110 Tampico Suite 210 Walnut Creek, CA 94598
Tel 925-935-6952 Fax 925-935-1396 Email Info@Leachobgyn.com

Please PRINT and complete all sections below.

Last Name	First Name	MI	Marital Status
DOB	Email		Primary Care Physician
Address	City	State	Zip
Home Number- Ok to leave message? Yes No	Cell number- Ok to leave message? Yes No		Do you want TEXT message reminders Yes NO
Emergency contact	Relationship	Emergency Contact's Phone#	
Do you need an interpreter?	Preferred Spoken Language	Preferred Written Language	

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino
- ☐ Unknown
- ☐ Decline to disclose

Race
- ☐ American Indian / Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ White or Caucasian
- ☐ Other
- ☐ Unknown
- ☐ Decline to disclose

Religion
- ☐ ______________________________
- ☐ Decline to disclose
- ☐ None

Employer ______________________________
- ☐ Full time
- ☐ Part time
- ☐ Other

I authorize the following person(s) to receive my Personal Health Information (valid for 1 year)

Name ______________________________ Relationship______________________

Name ______________________________ Relationship______________________

I understand I have the right to revoke this authorization at any time, via written or verbal request.

Primary Insurance Name ☐ **PPO** ☐ **HMO**			
Address	City	State	ZIP
Name of Insured (Subscriber)	DOB (Subscriber)	Relationship to Patient	
ID #	Group #	Copay $	
Secondary Insurance Name			
Address	City	State	ZIP
Name of Insured	DOB	Relationship to Insured	
Policy #	Group #	Copay $	

Pharmacy Information			
Name			
Address	City	State	ZIP

I hereby assign medical benefits otherwise payable to me, to Women's Health Partners of California, Inc. I understand and agree I am financially responsible for any unpaid balance for services rendered along with legal fees incurred in collecting payment from me. If applicable, I understand that I am responsible for all copays, deductibles, co-insurance, and balances. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

Patient Signature ______________________________ Date ____________________

Timothy A. Leach, MD
Obstetrics, Gynecology and Menopause
110 Tampico Suite 210 Walnut Creek, CA 94598 Tel 925-935-6952
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Name ______________________________ Date _________________Primary care M.D.___________________
Address ____________________________ City ____________________________________Zip _____________
Phone ______________________________ Age ______________Birth date ______________________________
Marital status M D S W Occupation ____

PERSONAL HISTORY

Allergies: _______________________________________
____
____
____
____

Type of surgery (include cervix surgery) year done:_______
____
____
____
____

Medications: Type Dosage
____
____
____
____
____

List any current medical problems you have:
____
____
____
____
____

Tobacco: ☐ No ☐Yes _____Packs/Day
Alcohol: ☐None ☐Occasionally ☐Daily

MENSTRUAL HISTORY

Age at start: __________Regular? ☐Yes ☐No Cycle length: __________________________________
(every how many days):_____________________Usual duration: ____________________days
Flow: ☐Light ☐Medium ☐Heavy
Pain or Cramps? ☐Yes ☐No
Ever missed a period? ☐Yes ☐No
First day of last menstrual period: ___________________

GYNECOLOGICAL HISTORY

Date of your last pap smear: ____
Any abnormal pap smears? ☐Yes ☐No
Dates:____
Procedures to treat:____
Date of last mammogram: ____
Any abnormal? ☐Yes ☐No
Dates:____
Procedures done:____

Present method of birth control. ____
Any problems with this method?____
How long have you used this method? ____

Have you ever used birth control pills ☐Yes ☐No
Circle other method you have used: Pills Suppositories Condom Diaphragm Rhythm Withdrawal Vasectomy IUD Foam Patch Tubal Lig. Other __________________________

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MEDICAL and FAMILY HISTORY

Do you have or have you ever had (please check all that apply)

	Yes	No	When
Breast cancer	☐	☐	
Breast discharge	☐	☐	______
Breast lumps	☐	☐	______
Depression	☐	☐	______
Fibroids	☐	☐	______
High blood pressure	☐	☐	______
High cholesterol	☐	☐	______
Loss of urine	☐	☐	______
Ovarian cysts/tumors	☐	☐	______
Thyroid disease	☐	☐	______

Relation	Living	Breast Cancer	Ovarian cancer	Cervical cancer	Endometrial cancer	Clots in veins	High Blood Pressure	High cholesterol	Pre Term labor	Stroke
Father										
Mother										
Sister										
Brother										
PGFather										
PGMother										
MGFather										
MGMother										

CHECK IF YOU HAVE EVER HAD:

☐Venereal warts ☐Gonorrhea ☐Herpes ☐PID ☐Other ☐Syphilis ☐Trichomonas ☐Chlamydia

Did your mother take the drug DES when she was pregnant with you? ☐Yes ☐N

PREGNANCY HISTORY

Have you ever been pregnant? ☐Yes ☐No

Number of pregnancies ____________________ Number of children ______________________

Number of: Full term _____________ Premature _________ Miscarriages ________ Stillbirths __________

Ectopic Preg _________ Abortions __________

Delivery Type: Vaginal ______________C-section ___________ Why?____________________________

Are you presently sexually active? ☐Yes ☐No

Dates of pregnancies: ______________ __________________ __________________

Any complications/problems with pregnancy (circle)__ Diabetes High blood pressure

Bleeding Preterm labor DES problems Other_______________

Any complications after delivery? (circle) Infection Excessive bleeding Other_______________

Please sign: ____

Signature Date

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FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and our practice, we have adopted the following financial policy. We are dedicated to providing the best possible care and service to you. We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE, unless other arrangements have been made in advance by either yourself or your health coverage carrier (medical insurance). For your convenience we do accept MasterCard, Visa, American Express and Discover.

YOUR MEDICAL INSURANCE:

If you do not bring us sufficient information to bill your insurance (i.e. Name, address, phone # of insurance company, medical group if relevant, ID and group ID's; name and date of birth of insured/guarantor), then full payment is due at time of service.

IT IS THE POLICY OF OUR OFFICE TO COLLECT ANY CO PAYMENTS WHEN YOU ARRIVE FOR YOUR APPOINTMENT.

WE DO REQUIRE A 72-HOUR NOTICE FOR CANCELLATIONS. WE WILL BILL A $50 FEE TO PATIENTS WHO DO NOT CANCEL WITHIN 72 HOURS OF APPOINTMENT TIME. We hold contracts with many insurers and health plans. We will bill those plans with which we have a contract, and will only require you to pay the authorized co-payment at time of service. If your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. If we determine prior to your visit that a service is "not covered", full payment is due at time of service.

We will only release the minimum amount of personal information necessary to get your claim processed.

If you have insurance with a plan with which we do not have a contract, we will be happy to prepare and send a claim for you on an unassigned basis. This means that your insurer will probably send payment directly to you. Payment is due upon receipt of a statement from our office.

We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility, and is due upon receipt of a statement from our office. Secondary

MINOR PATIENTS:

For all services rendered to minor patients, we will look to an adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient/ Responsible Party (if minor) ______________________________

Please Print Name of the Patient: ______________________________

Date: ______________________________

HIPAA - Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent for Timothy A. Leach MD Inc to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).
(The Notice of Privacy Practices provided by Timothy A. Leach MD Inc describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Timothy A. Leach MD Inc reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to [Insert name and address of privacy officer for the practice].

With this consent, Timothy A. Leach MD Inc may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Timothy A. Leach MD Inc may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Timothy A. Leach MD Inc may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Timothy A. Leach MD Inc restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Timothy A. Leach MD Inc to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Timothy A. Leach MD Inc may decline to provide treatment to me.

____
Signature of Patient

______________________________ ______________________
Print Patient's Name **Date**

____
Legal Guardian Signature - if under 18 yrs

____
Legal Guardian printed name, if applicable

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Timothy A. Leach, MD
Obstetrics, Gynecology and Menopause

Electronic Payment Authorization Form

COMPANY INFORMATION

Company Name	Merchant ID		
Timothy A. Leach MD, Inc			
Street Address	**City**	**State**	**ZIP Code**
110 Tampico Suite 210	Walnut Creek	CA	94598

PAYOR INFORMATION

Name and Title	Phone	Fax	Email
Address	**City**	**State**	**ZIP Code**

PAYMENT PLAN

Total Payment Amount	Start Date
Number of Payments	Frequency of Payments One-Time Weekly Monthly Other
Fee per Payment	Total Amount per Payment

PAYMENT INFORMATION

Charge my Bank Account	Charge my Credit Card
Bank Name:	Card Type: Visa MasterCard Discover American Express
Name on Account:	Card Number:
RT Number:	Expiration Date:
Account Number:	

SIGNATURE AND AUTHORIZATION

I authorize NetDeposit, LLC, on behalf of the Company to debit my account as identified above according to the terms stated here. This authorization shall remain in effect until the balance is paid in full or Company receives written notification from me of any intent to terminate this payment plan and at such time and in such manner as to afford Company reasonable opportunity to act (minimum of 30 days).

I understand that if the total amount owed to Company is increased, I authorize this plan to continue as long as the payment amount remains unchanged until the amount owed to Company is paid off, or unless the plan is terminated earlier by me above. I understand any added amounts can be applied for with a new authorization form.

All other changes such as payment amount, frequency, and bank account or credit card numbers, will require a new Electronic Payment Authorization Form to be filled out and submitted to NetDeposit, LLC 15 days prior to any change being implemented. I understand that this payment plan may be cancelled by Company or NetDeposit, LLC, due to Non Sufficient Funds (NSF). I understand that I will be liable to pay the NSF fees that will be charged by my bank.

I represent and warrant that I am authorized to execute this payment authorization for the purpose of implementing this electronic payment plan. I indemnify and hold Company, the bank, NetDeposit, LLC, harmless from damage, loss, or claim resulting from all authorized actions hereunder.

Signature	Date

Print Name	Title

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