Genesis Gynecology, P.A.

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is release only with your consent.

Patient Information Form

Patient Name (Last, First, Middle):_____Date of Birth: _____ Age: _____

Social Security Number: _____ Email address: _____

Home Address: _____City: _____ State: _____ Zip: _____

Mailing Address (if different):_____ City: _____ State: _____ Zip: _____

Phone number (Home): _____ (Work): _____ (Cell): _____

Employer: _____ Occupation: _____

Employer's Address: _____City: _____ State: _____ Zip: _____

Marital Status: _____ Spouse's name: _____ Spouse's Employer_____

Primary Care Physician's Name: _____ Referred to our practice by: _____

Do you have an Advanced Directive? _____ If yes, please provide a copy to us for your records.

How did you hear about our practice? _____

Emergency Contact Information

Name: _____ Relationship: _____

Phone Number (Home): _____ (Work): _____ (Cell) _____

Insurance Information

Name of person responsible for fees: _____ Phone: _____

Insurance Company: _____ Claim Address: _____

Primary Policyholder's Name: _____ Date of Birth: _____ Relationship: _____

Policy ID #: _____ Group #: _____ Policyholder's Social Security #: _____

Secondary Insurance Co: _____ Claim Address: _____

Policyholder's Name: _____ Date of Birth: _____ Relationship: _____

Policy ID #:_____ Group #: _____ Policyholder's Social Security #: _____

Genesis Gynecology, P.A.
176 Fairway Drive
Kerrville, Texas 78028
(830) 792-0805 Fax (830) 792-0833

FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

If you are new to our office, thank you for choosing this office for your medical needs. If you are an established patient of Genesis Gynecology our policy may be new to you. It is our intent to treat our patients in a courteous and professional manner with regard to financial matters. Our goal is to obtain a desirable financial arrangement for our services. However, our office is a business which provides services to patients and sometimes provides supplies that we purchase from other vendors. Our physicians are here to provide medical advice, services and treat patients, not to discuss financial arrangements. All financial arrangements are made through our business office.

Our policy is to be paid at the time services are rendered. If you do not have insurance to help you with your medical cost, or if you have deductibles or co-insurance your insurance holds you responsible for, we ask for payment of such liabilities prior to or directly after services are provided. If Dr. Truelock suggests a procedure or surgery, then it is the patient's responsibility to discuss and meet their financial obligations with the business office manager. If you are unable to pay at the initial time set forth, we are willing to discuss options that are available and come to a mutual agreement. We are not able to provide services to patients free of charge; however, we will be happy to recommend you to other facilities and services in the community who can assist you. We are here to discuss these options with you if you so desire.

If you are an established patient of Genesis Gynecology, your credit history with this office will be reviewed upon each new procedure or surgery scheduled.

If you have questions regarding our policy, please feel free to speak with our business office manager prior to your services.

Basic policy: Payment for service is due in full at the time service is provided in our office.
For patients with insurance: We bill most insurance carriers and secondary insurance companies for you if proper paperwork is provided to us. Co-payments and deductibles are due at the time of service.
Medicare patients: We will bill Medicare for you. We will also bill secondary insurance carriers for you. All co-payments and deductibles are due and payable at the time of service provided.
Surgery Fees: All co-pays and deductibles, payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.
Noncovered services: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Yearly Health Checks: Periodic preventive health checks may or may not be covered under your health insurance policy.
Missed appointments: In fairness to other patients and to the doctors, we require at least 48 hours' notice to cancel appointments. You may be charged a fee for missed appointments and/or dismissed from the practice for multiple missed appointments if notice is not given.

Medicare Patients: Signature on file: I request payment of authorized Medicare benefits be made either to me or on my behalf to Genesis Gynecology, P.A. for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (print): _____ Medicare #: _____

Patient's Signature: _____Date:_____

Assignment of Insurance Benefits: Patients with insurance please read and sign below.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Genesis Gynecology, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature:_____ Date:_____

I have read, understood, and agreed to the above financial policy for payment of professional fees. The patient is ultimately responsible for all professional fees.

Signature: _____ Date:_____

Understanding Your Health Insurance

Your health insurance policy is a contract between you and the insurance company. It is an agreement that your insurance will pay for covered medical services if your premiums have been paid. They may not pay for every bill or treatment. It is very important that you know which medical treatments they will pay for and what they will not cover. Please keep in mind that determination of benefits is ***NOT*** *a guarantee of payment.*

DEDUCTIBLE:

The deductible refers to the amount of money that you would need to pay before any benefits from the health insurance policy can be used. This is usually a yearly amount so when the policy is renewed, usually after the year, the deductible would be in effect again. Some services may be available without meeting the deductible first. Usually there are separate individual deductible amounts and total family deductible amounts.

CO-INSURANCE:

The insurance company has a set fee limit for each type of treatment. The insurance company will pay the maximum according to your plan policy and anything beyond that is your responsibility. This is usually a percentage amount that is your responsibility. A common co-insurance split is 80/20. This means that the insurance company will pay 80% of the procedure and you are required to pay the remaining 20%.

CO-PAYMENTS:

The copayment is a fixed amount that you are required to pay at the time of service. It is usually required for basic doctor appointments.

OUT-OF-POCKET:

This is the cost one would pay out of their own pocket. An out-of-pocket expense may refer to the co-payment, co-insurance, or deductible. Also, when the term annual out-of-pocket maximum is used, that is referring to how much you would have to pay for the whole year out of your pocket, excluding premiums.

Signature **X** _____

Genesis Gynecology, PA

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal health care information (PHI). Please read it carefully before signing.

Genesis Gynecology, P.A. will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure.

By signing this authorization you acknowledge and agree that Genesis Gynecology, P.A. may use or disclose protected health information for the purpose(s) of diagnosing or providing treatment, obtaining payment for services rendered or to conduct health care operations.

By signing this authorization you agree that Genesis Gynecology, P.A. or its Business Associates may disclose your personal health care information by fax, telephone, mail or e-mail to other physicians, healthcare facilities, or insurance companies.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Genesis Gynecology, P.A.'s HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Genesis Gynecology, P.A. has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Genesis Gynecology, P.A. or by sending a written request with return address to 176 Fairway Drive, Kerrville, Texas, 78028.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Genesis Gynecology, P.A. for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Genesis Gynecology, P.A. has taken action in reliance on it. A revocation is effective upon receipt by Genesis Gynecology, P.A. of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization; (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA; (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Genesis Gynecology, P.A.; or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

I have reviewed the completed information on the Patient Registration Form and the information is accurate and true. I also have read and understand the Financial Policy statement. I know that the HIPAA notice of privacy practices is posted in the office of Genesis Gynecology, P.A., and that I may request a copy.

I hereby authorize Genesis Gynecology, P.A. and its physicians to furnish information concerning illnesses and treatments of the above named patient to any third party payor with whom the patient is under contract. I hereby authorize payment of benefits directly to Genesis Gynecology, P.A. otherwise payable to me for medical and/or surgical services rendered.

I hereby permit the doctor or their assistant to take photographs or other digital images of the above named patient. I understand that these images are for legal documentation or presentation at professional meetings and discussions, and I give permission to use them as such.

The following people may have access to my chart _____

_____

Signature:_____

Date:_____

Data Exchange Consent

healow Insights® is a cloud-based service designed to automate the bidirectional exchange of actionable data between health plans and providers — and deliver those critical insights. In other words, this allows us to electronically send and receive your healthcare information with your providers and/or facilities.

Please check the box below to determine if you would like to share any medical information you may have with your providers and/or facilities using **healow Insights®** with Genesis Gynecology.

☐ Opt **in** – Send and receive documents to and from Genesis Gynecology and your providers/facilities

☐ Opt **out** of all communication

Print Patient Name: _____ Date: _____

Patient/Guarantor Signature: _____

Genesis Gynecology
176 Fairway Drive, Kerrville, Texas 78028
(830) 792-0805 Fax (830) 792-0833

Patient Name: _____ Age: _____ Date: _____
Reason for visit: _____
Current Medications (include all over the counter medications):_____
_____
_____

Medical History:
Have you ever had or do you currently have any of the following?

Serious Heart Trouble (coronary artery disease), Cholesterol problems (hypercholesterolemia), High Blood Pressure (Hypertension), Stroke, Diabetes, Hypothyroidism, Blood Clot to the lung (pulmonary embolism), Infections/Clots in the veins (deep venous thrombosis), Emphysema, Asthma/Lung disease, Stomach ulcers (peptic ulcer disease), Hernia, Breast Cancer, Ovary Cancer, Colon Cancer, Other Cancers, Gallbladder disease, Hepatitis/Liver disease, Anemia (low blood count), Osteoporosis, Drug/Alcohol abuse, Mental/Nervous disorders, Depression, Migraine Headaches, Epilepsy (seizures), Anesthesia complications, History of a blood transfusion, Major accidents, Mitral Valve Prolapse, Rheumatic fever, Urinary incontinence, Infertility, Other_____

Allergies to any medications: _____

Surgical History:
Have you ever had surgery for any of the following? (Please give dates, if yes)

Skin Cancer	Appendix	Tonsils/Adenoids
Gallbladder	Hernia repairs	Hemorrhoids
Breast Lump	Infertility	Tubal ligation

Hysterectomy: Yes No
Abdominal or Vaginal
Ovaries removed?
Other surgeries (dates) _____
Have you ever been hospitalized for any other reason? _____

Family History:
Have any of your family members had any of the following? If so, Please indicate how they are related to you- (M) mother, (F) father, (B) brother, (S) sister, (MGP) maternal grandparents, (PGP) paternal grandparents, (C) children

Heart disease (coronary artery disease) _____ Cholesterol Problems (hypercholesterolemia) _____
High Blood Pressure (Hypertension) _____ Stroke _____ Blood Clot to the lung (pulmary embolism) _____ Infections/Clots in the veins (deep venous thrombosis) _____ Emphysema ____
Lung Disease _____ Stomach ulcers _____ Hernia _____ Breast Cancer _____

Ovary Cancer _____ Other Cancers _____ Gall Bladder disease _____
Hepatitis/Liver disease _____ Bowel/Rectal disease _____ Diabetes _____
Kidney disease/Infections _____Thyroid disease _____ Anemia (low blood count) _____
Osteoporosis _____ Drug/Alcohol abuse _____ Mental/Nervous disorders _____
Depression _____ Anesthesia complications _____ Urinary incontinence _____
Mitral Valve Prolapse _____ Other _____

Social History: (please circle answer)
Smoking: Yes No Quit Exercise: Yes No Swimming Walking Jogging
Smoke for: <1 yr 1-5yrs >5yrs Cycling Other
Passive smoke exposure: Yes No
Alcohol: Yes No Daily Weekly Monthly Socially
1 drink/session 1-3 drinks 3-6 drinks >6 drinks

Sexually Active: Yes No Travel outside the U.S.? Yes No
Recreational drug use: Yes No Occupation: _____

Do you have any reasons why you would NOT accept a blood transfusion?
_____
Primary Care Physician: _____
Local Pharmacy that you use: _____

Review of systems (Please circle any that apply):
*Are you **CURRENTLY** experiencing any of the following:*

Constitutional: weight gain loss of appetite fever weakness weight loss night sweats

Dermatology: rash moles lumps dry or sensitive skin hives

Endocrinology: fatigue excessive thirst excessive urination cold intolerance
heat intolerance dry skin hair loss

Neurology: headaches tingling/numbness seizures insomnia memory loss
dizziness gait abnormality

Respiratory: shortness of breath chest pain wheezing cough chest congestion

Allergy: runny nose itchy eyes ear fullness sinus congestion

Hematology/Lymph: fatigue varicose veins easy bruising swollen glands

Urology: difficulty urination blood in the urine frequent urination urinary incontinence
nocturia burning with urination
Ear/Nose/Throat: recent cold/URI hearing loss ringing in ears sore throat sinus problems

Cardiology: chest pain heart palpitations leg swelling

Gastroenterology: nausea heartburn vomiting abdominal pain diarrhea
constipation blood in stool

Musculoskeletal: joint pain leg cramps low back pain restless leg syndrome

Psychology: high stress level depression sleep disturbances eating disorder
mental/physical abuse anxiety

Female Reproductive (genital): heavy periods dysparuenia (painful sex) sexually active
infertility pelvic pain using contraception intermenstrual spotting
postmenopausal bleeding abnormal vaginal bleeding hot flashes

OB History:
Number of pregnancies _____ Number of live births _____ Cesareans _____
Premature births _____ Miscarriages _____ Abortions _____
Weight of child at birth _____
Problems/complications of any pregnancies _____
Are your tubes tied? Yes No Vasectomy (Spouse)? Yes No

GYN History:
Age of first menstrual period: _____ Date of last menstrual period: _____
Frequency of periods: _____ Duration: _____
Is your menstrual flow: Light Moderate Heavy
Menstrual pain: Mild Moderate Severe

Date of last pap smear: _____ Any abnormal pap smears: _____ When? _____
Date of last mammogram: _____
History of any sexually transmitted disease: Herpes HIV Gonorrhea Chlamydia
HPV Syphilis Trichomonas
Current birth control method: _____
Have you EVER had any of the following?

Severe menstrual pain	Painful intercourse	Vaginal infections
Pelvic Inflammatory Disease	Endometriosis	Infertility
Cancer of any female organs	Sexual Dysfunction	Pelvic Pain

Have you undergone menopause ('the change")? _____ If so, when? _____
Have you had a hysterectomy? _____ Were one or both ovaries removed? _____

Have you had problems trying to conceive or with infertility? __ _____
Do you leak urine if you cough, sneeze, jump or laugh? _____
Are your periods so heavy that they are bothersome? _____