OBSTETRICAL MEDICAL HISTORY

PHYSICIAN NOTES

Patient Name _____ Date_____

PERSONAL HEALTH HISTORY

1. Are you allergic to any medications? YES NO
   If yes, please list reactions: _____
   Are you allergic to any foods? YES NO
   If yes, please list reactions: _____
   Are you allergic to any environmental elements? YES NO
   If yes, please list reactions: _____
2. Please circle any conditions that you have or have had in the past:

Arthritis or lupus	Depression	Hepatitis
Asthma	Diabetes	Recurrent UTI's
Blood Disease	Epilepsy	High Blood Pressure
Bowel Disease	Headaches	Kidney Disease
Chicken Pox	Heart Disease	Migraine Headaches
Thyroid Disease	Herpes	Other

   Describe, if needed: _____
   _____
3. Please indicate any surgery that you have had: _____
   _____
4. Please describe any health problem, or symptoms that you are having are having at this time: _____
   _____
5. Do you have any religious objectives to any form of medical treatment that you would like to make us aware of (i.e. refusal of blood transfusions)?
   _____
6. Do you have any special needs for:
   Hearing YES NO Vision YES NO Language YES NO
7. Have you ever had an influenza vaccine? Yes No If yes, when? _____
8. Do you have cats? Yes No

EXPOSURE AFFECTING HEALTH

1. Do you smoke cigarettes? YES NO If yes, how many packs a day?____
2. Do you drink alcoholic beverages? Yes No If yes, how often? _____
3. Please list any medication taken since your last period: _____
   _____
4. Please list any "recreational" drugs used since your last period (i.e. cocaine, marijuana, etc.) _____
5. Do you have a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bi-sexual male, exposure to an intravenous drug user, or have any reason to believe you may have been exposed to AIDS?_____
   _____
6. Please list any sources of chemical or radiation exposure that you encounter:
   _____
7. If you are on a restricted diet, please describe: _____
   _____
   _____
   _____

GYNECOLOGICAL HEALTH HISTORY

1. When was your last Pap Smear: _____ Have you ever had an abnormal Pap Smear? YES NO If yes, when and where were you treated? _____
   What was the diagnosis? _____
2. Have you ever had gonorrhea, Chlamydia or pelvic inflammatory disease? YES NO If yes, when and where were you treated? _____
3. Have you ever had herpes? YES NO
4. Have you ever used an IUD (intrauterine device) for contraception? YES NO If yes, please indicate when: _____
   Did you have any problem with the IUD? YES NO Please describe: ___
5. Do you have a history of infertility? YES NO If yes, please describe: __
6. Please list any other concerns you have related to your past health history:
7. When was the first day of your last menstrual period? _____

FAMILY HISTORY & GENETIC HISTORY

1. Heave either you or the baby's father had a child born with a birth defect? YES NO If yes, please describe: _____
2. Did either you or the baby's father have a child defect yourselves? YES NO If yes, please describe: _____
3. Please describe any abnormalities that have occurred in children in your family or the baby's family (for example, mental retardation birth defects; deformities, or inherited diseases like hemophilia, muscular dystrophy or cystic fibrosis). _____
   How is the affected child/person related to you? _____
4. Do either you or the baby's father have a history of pregnancy losses (miscarriages or stillborn)? YES NO
5. Some genetic problems occur more in couples with certain racial or ancestral backgrounds. Please circle if either you or the baby's father is one of these backgrounds:
   - Jewish ancestry? YES NO — If yes, have you had Tay-Sachs screening tests? YES NO
     Date: _____ Result: _____
   - African-American? YES NO — If yes, have you had Sickle Cell screening? YES NO
     Date: _____ Result: _____
6. Please circle if anyone in your family or the baby's father's family has:
   - Diabetes YES NO — If yes, how is that person related to you? _____
   - Bleeding Disorder YES NO — If yes, how is that person related to you? _____
   - Hypertension YES NO — If yes, how is that person related to you? _____
   - Cancer YES NO — If yes, how is that person related to you? _____
7. Please list any other concerns you have about birth defects or inherited disorders:
8. Do you or the baby's father have a history of twins/ multiple babies? Yes No
9. Will you be 35 or older at the time the baby is born? YES NO
10. Will the father be 50 or older? YES NO

Advanced Directives (end of life issues)

Do you currently have a living will or advanced Directives:____yes ____no

Please consult with your health provider with any of life issues, advanced care directives that you desire to put in place or receive information regarding these issues.

Yes, I would like to receive information __ No, I don't not require any information ___

How did you hear about us? Did someone refer you?
If so… We would like to thank them!
Doctor: _____ Family/Friends: _____
Web: Google Yahoo MSN : search keywords _____
Insurance Co: _____ Other: _____

Are you pregnant with multiple babies _____ If so, how many_____
Baby's Name _____
Estimated Due Date _____
Number of previous pregnancies _____
Number of Children _____

Have you experienced any changes recently: (CIRCLE all that apply)

Loss of work	Promotion	Loss of income	Increase in Income
Death in Family	Addition to Family	Injury to self or family member	ADHD
Sore Breast	Bleeding	Nausea	Varicose Veins
Sleep Disturbance	Anxiety	Depression	Sudden Swelling

Current Nutrition/Diet _____
Current Complications _____
Hospital Preference in case of Emergency: _____ _____
Name of Hospital Phone Number
What medications are you currently taking: _____
_____
Do you consume alcohol? _____ How often? _____
Do you take recreational drugs? _____ How often? _____
Do you have medical problems, recent injuries or surgeries: _____

Please CIRCLE any of the following that apply:

Back Pain/Type?_____	Stroke	Diabetes	Carpal Tunnel
Cancer/Type? _____	Arthritis	Anemia	Low Blood Pressure
Allergies/Type? _____	Heart Disease	Sciatic Nerve Pain	
Surgery/Where? _____			
Other _____			

When was your last Massage _____ How often do you get Massaged _____
Would you be interested in an Aromatherapy Massage? YES NO
If you answered yes, do you have any allergies? _____

Support Network:
Partner _____
Name Occupation Phone Number
Obstetrics & Gynecology Surgeon _____
Name Address Phone Number
Doula _____
Name Address Phone Number

Authorization: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for all service rendered on my dependents or my behalf. I consent to/and authorize treatment for the above named patient. I authorize the release of any information requested by health professionals participating in my care.
Name: _____
Signature: _____ Date: _____

PATIENT/CLIENT NOTIFICATION OF PRIVACY PRACTICES SIGNATURE OF ACKNOWLEDGEMENT FORM

Dr. Christine Brass-Jones DO, Dr. Denise Grobe ND, Mary Ann Shostek PA-C,
Center For True Harmony Wellness & Medicine, PC

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that **Center For True Harmony Wellness & Medicine, PC** has the right to change its Notice of Privacy Practices and that I may contact the Privacy Officer at any time to obtain a current copy of such practices.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment or health care operations. If restrictions are placed, we **Center For True Harmony Wellness & Medicine, PC,** are not required to agree, but if agreed upon will abide by such restrictions.

Patient/Client Name: _____ DOB: _____

Signature: _____ For Minor- Parent/Guardian _____

____ YES ____ NO **I consent to receive calls from Dr. Christine Brass-Jones DO, Dr. Denise Grobe ND, and Center For True Harmony Wellness & Medicine, PC for my protected healthcare and other services at the phone numbers below, including any wireless number provider. I understand I may be charged for such phone calls by my wireless carrier and that such calls may be generated by an automated dialing system.**

____ YES ____ NO **I consent to have information regarding my health insurance left on my voicemail**

____ YES ____ NO **I consent to have information regarding my lab results left on my voicemail**

____ YES ____ NO **I consent to have information regarding my upcoming appointment including; time/date, information requested before appointment, information regarding any prescriptions needing to be taken before appointment, etc. left on my voicemail.**

____ YES ____ NO **I consent to have information regarding any private information including; prescriptions, notification of medicinary items I am needing in stock, Center For True Harmony Wellness & Medicine, PC, requesting lab results from other offices, etc. left on my voicemail.**

I understand that I am not required to give my consent to do so and that I may revoke this authorization at any time.

Phone Calls at: _____ (Phone Number) _____ (Name of Person)

Calls & Voicemails at: _____ (Phone Number) _____ (Name of Person)

I authorize _____ to pick up medical records; medicinary; or other medical supplies on my behalf.

_____ Patient Signature

_____ Date

FINANCIAL POLICY
CENTER FOR TRUE HARMONY WELLNESS & MEDICINE; TRUE NATURAL HEALTHCARE INC.

Thank you for choosing us as your health care provider. We are committed to providing quality medical care. We have adopted the following Financial Policy to reduce confusion regarding your treatment and require you to read and sign it prior to services being performed.

INSURANCE

- Deductible, Co-Payment and Co-Insurance

Your insurance policy is a contract between yourself and the insurance plan. *It is your responsibility to verify your benefits with your insurance company, we do so as an added courtesy to you.* Your insurance plan determines your annual deductible, your visit co-pay and your visit co-insurance. (For example, your annual deductible may be $500, your co-pay $25 and your co-insurance 90/10%. This means at every year, you're required to pay $500 cash before your 90/10 co-insurance will take effect. Upon reaching your deductible you will only be required to pay your co-pay and co-insurance amount for each visit.) You will also be responsible for any and all **deductibles, co-insurance, co-pays, and all balances at the time of service. You may still receive a bill if your insurance plan adjusts its coverage from what they dictated to us.** **Initial _____**

- Billing – Office Visits

We must bill your insurance with current and valid information (i.e., ID #'s, copy of card, etc.). **We will bill insurance for those plans with which we have a contract**. Not all health plans have coverage for certain procedures, benefits, and in the event your insurance company deems services "non-covered," you will be responsible for the bill.

You may also be required to get pre-authorization for certain procedures and visits. It is *always best* for you to call your insurance plan to verify coverage and determine any pre-authorizations needed or any requirements and restrictions in your plan. If these requirements are not followed correctly you may be financially responsible for all or part of the services rendered.

Initial _____

- Billing - Lab work

Lab work and imaging, ie ultrasounds et al. may be recommended by your provider. It is *your responsibility* to confirm that all lab work will be covered by insurance and what if any costs you may be responsible for paying. Each individual lab and imaging center bills out for your lab work that is ordered. The Center for True Harmony is not responsible for lab costs which are not covered by insurance. **Initial _____**

-Requirements and Restrictions

It is your responsibility to notify our office of insurance changes and to know your own coverage. This includes co-pays, labs, radiology & hospital coverage. **If we are not contracted with your insurance**, you will be expected to pay for services at the time they are rendered. All payments are due at the time of service. If you have any questions about your insurance billing, call our billing office that handles insurance billing at 480-539.6646. **Initial _____**

MINORS- **A parent or legal guardian must accompany a minor patient** on their first visit, so as to obtain a legal signature for treatment and billing purposes. The minor may receive treatment on subsequent visits, unaccompanied, with parental permission at initial visit.

APPOINTMENTS – If you cannot keep your scheduled appointment, you must call our office to cancel or reschedule. There will be a cancellation fee charged to you without proper notification. **This $25 fee will be charged to you regardless of insurance and/or private pay patients/clients.**

BILLING STATEMENTS/FEES/COLLECTIONS –I understand that billing statements may be emailed or mailed to me. I understand that the billing statement date constitutes when all charges are due, not when I open and read the emailed/mailed billing statement. **Initial _____**

I understand and promise to pay all outstanding balances within 30 days of the billing statement date. I understand that I if I do not pay within 30 days, and a followup call/statement is sent I will owe extra fees and interest as outlined below. **Initial _____**

Outstanding Balance Fees/No response within 30days	**Payment Plan Fees**
2% monthly interest for Outstanding Balances	1% monthly interest for Payment Plans
30% fee for Balances sent to Collections	$3 Monthly Payment Plan Processing Fee
	Other Fees
	$25 Late Cancelation/No Show Fee

I hereby authorize **Center For True Harmony Wellness & Medicine, P.C.** to release any information that may be necessary to my insurance carrier for payment and processing of my claims for medical/treatment charges, or to review information related to my health care providers participation with my health plan. I assign to **Center For True Harmony Wellness & Medicine, P.C.** any and all benefits to which the patient/client or insured party is entitled for medical services. **I have read the Financial Policy. I understand and agree to the above Financial Policy.**

_____ _____

Signature Patient/Client or Responsible Party Date

THE CENTER FOR TRUE HARMONY WELLNESS & MEDICINE

TRUE SPA

TRUE NATURAL HEALTHCARE

Patient Demographics Information Sheet

(Please Print) SS# _____ - _____ - _____

Patient's Name: _____
Last Name First Name Middle Initial

Permanent Address: _____Apt #_____

City: _____State: _____ ZIP: _____

Local Address: _____ Apt #_____

City: _____ State: _____ ZIP: _____

Date of Birth: _____/_____/_____ Sex: F / M Marital Status: S / M / W / D

Phone #: (_____) _____ - _____ Work Phone #: (_____) _____ - _____

Other #: (_____) _____ - _____

Primary Care Physician: _____ PCP Phone #: _____
Last Name First Name

Patient Employer: _____

Primary Insurance

Ins Company Name: _____

ID/Policy #: _____

Group #: _____

Primary Policy Holder's Name: _____

Primary Policy Holder's Date of Birth: _____M / F

Policy Holder's Relation to Patient: _____

Policy Holder's Employer: _____

Primary Policy Holder's SSN# _____ - _____ - _____

Secondary Insurance

Ins Company Name: _____

ID/Policy #: _____

Group #: _____

Primary Policy Holder's Name: _____

Primary Policy Holder's Date of Birth: _____M / F

Policy Holder's Relation to Patient: _____

Policy Holder's Employer: _____

Primary Policy Holder's SSN# _____ - _____ - _____

Who may receive information regarding your protected health information? (Check all that apply)

Spouse: _____ Name: _____Date of Birth: _____

Children: ____ Name: _____Date of Birth: _____

Name: _____Date of Birth: _____

Name: _____Date of Birth: _____

Parent/Guardian: ____ Name: _____Date of Birth: _____

Name: _____Date of Birth: _____

Significant Other/Friend: _____ Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

May we leave messages regarding test results and appointments on your answering machine? Yes_____ or No_____

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

Date: _____ Signature of Patient or Guardian: _____

IF YOU HAVE TWO INSURANCE COMPANIES, PLEASE PRESENT BOTH CARDS SO THAT WE MAY FILE WITH YOUR SECONDARY CARRIER FOR ANY BENEFITS DUE.