J. Shan Young, MD

Patient Information

Patient Name: _____ **Name you go by:**_____

Date of Birth: _____ **SSN:** _____

Mailing Address: _____

City, State, Zip Code: _____

Home Phone: _____ **Cell Phone:** _____

Employer: _____ **Work Phone:** _____

DO WE HAVE PERMISSION TO CALL YOU AT WORK IF NEEDED? YES ___ NO ___

Race: _____ **Marital Status: S M D W Name of Spouse:** _____

Spouse's DOB: _____ **Spouse's Employer:** _____

Emergency Contact (other than spouse): _____

Phone: _____ **Relationship:** _____

Primary Insurance: _____

Member ID/Contract Number: _____

Subscriber's Name: _____ **DOB:** _____

Secondary Insurance: _____

Member ID/Contract Number: _____

Subscriber's Name: _____ **DOB:** _____

I UNDERSTAND THAT MY SIGNATURE AUTHORIZES THE RELEASE OF INFORMATION TO THE INSURER SHOWN. IN MEDICARE ASSIGNED CASES, THE PHYSICIAN AGREES TO ACCEPT CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE. THE PATIENT IS RESPONSIBLE FOR ANY DEDUCTIBLES, CO-INSURANCE, CO-PAYS, AND NON-COVERED SERVICES.

****PAYMENT IS REQUIRED AT THE TIME SERVICE IS PROVIDED.****

Signature: _____ **Date:** _____

J. Shan Young, MD
409 E 10th St. Suite 300 Anniston, AL. 36207
Phone: (256) 435-1399 **Fax:** (256) 435-1911

Consent for the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which third-party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I can be provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out our treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that this is in effect until changes are submitted in writing.

-I allow the following **person(s)** to be allowed access to my health information.

_____

-I allow the following **Physician(s)** to be allowed access to my health information.

_____

-I agree to allow a referral to any **specialist(s)** as deemed necessary based on my results, and physical exam. This includes the sharing of my medical records. Yes or No

Phone Number to best reach you for test results and appointment reminders: _____

May we text this number for Appointment Reminders only? Yes or No

Email for access to our **Patient Portal:** _____

_____ _____

Signature of Patient or Legal Representative **Witness (office staff only)** **Date**

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Medical History Page 1

Patient Name: _____ **DOB:** _____

Name of your Primary Medical Doctor: _____

Last Menstrual Period: _____

Do you have a history of any of the following conditions? (Please circle)

Thyroid Disease	Gallstones	Kidney Infection
Hypertension	Hepatitis	Bladder Infection
Heart Disease	Ulcers	Kidney Stones
Heart Murmur	Hiatal Hernia	Depression
Seizures	Diabetes	Anxiety
Tuberculosis	Colitis	Irregular Periods
Pneumonia	Anemia	Blood Clots in Legs
Asthma/Emphysema	Blood Transfusion	Other: _____

Please list any previous surgeries you have had.. Please give dates and hospital.

_____

_____

GYN History

Age of your first period: _____ Cycle Interval: _____ Cycle Length: _____

Have you ever had any of the following?

Syphillis____ Gonorrhea ____ Chlamydia ____ Herpes____ HIV____ Warts ____ PID____ Trichomonas_____

Abnormal PAP Smear _____ Type of abnormal _____ Treatment _____

Have you ever had any breast abnormalities? _____

Did your mother use DES while she was pregnant? _____

Have you ever used an IUD? _____

OB History

Please list all previous pregnancies including miscarriages, abortions, and stillbirths.

	Date	Location	Type of Delivery	Sex	Weight	Complications
1.						
2.						
3.						
4.						
5.						
6.						

J. Shan Young, MD

Medical History Page 2

Patient Name: _____ **DOB:** _____

Social History

Have you ever smoked cigarettes? Y N **Have you ever used E-Cigarettes/Vapes? Y N**

Number/Packs per day: _____ **Years smoked:** _____

How often do you drink alcohol? Never Monthly Weekly Daily **Total drinks per week:** _____

Have you ever used any of the following? (please circle)

Marijuana Cocaine/Crack Amphetamines LSD

Heroin IV Drugs PCP

Have you ever had a partner that used IV Drugs? _____

Have you ever had a partner that has had intimate contact with an IV Drug user or another person at risk for the AIDS Virus? _____

Religious Preferences

Do you have any religious preferences or special needs? _____

Family History

Do you have a family member with any of the following conditions? Please indicate relationship of family member.

Hypertension _____ Diabetes _____

Heart Disease _____ Birth Defects _____ Sickle Cell _____

Hemophillia _____ Other _____

Cancer _____

Medications

Please list your current medications, the dosage, and frequency. Attach list if available.

_____

_____

_____

Allergies

Are you allergic to any medications? If so, please list the medication and the reaction.

_____

_____

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FRAX ASSESSMENT

The FRAX Tool has been developed by WHO to evaluate men and women aged 50 years and over. This tool will give a 10 year probability of a hip fracture or major osteoporotic fracture (spine, forearm, hip, or shoulder fracture). Please fill out the questionnaire below to see if you are at an increased risk for bone loss.

-Age (between 40 – 90 years) _____

-Date of Birth: _____

-Weight: _____

-Height: _____

-Have you ever had a fracture in your adult life that occurred spontaneously, or arose from trauma? Yes or No

-Have either of your parents ever had a fractured hip? Yes or No

-Do you currently smoke? Yes or No

-Do you take Glucocorticoids (steroids) on a daily basis? Yes or No

-Have you ever been diagnosed with Rheumatoid Arthritis? Yes or No

-Do you have any of the following:

- Liver Disease Yes or No
- Hyper/Hypothyroidism Yes or No
- Diabetes Yes or No

Do you drink alcohol 3 or more servings per day? Yes or No

J. Shan Young, MD

Patient Name: _____ DOB: _____

Yes No N/A Do you plan on bècoming pregnant in the future?

Yes No N/A Have you stopped taking your birth control?

Have you, or a close relative (father, mother, brother, sister, uncle, aunt, grandfather, grandmother) had any of the following?: PLEASE CHECK ALL THAT APPLY

Yes	No	Have you been diagnosed with breast cancer?
Yes	No	1 breast cancer diagnosed under age 50?
Yes	No	Ovarian cancer diagnosed at any age?
Yes	No	3 breast cancers on the same side of the family?
Yes	No	1 colon and/or uterine cancer diagnosed under age 50
Yes	No	3 or more colon and/or uterine cancers on the same side of the family diagnosed at any age?
Yes	No	Pancreatic cancer diagnosed at any age?

J. Shan Young, MD

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO SURESCRIPTS, INC.

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. J. Shan Young, MD, LLC uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking, and/or have taken in the past.

2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to J. Shan Young, MD, LLC.

3. I have the right to revoke this authorization at any time by writing to J. Shan Young, MD, LLC. I understand that I may revoke this authorization, except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by state or federal law.

6. This authorization expires one year from the date of my signature below.

7. THIS AUTHORIZATION DOES NOT AUTHORIZE J. SHAN YOUNG, MD, LLC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

Signature of Patient or Legal Representative **Witness (Office Staff Only)** **Date**

J. Shan Young, MD

Financial Policy

We want to thank you for choosing Dr. Young as your Gynecologist. We want to do everything we can to provide you with the care you deserve. Dr. Young may schedule tests or a procedure that your insurance does not feel is medically necessary. If your insurance does not pay, or you do not have insurance, you are responsible for your bill. If you have any questions about our policy, please call our financial representative and she will be glad to assist you. Listed below are ways our office handles all accounts.

Deductibles: If your insurance has a deductible, you are responsible for this amount. Deductibles start over at the beginning of each calendar year. If you receive a bill from us after paying your co-pay, it is more than likely due to your individual deductible. On your statement there will be a note explaining the reason for the balance. Please realize that deductibles are a part of insurance. Deductibles are your responsibility and must be paid.

Office Visits: Co-Pays are due at time of visit unless other arrangements have been made in advance.

FMLA or Short Term Disability Forms: There is a **$15.00 fee** for any FMLA Forms, Short Term Disability Paperwork, or any insurance paperwork. This is due at the time the papers are presented for completion by the physician.

Ultrasounds: Our office bills ultrasounds as they are performed. Some insurances companies will pay 100%, while others pay a percentage, or apply the balance towards your deductible. You will be billed accordingly.

In-Patient and Out-Patient Surgery: Surgery Benefits are verified prior to your surgery. We will quote what your insurance says they will pay and if you have any waiting periods. If your insurance requires you to pay a percentage (co-insurance), we will set up a payment agreement with you for this amount. This amount is due before surgery.

Medical Record Copies: There is a fee for any and all copies of medical records that the patient receives that are printed and given to them. The fee is **$1.00** per page up to 25 pages and **$0.50** per page thereafter.

Outstanding Balances: If you owe an outstanding balance, and are unable to satisfy it in full, you will be set up on a payment plan. You will receive the information such as payment amount and due dates when that is set up. Outstanding balances will be turned over to our collection agency.

This information is accurate and true to the best of my knowledge. I understand that I am responsible for paying for any services rendered, including any attorney's fees and cost for collection in the event of default.

Signature of Patient or Legal Representative	**Witness (office staff only)**	**Date**