# Premier Women's Health, LLP.

*Please PRINT AND complete ALL sections below!*

## PATIENT'S PERSONAL INFORMATION

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

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

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

## PATIENT 'S / RESPONSIBLE PARTY INFORMATION

**Relationship to Patient:** ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

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

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

## PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $ _____

## PATIENT'S REFERRAL INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: ( _____ ) _____ Fax: ( _____ ) _____

## PHARMACY INFORMATION

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: ( _____ ) _____ Fax: ( _____ ) _____

## EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

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

**Assignment of Benefits • Financial Agreement**

I herby give authorization for payment of insurance benefits to be made directly to PREMIER WOMEN'S HEALTH,LLP. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I also acknowledge that a picture will be taken and placed in my electronic chart for the purpose of identification only.

Date: _____ Your Signature: _____

# Premier Women's Health, LLP

**1758 Broad Park Circle South**
**Mansfield, Texas 76063**
**Office 972-780-7330 Fax 972-780-7385**
**Carolyn Kollar, DO, FACOOG**
**Magen Hutchins, WHNP**

**Office Hours:** Monday – Thursday 8:00 am to 5:00 pm Friday - 8:00 am to 1:00 pm

## Office Policies

Below you will find our office policies. Please read each one carefully. We hope this information will be helpful to you when accessing our office and making decisions about your health.

### Appointments:

Office visits are by appointment only. We strive to see our patients as close to their appointment times as possible. As you know, emergencies do arise and can cause an increase in waiting time. We understand that there are times when it will be necessary for you to cancel or reschedule your appointment. In order for us to be available to as many patients as needed, we ask that you kindly provide our office with a 24-hour notice. Our office will give you a reminder call within 5-7 days of your appointment.

- **There will be a $ 50.00 fee for a no-show appointment or a non-emergent cancellation the same day of your appointment or less than 24 hours before your appointment.**
- **There will be a $ 75.00 fee for a no-show or a cancellation the same day of a scheduled procedure or less than 24 hours before your scheduled procedure.**
- **There will be a $ 200.00 fee for a cancellation of a surgical procedure less than 72 hours before your surgery.**

This fee is billed directly to you and must be paid before your next scheduled appointment.

**Multiple "no shows" in any 12 month period may result in termination from our practice**

### Telephone Calls, Medication Refills, and Test Results:

We ask that you make all non-emergent calls and prescription refills during our regular office hours. Calls made after 4 pm might not be returned until the next business morning. Please allow 5-7 days to process the prescription refills and or requests. **Please allow 14 days to receive calls for your results pending provider's review.**

### Referrals:

Allow 5 to 7 business days to process routine referrals.

### NSF/Closed Accounts:

There is a $50.00 charge for all returned checks

### Patient / Insurance Payments:

Payment is expected at the time services are rendered. Payment will be accepted in the form of cash, check, Visa, MasterCard, or Discovery. We require that you update your information annually or as often as the information changes to assure you receive correspondence from our office as well as your prescription refills. Please be aware that most insurance plans do not cover 100% of the services provided. Account balances exceeding 90 days will be turned over to an outside collection agency and your care will be terminated with our practice.

### Medical Records / FMLA:

All medical record requests require written release of information. Please allow two weeks for the processing of all medical records. There is a **$25.00** patient fee for medical record requests and must be paid prior to disbursement of records.

There is a **$35.00** initial fee for forms requiring completion by your provider and **$15.00** fee for additional forms for the same encounter. This includes Family Medical Leave, Disability, etc. Please allow two weeks for completion of all forms.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

**I have read and understand the office policies related to care provided by Premier Women's Health, LLP**

_____

**Patient/Guardian Signature** **Date**

# PREMIER WOMEN'S HEALTH, LLP
# CONSENT FOR TREATMENTS

## Consent to treat

By signing this consent, I am authorizing my physician and/or other individuals she deems appropriate to perform and/or order exams, test, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Premier Women's Health unless revoked by me orally or in writing.

_____

Patient/Legal Representative Signature Date

## Well Woman Exam Consent

The American College of Obstetricians and Gynecologists explains the need for an annual assessment as a fundamental part of medical care and is valuable in promoting prevention practices, recognizing risk factors for disease, identifying medical problems, and establishing the clinician–patient relationship. The annual health assessment should include screening, evaluation and counseling, and immunizations based on age and risk factors. The performance of a physical examination is a key part of an annual health assessment visit, and the components of that examination may vary depending on the patient's age, risk factors, and physician preference.

_____

Every insurance plan has different stipulations and/or guidelines that must be met. Premier Women's Health, LLP leaves the responsibility to you as the patient to understand what your insurance will and will not cover for your annual well woman exam. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services. As your physician, I believe that certain services are an important part of your medical care and recommend that you receive these services as part of your current treatment plan. However, in the event the services are not considered to be covered benefits under your health insurance you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services that may or may not be covered by your health insurance.

_____

Patient/Legal Representative Signature Date

## Non-Covered Services

I acknowledge that I have been informed in advance of receiving services at Premier Women's Health that may or may not be covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges.

_____

Patient/Legal Representative Signature Date

_____

Relationship to Patient

*****This form must be signed by the patient or legal guardian *PRIOR* to receiving any services *****

# Premier Women's Health, LLP
## PATIENT PROFILE

NAME_____ DATE_____
(Last Name) (First Name) (Middle)
AGE____ MARITAL STATUS____ OCCUPATION _____Race_____
FAMILY PHYSICIAN_____ PHONE_____

**HISTORY: PLEASE CIRCLE**

| | | |
|---|---|---|
| Measles | Mumps Tuberculosis | Neurological (Nerves) |
| German Measles | Diphtheria | Bronchial/Asthma |
| Chicken Pox | Malaria Pneumonia | Sickle Cell |
| Whooping Cough | Tonsillitis | Cardiac (heart) |
| Scarlet Fever | Typhoid Fever | Mitral Valve Prolapse |
| Rheumatic Fever | Stomach | Joint |
| Smoke | How many packs per day: _____ | Alcohol use and type: |

Drug Allergies_____

Operations_____
_____

Medications_____
_____

- Last Pap smear: Date_____ Results_____
  Where_____
  Have you ever had an abnormal Pap: No_____Yes_____?
  If yes: When:_____ Treatment:_____
- Colonoscopy: Date:_____ Results: _____
- DEXA Scan (Bone density test:): Date:_____ Results:_____
- Mammogram: Date:_____ Results:_____

**FAMILY HISTORY** (please specify which family member, for example, Maternal Grandmother, Paternal grandfather)
_____Diabetes _____Heart Disease _____ HTN _____High cholesterol/triglycerides
_____Ovarian Cancer _____ Breast CA _____Uterine CA _____Colon CA

PLEASE LIST ALL PREVIOUS **PREGNANCIES, MISCARRIAGES AND ABORTIONS:**

| Year | Month | Length of Pregnancy | Time in Labor | Weight of Baby | Anesthesia | Complications |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Menstrual History**
Age of first menstrual cycle_____ Are your cycles regular? _____ Cramping? _____
Clotting? ____How long does your cycle last? _____
Please Circle: Are your cycles: light, moderate, heavy
Age of 1st sexual intercourse: _____ Number of sexual partners: _____

# Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date Completed: _____ Date of Birth: _____

Please mark below if there is a ***personal or family history*** of any of the following cancers. If yes, then indicate family relationship and ***age at diagnosis*** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

| | YOU Age at Diagnosis | SIBLINGS/ CHILDREN Age at Diagnosis | MOTHER'S SIDE Age at Diagnosis | FATHER'S SIDE Age at Diagnosis |
|---|---|---|---|---|
| *For example:* Colorectal cancer | none — | Brother 36 yrs | Aunt 44 yrs<br>Cousin 58 yrs | Grandfather 65 yrs |
| **BREAST AND OVARIAN CANCER** | | | | |
| Breast cancer | | | | |
| Ovarian cancer | | | | |
| Breast cancer in both breasts OR multiple primary breast cancers | | | | |
| Male breast cancer | | | | |
| Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No | | | | |
| **COLON AND UTERINE CANCER** | | | | |
| Uterine (endometrial) cancer | | | | |
| Colorectal cancer | | | | |
| Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer | | | | |
| 10 or more cumulative colon polyps | | | | |
| **MELANOMA** | | | | |
| Melanoma | | | | |
| Pancreatic cancer | | | | |
| **OTHER CANCER** | | | | |
| _____ | | | | |

**HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER BEEN TESTED FOR HEREDITARY RISK OF CANCER?**

☐ Yes ☐ No If yes, please explain: _____

| FOR OFFICE USE ONLY | |
|---|---|
| ☐ Patient appropriate for further risk assessment and/or genetic testing<br>☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer Syndrome<br>☐ COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer)<br>☐ COLARIS *AP*® – A test for Adenomatous Polyposis Syndromes<br>☐ MELARIS® – A test for Hereditary Melanoma | ☐ Discussed hereditary cancer risk with patient<br>☐ Patient offered genetic testing<br>☐ ACCEPTED ☐ DECLINED<br>☐ Follow up appointment scheduled<br>Date: _____ |

Myriad Genetic Laboratories, Inc. • 320 Wakara Way • Salt Lake City, UT 84108-1214 • 1-800-469-7423 • www.myriadtests.com

# PREMIER WOMEN'S HEALTH, LLP
## PRIVACY COMMUNICATION FORM

In complying with Health Insurance Portability and Accountability Act, HIPAA, we want to make sure that we guard your privacy according to your wishes when it comes to family, friends, and co-workers.

**Please answer the following questions and indicate with a check your first choice:**

- ☐ May we leave messages concerning your appointments with a co-worker, receptionist or secretary that regularly answers your calls? **YES or NO**
- ☐ May we leave messages on your answering machine at home? **YES or NO**
- ☐ May we leave messages on your cell phone voice mail? **YES or NO**
- ☐ May we leave messages on your voice mail at work? **YES or NO**
- ☐ May we discuss your appointment schedules with your spouse/partner/parent? **(Please circle all that applies)** **YES or NO**

List any other persons other than yourself (i.e. spouse, children, or other family members, etc.) that you would wish us to discuss your medical care or financial responsibility with upon request.

**Please list name, relationship, and what you wish to be discussed:**

1._____

- ☐ **Medical Care**
- ☐ **Financial Responsibility**
- ☐ **Both**

2._____

- ☐ **Medical Care**
- ☐ **Financial Responsibility**
- ☐ **Both**

You must inform us, **in writing**, of any changes in your directives. This will be kept in your file along with your acknowledgement of receipt of our Notice of Privacy Practices.

**Printed Name:** _____

**Signature**: _____**Date:**_____

*****Please provide a number for which detailed messages may be left. *****

**Number:** _____ **Type:** _____

**Email:** _____

**PREMIER WOMEN'S HEALTH, LLP**
**NOTICE OF RECEIPT FORM**

## Acknowledgment of Receipt of Notice of Privacy Practices

These policies are to provide a description of the uses and disclosures of certain health information. I understand that Premier Women's Health, LLP reserves the right to change its Notice of Privacy Practices, Patient Financial Policy and Office Policy. Prior to implementation an updated copy will be provided at the office. A copy of the updated Policies may be requested by calling the physician's office or requesting a copy in person at an appointment.

_____

**Patient's Printed Name** **Date**

_____

**Patient/Legal Representative Signature** **Relationship to patient**

## Acknowledgment of Receipt of Cellular Phone Disclosure

I authorize Premier Women's Health, LLP to contact me via current and any future cellular phone number(s), email address, or wireless device(s) regarding my delinquent account(s) I owe to Premier Women's Health, LLP or to receive general information Premier Women's Health, LLP. I also authorize its agents, representatives, and attorneys (including collection agencies) to use automated telephone dialing equipment and artificial or pre-recorded voice messages and personal calls, in their effort to contact me for purposes of collecting any portion of my account which is past due. I understand that I may withdraw my consent to call my cellular phone by submitting my request in writing to Premier Women's Health, LLP or its agents.

**I have read this disclosure and agree to the terms described above.**

_____

**Patient's Printed Name** **Date**

_____

**Patient/Legal Representative Signature** **Relationship to patient**

# Premier Women's Health

Carolyn Kollar, DO FACOOG
1758 Broad Park Circle South
Mansfield, TX 76063
(972) 780-7330
Fax: (972) 780-7385

## Authorization for Release of Information

**Patient Name: _____**
**Previous Name: _____**
**Date of Birth: _____ Social Security #: _____**

I understand and authorize my medical information to be released to Premier Women's Health from:

_____

_____

This information is to be released to:

**Premier Women's Health**
**Dr. Carolyn Kollar**
**1758 Broad Park Circle South**
**Mansfield, TX 76063**
**Fax (972) 780-7385**

I understand that the information is to be released for the following purposes:

_____ Treatment _____ Referral _____ Co-management

_____ Continuity of care _____ Record Review _____ Patient Request

_____ Other, please specify: _____

Information to be requested from following time period:

From: _____ (month/year) To: _____ (month/year)

I hereby authorize Premier Women's Health to use/disclose my protected health information in accordance with the current Health Insurance Portability and Accountability Act (HIPAA) guidelines. I understand that I may be responsible for any processing fee that may be required for the requested information. Identification will be required for patient privacy and confidentiality.
I understand that my medical information may include sensitive health information. I understand that I a may revoke this authorization in writing at any time. I understand that the authorization expires 180 days from the date of my signature. A photocopy of this authorization is considered as valid as the original. I understand that if the recipient authorized to receive the health information is not a health plan or health care provider the released information may no longer be protected by federal and state privacy regulations.

_____

Signature of Patient or Legal Representative Date/Time

_____

If Representative, specify relationship to patient Date/Time

**If more than 10 pages please mail the records to our office**