Consent to Treatment and Other Acknowledgments

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following: While routinely performed without incident, there may be material risks associated with any procedure. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.

I hereby expressly authorize and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to Modern OB/GYN of North Atlanta and all professionals (including independent contractors) providing for such care and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to Modern OB/GYN of North Atlanta and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits).

A copy of this document may be utilized the same as the original.

Name:_______________________________________ **DOB:**_______/_______/_______

Today's Date:_______/_______/20__

Revised 10/18

Patient Consent & Acknowledge 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, personal information and insurance data..

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 the protected health information about me for the purpose of treatment, payment and health care operations. I understand that 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:_________________________________

Signature:_______________________________ **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

OR: ☐ Do not share my information with anyone outside of my PCP, Referring MD and Insurance Company.

I wish to be contacted in the following manner:

☐ Home/Work/Cell Number;____________________ OR: ☐ Written Communication:

☐ OK To Leave a Detailed Message
☐ Leave A Simple Message With A Call Back Number

☐ OK To Mail To My Home 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 Obgyn of North Atlanta, P.C., including transferring of medical records to support medically necessary referrals to other health providers.

Signature of Patient:______________________________________ **Date:**______/______/______

Revised 2/2014

MEDICAL RECORDS RELEASE REQUEST

JOHNS CREEK · CUMMING · ALPHARETTA

Ph: 404-446-2496 Fax: 404-446-2497

www.reyesobgyn.com

Patient Information:

Patient Name:____ Contact Number:______________________________

Home Address:______________________________________ DOB:________/________/__________

City, State and Zip:___________________________________

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

To / From:

Modern Ob/Gyn of North Atlanta
10692 Medlock Bridge Road, Suite 100-A
Johns Creek GA 30097
Fax: 404-446-2497
Office: 404-446-2496

To / From:

Name:______________________________________
Address:____________________________________
City, State, Zip:______________________________
Fax:____
Phone: ____

Note: All records requests that come *into* our office will initially be processed by our Medical Records Coordinator. From that point, requested information will be forwarded to the provider for approval and signature. No records are to be released without the provider's approval, and Administrative Certification. Please note, there will be a Fee of $35.00 if the records are released ***to you*** directly.

What Records Do You Need:

- ☐ Entire Record
- ☐ Operative Reports
- ☐ Laboratory Results
- ☐ Other:_______________
- ☐ Ultrasound/Radiology/Xray Reports
- ☐ Pathology Reports
- ☐ Labor & Delivery Records
- ☐ ER/Hospital Reports

Reason For Records Request: ☐ Relocation ☐ Insurance Change ☐ Patient Discontent ☐ Second Opinion ☐ Employment/Insurance Request ☐ Other:______________________________

Patient Signature Of Release:____ Date:________/________/_____

________Staff Initials
________ Date Completed
Faxed/Mailed (circle one)

Updated 10/7/2019

Financial Policy/Cancellation Policy

Thank you for choosing us as your healthcare provider. We are committed to you and your healthcare needs. 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/provider.
PAYMENT IN FULL IS DUE (UPON REQUEST) AT THE TIME OF SERVICE.
For your convenience, we accept Cash, Credit or Debit cards.

(Please initial after each number.)

1. ______ It is the responsibility of the patient to confirm that the physician/provider is participating with 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. 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 the services provided may be non-covered services and not 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 (coinsurance, deductible or out-of-pocket fees) at the time of service. In office we accept Visa, MasterCard, Discover, American Express and cash. If a check is returned from your bank, there will be a **$40** returned check fee added to your total amount due. Ultimately, you are responsible for all charges incurred in our office. The insurance contractual obligation does not allow us to write off co-pays or deductible amounts.

3. ______ If the patient cannot keep the scheduled appointment, **it is the patient's 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. 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.

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

____ **DOB:________/________/________**

Patient, Legal Guardian or Responsible Party Signature

Today's Date: _________/_________/20__

Revised 10/18

Modern Ob/Gyn of North Atlanta, P.C. **Patient Medical History**

Please complete the following information as accurately as possible. Your answers on this form will help your provider understand your medical concerns and conditions better. If you cannot remember specific details, please give best estimates. We realize this a very lengthy form, but we are asking you to provide a comprehensive history for our Electronic Medical Record which results in improved care for you.

Name:____ **DOB**:________________**Date**:____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner **SS#**:_____/______/______

Address:____**City**:___________________________**State**:______**Zip**:________________

Home Phone:_________________________**Work Phone**:_____________________**Cell Phone**: ___________________________

Occupation: _______________________________________**Email**:____

Preferred Method of Communication: ☐ Phone ☐ Mail ☐ E-mail ☐ Text

How did you hear about us? __________________________________ **Referred by:**__________________________________

Spouse's Name: _______________________________________ **Spouse's Contact Phone**: _____________________________

Spouse's Occupation: ____ **Spouse's DOB:**________________________________

Emergency Contact Name:__________________________________**Emergency Contact Phone**: _______________________

Primary Care Physician:____________________________**Phone**:____________________**Fax**:____________________________

Pharmacy Name: __________________________________**Phone**:________________ **Location**: _________________________

<u>Insurance Information:</u>

Primary Insurance: Carrier ______________________ **Policy ID Number:** ________________________________

Do you have a Secondary Insurance? (for example, under spouse or parents) ☐ **Yes** ☐ **No**

Secondary Insurance: Carrier ____________________ **Policy ID Number:** _______________________________

<u>Reason for Visit</u>:

What is the reason for your visit: ☐Annual exam ☐Obstetric first visit ☐Gyn Problem

If you are here for a problem what are your concerns? ____

____

____

Health Maintenance/Preventive Screening History:

Colonoscopy	□Yes □No	If yes, date / /	Results:	□Normal	□Abnormal
Dexa Scan	□Yes □No	If yes, date / /	Results:	□Normal	□Abnormal
Mammogram	□Yes □No	If yes, date / /	Results:	□Normal	□Abnormal

Pap Smear History:

Pap smear	□Yes □No	If yes, date / /	Results:	□Normal	□Abnormal
LEEP	□Yes □No	If yes, date / /	Results:	□Normal	□Abnormal
Colposcopy	□Yes □No	If yes, date / /	Results:	□Normal	□Abnormal
History of HPV?	□Yes □No	If yes, date / /			
Received HPV vaccine?	□Yes □No	If yes, date____/___/____	□Inj.1	□Inj.2	□Inj.3

Medical History:

Major illness	Yes	Major Illness	Yes
Anemia		Hepatitis □ A □ B □ C	
Anxiety		High blood Pressure	
Arthritis/Joint Pain		High Cholesterol	
Asthma		Hypothyroid	
Blood clot/DVT		Hyperthyroid	
Blood Transfusions		Interstitial Cystitis	
Breast Cancer		IBS (irritable bowel syndrome)	
Cancer- list type:		Jaundice	
Chronic Lung Disease		Migraines	
Depression		Osteopenia	
Diabetes Type1		Osteoporosis	
Diabetes Type 2		Ovarian Cancer	
Fibroids		Seizures	
Fracture		Sexually Transmitted Disease	
GERD		Stroke	
Heart Disease		Tuberculosis-TB	

Other:____

____

Past Surgical History: □ No past surgical history

Year	Surgery	Complications?

Current Medications: ☐ None *If there is not sufficient space please attach copy of medications list to this form. Prescription and non-prescription medicine, vitamins, home remedies, birth control pills, herbs:

Medication	Dosage (mg)	Frequency	Prescribing Physician

Allergies: (Food, Drugs, Environmental) ☐ None ☐ Latex ☐ Iodine

Allergy	Interaction	Allergy	Interaction

Family Medical History: Please indicate below significant medical problems of family members. Indicate which family member by checking the appropriate column and the AGE OF ONSET: ☐No Family History ☐Adopted

	None	Mother	Father	Brother	Sister	Grand Mother (Maternal)	Grand Mother (Paternal)	Grand Father (Maternal)	Grand Father (Paternal)	Aunt	Uncle
Blood Clots/DVT											
Breast Cancer											
Cervical Cancer											
Colon Cancer											
Diabetes											
Ovarian Cancer											
Hypertension											
Stroke											
Uterine Cancer											
Other Cancers not mentioned											
Other diseases not mentioned											

Genetic Screening: ☐ None Includes patient, baby's father, or anyone in either family

Indicate Yes or No	Yes	No		Yes	No
Tay-Sachs			Sickle Cell Disease or Trait		
Neural Tube Defect			Maternal Metabolic Disorder		
Other inherited Genetic or chromosomal Disorder			Mental Retardation/Autism		
Thalassemia			Medication/Street Drugs/Alcohol		
Hemophilia			Muscular Dystrophy		
Cystic Fibrosis			Huntington Chorea		
Down Syndrome			Congenital Heart defect		
Patient or father of the baby had/has a child with birth defects not listed			Recurrent pregnancy loss or a still birth		

Gynecology:

Age at first period:	1st day (date) of last period:
Frequency of period:	Describe Period: ☐Light ☐ Normal ☐ Heavy
Length of period:	Current Contraceptive Method:
Do you have concerns regarding your period? describe:	Are you in menopause? ☐Yes ☐ No ☐ Unsure Date of last period: Are you on hormone replacement therapy? ☐Yes ☐No

Obstetrics:

	Number		Number
Total number of pregnancies		Abortions Induced	
Full Term Births		Miscarriages	
Pre-Term Births		Living Children	

No.	Birth Date	#weeks at delivery	Sex	Birth Weight	Delivery Type	Complications	Location of Delivery
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

Social History

Are you currently sexually active? ☐ Yes ☐ No _______ If yes, what age did you become sexually active? __________

Current sexual partner (s) is/are: ☐ Male ☐ Female ☐ Male and Female

Have you had more than 5 sexual partners in a lifetime? ☐ Yes ☐ No If yes, how many?___________

Have you ever had any sexually transmitted diseases? (STDs): ☐ Yes ☐ No

If yes, what kind? ____

Are you interested in STD screening? ☐ Yes ☐ No

Do you drink alcohol? ☐Yes ☐ No If yes, ☐ Social Drinker ☐ Daily If yes, how many drinks per week? ____

Do you use recreational drugs? ☐ Yes ☐ No

If yes, what kind? ____

Do you use tobacco? ☐ Yes ☐ No If yes, Current every day ____________ Current some days __________
Former________________Never_______________

If current, how many cigarettes a day?___________________________________ If an occasional smoker – please describe:____

Life Style: Please check off answer and give detail if it applies:

Have you been a victim of abuse or domestic violence? ☐ Yes ☐ No

Do you feel safe at home? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

Do you perform self -breast exam? ☐ Yes ☐ No

Do you drink milk or consume dairy products daily? ☐ Yes ☐ No

Do you take calcium tablets? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No If yes, frequency - how many times a week? ______________

BLOOD TRANSFUSION/PRODUCTS:	YES	NO	IF NO, PLEASE BRIEFLY EXPLAIN WHY.
WOULD YOU ACCEPT A BLOOD TRANSFUSION OR BLOOD PRODUCTS IN THE EVENT OF A LIFE THREATENING SITUATION?			

Please add any additional information: ____

____

AUTHORIZATION AND RELEASE:

I hereby certify that I have completed the above information to the best of my knowledge. I authorize, consent, request, and agree to actively participate in such services as routine assessments, the performance of diagnostic tests and procedures, care and treatment as self-referred or as ordered by my physician, his/her assistant or designees.

____ ____________________________

Signature **Date**

Please mail or fax your completed form to our office prior to your appointment. If you cannot return your form prior to your appointment, you must arrive 30 minutes early so we can enter your information into the computer. Thank you for your attention and cooperation.

Revised 10/2018