Leslie S. Welborne, M.D.
Alisa Ward, M.D.

CENTENNIAL OB/GYN, P.A.
5757 Warren Parkway, Suite 210
Frisco, TX 75034
PH: 972-731-6565 FX: 972-731-6570

Melissa Bailey, M.D.
Ruth Whiddon, W.H.N.P.

Name _____ DOB _____ Marital Status _____ Date _____

Menstrual History

If menopausal, at what age did your periods stop? _____
Number of days between first day of one and first day of next period? _____
Length of period? _____ Regular or Irregular _____
Would you call your periods ( ) light ( ) medium ( ) heavy ( ) clots
When was the first day of your last menstrual period? _____ Do you have cramps?_____
Was it a normal period? _____ If not, when was the last normal one? _____
Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods/cramps? __Y __N

Contraception- (If premenopausal)

What is your current form of birth control?
Abstinence Birth Control pill Hysterectomy IUD Menopause Tubal ligation Vasectomy Nuvaring Patch Depoprovera Rhythm Condoms
How long have you been using your current form of birth control? (please check one)
__ 2 yrs or less __ 3-5 yrs __ 6-10 yrs __ over 10 yrs
When are you planning to have another child? (please check one)
__ within 1-2 yrs __ within 5-10 yrs __ my family is complete

Review of Symptoms: (Circle current symptoms)

GENERAL- Fatigue Fever Weight gain Weight loss
CARDIOVASCULAR- Palpitations Chest pain
PULMONARY- Cough Shortness of breath
GASTROINTESTINAL- Bloating Constipation Diarrhea Hemorrhoids Bloody stools Nausea
URINARY- Pain with urination Blood in urine Frequency UTI's Incontinence
GENITAL- Irregular periods Painful intercourse History of sexual abuse Vaginal discharge Vaginal itching
MUSCULOSKELETAL- Back pain Joint pain
Breast- Perform self breast exams-Regularly/Irregularly/Never Masses Tenderness Nipple discharge
SKIN- Rash Warts
NEUROLOGICAL- Dizziness Headache
BLOOD/LYMPHATIC- Easy bruising Bleeding easily History of blood transfusion Enlarged lymph nodes
ENDOCRINE- Hair loss Temperature intolerance Excessive hair growth
ALLERGIES- Seasonal allergies
PSYCHIATRIC- Anxiety Depression PMS Insomnia

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Dear Patient:

You are scheduled today for your annual routine Well Woman Exam. This exam includes a breast exam, pelvic exam, and could possibly include a PAP smear screening for cervical cancer prevention. A Well Woman Exam is preventative and does not address any current health problems or concerns.

We want to bring to your attention that if you are experiencing any problems, or if there is a problem identified during your exam, your insurance company may require us to collect an additional copay amount.

Please initial next to your preference for today's visit below:

_____ I want ONLY my Well Woman Exam today.

_____ I want ONLY to address my problems today. *
*Your office visit copay or co-insurance amount will be collected today.

_____ I want both my annual Well Woman Exam AND problems addressed today. *
*Your insurance company may require us to collect additional copay or co-insurance amounts.

_____ _____
Patient Printed Name Date of Birth

_____ _____
Patient Signature Today's Date

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Patient Information

Please Print ALL Information

Name _____ Marital Status _____

Address _____ City _____ St _____ Zip _____

SSN _____ Date of birth _____ Age _____

Cell _____ Work _____ Other _____

Email _____ Referred By _____

Emergency Contact _____ Relationship _____

Cell _____ Work _____ Other _____

Primary Insurance Information:

Is this a ☐ Group (Through employer) OR ☐ Individual (self purchased)

Primary Insurance _____ Policy Holder _____

Policy Holder's DOB _____ Relationship to patient _____

Claims Address _____ Insurance Phone # _____

Member ID# _____ Group# _____

Secondary Insurance Information:

Is this a ☐ Group (Through employer) OR ☐ Individual (self purchased)

Secondary Insurance _____ Policy Holder _____

Policy Holder's DOB _____ Relationship to Patient _____

Claims Address _____ Insurance Phone # _____

Member ID# _____ Group# _____

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, PPO plans, and all other health plans to CENTENNIAL OB/GYN, 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 the original. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize said assignee to release all information needed to secure the payment.

Signature _____ Date _____

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GENERAL CONSENT FOR TREATMENT

***The following is a general consent for treatment for any services rendered here in the office, e.g., pap smear, breast exam, pelvic exam. If your plan of treatment requires further procedures, you will be consented on those specific procedures.*

*The consent you are about to read was written by the Texas Medical Association and requires that all physicians have patient consent for general treatment.***

"I, knowing that I am suffering from a condition requiring diagnostic, medical, or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of the Physicians of Centennial OB/GYN, P.A., their assistants, or their designee as is necessary in their judgment.

I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examination by Centennial OB/GYN, P.A.
--Texas Medical Association.

****

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Centennial OB/GYN, P.A. for services rendered by them in person or under their supervision. I understand that I am financially responsible for all of the fees or any balance not covered by my insurance.

Authorization to Release Information

I hereby authorize Centennial OB/GYN, P.A. to release any medical or incidental information that may be necessary for either medical care or in processing claims or applications for financial benefits.

Medicare

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf to Centennial OB/GYN, P.A., Dr. Leslie Welborne, Dr. Melissa Bailey, Dr. Alisa Ward and Ruth Whiddon, W.H.N.P.

A photocopy of these assignments shall be as valid as the original.

Print Patient Name: _____ Date of Birth: _____

Print Parent or Guardian Name: _____

Signature: _____ Date: _____

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OFFICE POLICIES

At Centennial OB/GYN, we are dedicated to providing you with the best medical care available. In order to do that, we will need your assistance in providing us with necessary information. This information will be kept confidential and is protected by law. We hope you understand that the information provided is used for purposes of providing services to you and is shared only with the insurance company for the purpose of reimbursement. If any type of lab work is done, this same information will be provided to them as well. We will not release your information to any other facility or person unless requested by you in writing.

We will file your insurance if we are a participating provider under the plan for which you are enrolled. Any out of pocket expenses, copays, deductibles or co-insurance is the responsibility of the patient and are due at the time of service. If we are not a participating provider on the plan you are enrolled, payment will be due at the time of service. We accept checks, cash, Master Card, Discover, Amex & Visa. If a check will be used as payment, your driver's license must be provided.

****** Please review and initial each line below ******

_____ Your insurance is a contract between you, your employer, and the insurance company. We do file your claims as a courtesy only. The lab companies will file your lab claims. Ultimately, medical and lab charges are the responsibility of the patient.

_____ Unfortunately, we are not always aware of the particular details of each insurance plan. Therefore, please be sure you are aware of any exclusions and/or provisions with your plan. Any service not covered by the insurance will be the responsibility of the patient.

_____ Please be aware that out of network providers may provide all or part of any services performed outside the office of CENTENNIAL OB/GYN, P.A. These may include: labs, anesthesiologists, pathologists, radiologists, other physicians, or facilities, etc...

_____ **A copay will apply for Well Woman visits which address problems or require additional medical decision making, as a problem office visit will be billed as well.**

If you have any questions or concerns with these policies, please feel free to contact our office. This form must be signed prior to services being rendered. It will become part of your permanent record with our office.

Print Patient Name: _____ Date of Birth: _____

Print Parent or Guardian Name: _____

Signature: _____ Date: _____

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CANCELLATION AND NO SHOW POLICY

Thank you for trusting your health care to Centennial OB/GYN, P.A. When you have an appointment with our providers, we dedicate that time to focus on you and your medical care and concerns. Should you need to cancel or reschedule an appointment, we ask that you give us adequate notice to enable us to utilize that time for other patients in need of our care. We will pro-actively remind you of your appointment via text and/or phone call.

Cancellations / Rescheduled Appointments

We understand that there are a variety of reasons which can cause you to cancel or reschedule. We ask that you call us as soon as possible to do so. Out of courtesy to other patients' medical needs, please call us at least 48 hours (2 business days) prior to your appointment to cancel or reschedule.

No Show Appointments

A No-Show appointment is one which is missed without cancelling or rescheduling.

NO SHOW FEES

All fees are charged directly to the patient, not the insurance company, and must be paid before another visit will be scheduled. Fees will be assessed if you do not call to cancel or reschedule at least 1 business day in advance*.

Office Appointments – $25.

Diagnostic Appointments - (i.e. ultrasound, NST) - $50.

Procedure Appointments – (i.e. EMB, EndoSee, IUD, Nexplanon, etc) - $75.

Surgery Appointments – * $100 if not cancelled or rescheduled at least 72 hours (3 business days) prior to your appointed time. This applies to both in-office and hospital surgical procedures.

I HAVE READ AND UNDERSTAND THE CANCELLATION AND NO SHOW POLICY. I AGREE TO THE TERMS.

Signature (Patient / Legal Guardian)	Relationship to Patient
Printed Name	Date

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Disclosure of Health Information

I understand that as part of my healthcare, Leslie S. Welborne, M.D., Melissa Bailey, M.D., Alisa Ward, M.D. and/or Ruth Whiddon, W.H.N.P. ("PHYSICIAN") originates and maintains health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.
The PHYSICIAN's Notice of Privacy Practices provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the Notice f Privacy Practices and understand that I have the right to review the notice prior to signing this consent. I understand that the PHYSICIAN reserves the right to change the Notice of Privacy Practices. Prior to implementation of the revised Notice of Privacy Practices, the revised Notice will be mailed to me if I proved my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment of healthcare operations and that the PHYSICIAN is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the PHYSICIAN has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

☐ I restrict the use and/or disclosure of my personal health information from the following person(s).

_____

☐ I authorize the use and/or disclosure of my personal health information to the following person(s):

_____

☐ I authorize the use of my personal email for correspondence of my medical information:

Email: _____

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
I have been provided and have reviewed the PHYSICIAN's Notice of Privacy Practices dated_____.

_____ _____
Signature of Patient or Legal Representative Date

_____
Print Name of Patient or Legal Representative

*I request that changes to the Notice of Privacy Practices be sent to me at this address:

_____

_____