			
Chicken Pox			
Diabetes			
DES Exposure			
Endometriosis			
Excessive Bleeding			
Gall Bladder			
H. Hernia/Peptic Ulcer			
Headache/Migraine			
Heart Disease			
Hypertension			
Infertility			
Jaundice/Hepatitis			
Kidney Disease			
Respiratory Disease			
Psych. Illness/Depression			
Seizure Disorder			
Skin Disease			
Thyroid Disease			
Urinary Infections			
Varicose Veins/Phlebitis			

Past Surgical History:

<u>Date</u>	<u>Procedure</u>

Illness History (Other than Surgical Procedures):

<u>Date</u>	<u>Illness</u>

Tests

<u>Test</u>	<u>Year Performed</u>	<u>Not Sure</u>	<u>Never Done</u>	<u>Results</u>
Pap Smear				
Breast Exam				
Mammogram				
Rectal Exam				
Sigmoidoscopy				
Colonoscopy				
Cholesterol				
Rubella				
Triglycerides				
Thyroid Profile				
Tetanus (DPT)				
Bone Density				
Other _____				

Menstrual Periods:

Age Onset _____ Are you experiencing heavy bleeding with your periods? Y / N
Date of Last Period _____ Are you experiencing loss of urine with coughing, laughing, straining, etc.? Y / N
Periods: Regular _____ Irregular _____ Would you like to discuss this with your doctor? Y / N

Pregnancies:

of Children Born Alive _____ # of Cesarean Sections _____
of Premature Births _____ # of Stillborns _____
of Miscarriages _____ # of Abortions _____

Your Personal Habits:

	<u>Yes</u>	<u>No</u>	<u>Please Explain</u>
Do you exercise regularly (3 to 4 times per week)?			
Do you use illegal drugs?			
Do you use alcohol?			
Were you ever a heavy drinker?			
Do you smoke?			
If ever, when did you stop?			
Do you have an eating disorder? Anorexia _____ Bulimia _____			
Have you ever been physically abused?			
Are you currently being physically abused?			
Do you feel safe in your home?			
Do you have sex with: men _____ women _____ both _____			
Any concerns?			

My signature indicates that the above information is true and correct to the best of my knowledge.

Patient Signature _____ **Date** _____

Modern Obstetrics and Gynecology of North Atlanta, P.C.

John C. Reyes, M.D.

Ingrid V. Reyes, M.D.

6335 Hospital Parkway, Suite 204

Johns Creek, Georgia 30097

404-446-2496

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to you and your healthcare. Please understand that payment of your bills is considered part of your care. The following is a statement of our financial policy. We require that all of our patients read and sign it prior to treatment or consultation.

All patients must complete our Information and provide insurance information before seeing the doctor.

FULL PAYMENT IS DUE (UPON REQUEST) AT THE TIME OF SERVICE. For your convenience, we accept Cash, checks, and credit or debit cards.

(Please initial after each number.)

1. _____ It is the responsibility of the patient to confirm that the physician is on the insurance plan and that your benefits are active. Our office will file claims to your insurance company for professional services rendered. We cannot bill your insurance carrier unless you give us your current insurance information. Please remember, **INSURANCE COVERAGE IS A LEGAL CONTRACT BETWEEN THE PATIENT AND THE INSURANCE COMPANY.** Benefits may differ depending upon what type of contract you have with the carrier on your behalf. If your insurance company has not paid your account in full at the end of 90 days, the balance will automatically be transferred to your responsibility for payment in full. Please be aware that some or perhaps all of the services provided may be non-covered services and not be considered necessary under the Medicare Program or other medical insurances.
2. _____ All co-pays and deductibles are due at the time of treatment. We require payment in full for your portion at the time of service. Our office accepts Visa, MasterCard, Discover, American Express, checks, cash and money orders. If a check is returned from your bank, there will be a **\$40** returned check fee added. Ultimately, you are responsible for all charges incurred in our office. The law does not allow us to write off co-pays or deductible amounts.
3. _____ If the patient cannot keep the scheduled appointment, it is the patients responsibility to give our office at least 24 hours cancellation notice. We reserve the right to charge an **\$85.00** fee for missed or cancelled appointments with less than 24 hours notice. Surgeries and In-office procedures that are cancelled with less than 1 week notice will be subject to a **\$300.00** non-refundable service fee. Please help us serve you and other patients better by keeping scheduled appointments.
4. _____ If you are turned over to a collections agency, there will be a **\$50.00** processing/filing fee, as well as a fee of **40%** of your balance added to your account that you will be responsible for.

Should your account fall past due greater than 45 days, I authorize that the unpaid balance be charges to my major credit card as listed below:

_____	_____	_____	_____
Card Type	Card Number	Name as it appears on Card	Code
_____	_____	_____	_____
Exp. Date	Signature	Date	Name of Patient

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT FINANCIAL RESPONSIBILITY AS DESCRIBED ABOVE.

Patient, legal guardian or responsible party signature

Date

Modern Obstetrics & Gynecology of North Atlanta, P.C.

John C. Reyes, M.D.

Ingrid V. Reyes, M.D.

Patient Consent and Acknowledgment of Receipt of Privacy Notice

I, _____ understand that as a part of the provision of healthcare services, Modern Obstetrics & Gynecology of North Atlanta, P.C. creates and maintains health records describing my health information. This includes but is not limited to my health history, symptoms, diagnoses, examination and test results, treatment, and any plans for future treatment.

I have read and/ or have been provided with a copy of the Notice of Privacy Practices that provides a complete description of the uses and disclosures of certain health care information.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and health care operations. I have the right to revoke this consent in writing except where disclosures have already been made in reliance on my prior consent.

Patient Printed Name _____

Signed _____ Date _____

Witness _____ Date _____

I hereby authorize and give permission to Modern Obstetrics & Gynecology of North Atlanta, P.C., to disclose and discuss any information related to my medical condition(s) to/ with the following persons:

Name

Relationship

Name

Relationship

Medical Records Authorization

Release Records To:

***Modern Obstetrics & Gynecology
of North Atlanta, P.C.***
John C. Reyes, M.D.
Ingrid V. Reyes, M.D.
6335 Hospital Pkwy, Suite 204
Johns Creek, GA 30097
Phone 404-446-2496 Fax 404-446-2497

Release Records From:

Name: _____

Address: _____

City: _____ State _____ Zip _____
Phone _____
Fax _____

Patient Information

Patient Name: _____

Address: _____

City: _____ State _____ Zip _____

Primary Phone # _____ Secondary Phone # _____

Date of Birth _____ Social Security Number: _____

I, _____ authorize the above listed person/s physician/s, firm or entity (or its agents, representatives, or employees) to release for inspection and copying any and all of the Personal Health Information (PHI) listed below that pertains to my treatment, hospitalization, or care from date/s of: _____ to _____.

Entire Record Radiology/X-Ray Reports Operative Reports Pathology Reports

Laboratory Records ER Reports Labor & Delivery Records

Discharge Summary Other: _____

Reason for Requesting Records: _____

Signature of Patient or Legal Representative

Date

Witness

Special Authorization to Release HIV/AIDS Information

I hereby authorize my HIV/AIDS information to be released to the party listed above

Signature _____ DOB _____ Date of Authorization _____