Center for True Harmony Wellness & Medicine
GYNECOLOGY INTAKE

Name _____ Birth Date _____ Today's Date _____

Current health problems/concerns:

_____
_____
_____

Intention for this appointment:

_____
_____
_____

Allergies:

Please list drug allergies, with the reactions you have_____

Please list food allergies, with the reactions you have _____

Please list environmental allergies, with the reactions you have____

MEDICAL INFORMATION

General Health—Excellent _____ Good _____ Fair _____ Poor _____

Medications _____
_____
Vitamins & Herbals & Homeopathics _____
_____
Have you ever had your cholesterol checked? Date _____ Results _____
Have you ever had a mammogram? Date _____ Results _____
Do you do self-breast exams? _____

Surgeries/Hospitalizations

Date Hospital Diagnosis/Surgery Physician

_____
_____
_____

Pregnancies (include miscarriage/abortion please)

Date How far along Sex of baby Weight of baby Problems-

_____
_____
_____
_____

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 ___

Current Health Care Providers

Name Dates Care Provided

_____
_____

Would any of these healthcare providers prefer us to follow-up after your visit here?
Name _____ Address _____

Other Medical Conditions (Circle)

Heart problems	High Blood Pressure	Stroke	Varicose Veins
Phlebitis	Clotting defects	Bleeding tendency	Diabetes
Epilepsy	Blood Transfusions	Rheumatic Fever	Jaundice/Hepatitis
Fractures	Cancer	Arthritis Colitis	Asthma
Chronic Fatigue/EBV		Eating Disorder	Fibromylagia

Childhood diseases such as German measles or chicken pox _____
OTHER: _____

HABITS

Dietary preferences/restrictions: _____
Examples of a day's menu –
Breakfast: _____
Lunch: _____
Dinner: _____

What do you like to do for exercise? _____
How often do you exercise? _____ For how many minutes? _____
Tobacco use: how much? _____ how long? _____ when did you quit? _____
Caffeine use: how much? _____ how long? _____ when did you quit? _____
Alcohol use: how much? _____ how long? _____ when did you quit? _____
Other drug use? _____ how much? _____ how long? _____ when did you quit? ___
Any current or past history of physical abuse? _____ Or sexual abuse? _____

MENTAL/EMOTIONAL

Do you experience or have history of any of the following
Depression Anxiety ADHD Other Behavioral Conditions
If yes, please put dates (past/current), and treatments (past/current)
_____
_____
_____

LIFE STRESSES

Family, work, self, etc.
_____
_____
_____

Family History

Please include diseases, age of person if alive and age/cause of death if deceased…….
Thank you!!

Mother _____ Father _____
Sisters _____ Brothers _____
Maternal Grandmother _____ Maternal Grandfather _____
Paternal Grandmother _____ Paternal Grandfather _____
Aunts _____ Uncles _____
Other _____

GYNECOLOGICAL HISTORY

First day of last period: _____ Date of last pelvic exam: _____
Date of your prior period : _____ Date of last PAP smear: _____
Age first period began : _____ were the above normal? _____
Have you had the HPV vaccine? YES NO If yes, when? _____
Have you EVER had an abnormal PAP? _____ When? _____ Results? _____
Treatment: _____
Are you sexually active? _____ Do you have intercourse? _____ Do you practice safe sex? _____ Are your trying to get pregnant? _____ For how long? _____
Current birth control method- _____ How long? _____
Past birth control methods _____
Problems experienced with any birth control methods: _____
_____
Normally (not on pills) how many days from the start of one period to the start of the next? _____
Number of days of flow _____ Amount of bleeding _____ Amount of cramping __
Do you experience premenstrual symptoms? _____ When do they start? _____
Are there any current changes to your normal pattern _____

Bleeding between periods? _____ When? _____
Unusual pelvic pain or fullness _____ When & describe: _____
Unusual vaginal discharge/itching? _____ Describe: _____
How long has this occurred? _____ Treatments you have tried? _____
Any sexual concerns to discuss? _____
Past history of tubal infection? _____
Past history of sexually transmitted disease? _____
Any history of DES exposure? _____
Other: _____

REVIEW OF SYSTEMS: any present problems you are experiencing (Circle)

General

Fever Chills Hot flashes Unusual hair growth
Skin eruptions Weight Change

Head

Headaches Dizziness Visual changes Hearing defects
Sinus trouble Fainting

Abdomen

Bloating Heartburn/indigestion Cramps/pain Nausea/vomiting
Diarrhea Constipation Hemorrhoids Bloody/tarry stools

Chest

Chest pain Shortness of breath heart murmur MVP
Palpitations Chronic cough wheezing Other_____

Breasts

Lumps Bleeding Nipple discharge Tenderness Other_____

Bladder

Frequent urination Painful urination Blood in urine Inability to hold urine
Inability to empty bladder Need to get up at night to urinate
OTHER Concerns: _____

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: _____

How did you hear about us?:
Online search?- what were the keywords you searched?:_____
Website? Friend? Who may we thank?_____ Other?:_____

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.