Unified Premier Women's Care
574 Church Street NE, Marietta, GA 30060
P: 770-427-0285 F:770-424-5037

## New Patient Paperwork

It is your responsibility to present your insurance card & notify us of any changes at each appointment

*Please print your full legal name*

First_____M.I._____ Last_____DOB: ____/____/_____

Address_____Apt#_____SSN:_____

City_____State_____Zip_____

Employer/School_____

Home#_____ Work#_____ Cell#_____

What number is your preferred first contact number? Home Work Cell Other:_____

Race:_____Marital Status: Single Married Divorced Widowed

If married, spouse's name:_____

Email_____Pharmacy Name and Number_____

### EMERGENCY CONTACT INFORMATION

Name_____Relationship_____

Cell#_____Home#_____Work#_____

### INSURANCE INFORMATION

**Primary** Insurance_____ID#_____

Policyholder's Full Name_____MI____Last_____

DOB:____/____/_____ Group#_____Employer_____

Relationship of patient to Insured: Self Spouse Child

**Secondary** Insurance_____ID#_____

Policyholder's Full Name_____MI____Last_____

DOB:____/____/_____ Group#_____Employer_____

Relationship of patient to Insured: Self Spouse Child

Who referred you to us?_____

**ASSIGNMENT OF BENEFITS/GUARANTEE OF PAYMENT: I authorize payment of medical benefits to Unified Premier Women's Care for services rendered. I understand that if I have provided valid insurance information that my charges will be filed (including out of network) and do hereby agree to pay for these services in full.**

**Notice of special charges: New Patient missed appointment fee is $50.00. Established Patient Missed appointment fee is $25.00. Return Check fee is $35.00. Disability/FMLA Forms at $10 per page or $50 for max per submission.**

Signature_____ Date_____

# Unified Premier Women's Care, LLC

## COMMUNICATION CONSENT

*Patient confidentiality is a top priority of Unified Premier Women's Care and due to HIPAA guidelines, we are not allowed to give out your personal medical information to anyone without your consent. If there is someone you would like to have access to your medical information, please provide below:*
*Patients 17 years old and younger will need their parent or guardian to complete this information*

Please contact me at _____with any test results.
(Daytime phone number)

If I am unavailable at this number, you ***May or May Not*** leave a message on my voicemail.
(Circle one)

Consent to text appointment reminders? **YES or NO** (circle one) Cell number:_____

If there is any other person that we may talk to regarding your test results or any other medical information if you are not available, please list them below.

If you wish us only to speak with you, please circle NO ONE (here).

| Person's Name | Relationship to you | Their Daytime phone number | May we leave a voicemail message on this number? **YES or NO** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

I understand that if the status of any of the above information changes, it will be my responsibility to inform the doctor or staff.

Print Name Date of Birth

Patient Signature Today's Date

**GUARDIAN SIGNS BELOW FOR PATIENTS 17 YEARS OLD OR YOUNGER**

Parent/Guardian Signature Today's Date

UPDATED 1.23.19

# Unified Premier Women's Care, LLC

## Practice Policies

Patient Name_____ Date of Birth_____

Thank you for choosing us as your health care provider. We are committed to your medical care. Our goal is to keep your insurance or other financial arrangements as simple as possible as they are considered part of your treatment. In order to accomplish this, we ask that you adhere to the following guidelines. We require that you read and sign this prior to treatment.

**Insurance** - We are participating with most insurance companies. Please check with them prior to your appointment to confirm this. For those Insurance companies that we participate with, we will file all claims and accept assignment, however, *your insurance policy is a contract between you and your Insurance carrier.* We cannot guarantee payment, nor make excessive effort to collect payments from the insurance company. *The patient/guarantor is ultimately responsible for payment in full of charges for services rendered.* All co-pays and coinsurance amounts are due at the time of service. You will be asked for a valid insurance card at each visit. Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling future appointments. We realize that sometimes people have financial difficulty, and our business office will work with you to ensure you receive needed medical care. If you do not have insurance coverage, we will go over the estimated cost for your appointment. Payment in full is expected at the time of service.

**Appointments and Scheduling** – Patients are seen by appointment only. We understand that your time is as valuable as ours. We ask that you arrive on time for your appointments. Be assured that every effort is made to honor your appointment time. Due to the nature of our specialty, there may be delays when we have unexpected deliveries or surgeries. We will try to keep patients informed of delays, and will give the option of rescheduling. If you cannot keep your appointment for any reason, please call us 24 hours prior to your appointment time. If you do not provide us with the requested 24-hour cancelation notice, *you will be charged $50.00 for new patients or $25.00 for existing patients.* You will personally be responsible for this charge. It will not be billed to or paid by your insurance company. Future appointments will not be scheduled until this fee is paid. Missing more than three appointments without proper notification may result in discharge from the practice.

**Payments** - Payments may be made with cash, check, credit card or care credit. There will be a $35.00 charge added to your account for any checks that are returned by your bank. All co-pays are due at the time of service. There is also a $35.00 fee charged to any account over 90 days old that we send to an agency for collections.

**Completion of Forms** – There is a $10.00 per page charge up to a max of $50.00 for Disability, FMLA, Life Insurance or other letters. These may take up to 7 days for completion.

**Prescription Refills** – You are encouraged to have prescriptions refilled at the time of your visit. We generally give you at least enough medication until your next visit. Should you need a refill between visits, *please call your pharmacy.* Prescription refills are only given during office hours (Mon-Fri 9am-5pm). We generally complete refill requests within 24 hours, however, some may take up to 48 hours. Please check with your pharmacy to make sure it is ready. Requests made after 4 pm may not be ready until the next day. Also, request that are received on Friday, may not be ready until Monday. *Please do not call after hours for routine medication refills.*

It is your responsibility to provide us with your current address, telephone numbers, and insurance information at each visit.

My signature below confirms that I have read, understand and will comply with the above listed Practice Policies of Unified Premier Women's Care, LLC.

_____ _____

Patient/Responsible Party Date

Unified Premier Women's Care, LLC

**Review of Health History: Please fill out form completely.**

**Medical Conditions / Problems / Illnesses:** *(Please list date of diagnosis and type).*

| Date | Type |
|---|---|
| | |
| | |
| | |
| | |

**Surgeries:** *(Please list date of surgery, type of surgery, and reason)*

| Date | Surgery/Reason |
|---|---|
| | |
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**Current Medications/Supplements/Vitamins with Dose:**

_____

_____

_____

_____

**Date of Last Immunization:**

Flu Vaccine: _____ Shingles Vaccine: _____

HPV Vaccine: _____ Tetanus Vaccine: _____

Pneumonia Vaccine: _____ Tuberculin Skin Test: _____

**Allergies:** *(Please list allergies and type of reaction)*

| Medication | Reaction |
|---|---|
| | |
| | |
| | |

**SOCIAL HISTORY** *(Please fill out completely. Mark N/A if it does not apply)*

| | |
|---|---|
| Do you **currently** smoke: | Religion: |
| Have you ever smoked: | Marital Status: |
| If yes, how many years have you smoked: | Spouse/Partner's Name: |
| How many cigarettes/ packs per day: | Children's names and DOB: |
| Use of Illicit Drugs: | |
| Alcohol Intake: | |
| Country of Birth: | |
| Ethnic Background: | Domestic Violence: |
| Highest Level of Education: | Hobbies/Activities: |
| Occupation: | General Stress Level: |

**FAMILY HISTORY**

| **Mark "X" in box** | **Father** | **Mother** | **Brother** | **Sister** | **MFG Mom's dad** | **MGM Mom's mom** | **PGF Dad's dad** | **PGM Dad's mom** |
|---|---|---|---|---|---|---|---|---|
| Asthma | | | | | | | | |
| Blood Clots | | | | | | | | |
| Cancer: Breast | | | | | | | | |
| Cancer: Colon | | | | | | | | |
| Cancer: Ovarian | | | | | | | | |
| Other Cancer: *(Please list type)* | | | | | | | | |
| Cardiovascular (Heart) Disease | | | | | | | | |
| Cystic Fibrosis | | | | | | | | |
| Diabetes | | | | | | | | |
| Down Syndrome | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| High Cholesterol | | | | | | | | |
| Lung Disease | | | | | | | | |
| Osteoporosis | | | | | | | | |
| Parkinson's Disease | | | | | | | | |
| Stroke | | | | | | | | |
| Thyroid Disease | | | | | | | | |

**GYN HISTORY** *(Please fill out completely. Mark N/A if it does not apply)*

| | |
|---|---|
| Date of last Mammogram: | First day of last menstrual period: |
| Date of last Colonoscopy: | Are you **currently** sexually active? |
| Date of last Dexa Scan *(50 and older)*: | Age at first sexual contact? |
| Date of last Pap Smear: | Total lifetime number of sexual partners: |
| Had HPV vaccine: | Sexual orientation: |
| Did you complete HPV vaccine (series of 3 shots): | History of Sexually Transmitted Infection? |
| History of Abnormal Pap: | Current Birth Control Method: |
| History of Cervical Dysplasia: | Age of Menopause: |
| History of Endometriosis: | Post-Menopausal Hormone use: |
| History of Fibroids: | Have you had a hysterectomy: |
| History of Infertility: | Have you had an ablation: |
| History of Ovarian Cyst: | Have you had a tubal ligation: |
| History of Polycystic Ovarian Syndrome: | |

Other Providers you see:

PCP: _____

Other: _____

Other: _____

***Pharmacy Info: (We will send most prescriptions to the pharmacy listed below).***

Preferred: _____ Address/phone: _____

***Patient History – (Please list any other history not otherwise noted on this form).***

_____

_____

***Prenatal History***

Any problem with your pregnancies: _____

_____

***Birth History***

Any problems with the births: _____

_____

***Past Pregnancies: (Please list all births/deliveries)***

| *Date of Birth* | *# of babies* | *Gestational age in weeks* | *Length of Labor* | *Birth Weight* | *Sex* | *Type of Delivery* | *Problems* | *Anesthesia* | *Hospital Delivered* |
|---|---|---|---|---|---|---|---|---|---|
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***Obstetric History***

Total number of times pregnant:

Number of full term births:

Number of premature births:

Number of miscarriages:

Number of abortions:

Number of living children:

**Past Medical History:** *(Mark if you have ever had any of these conditions. Please list dates if known).*

| | √ | | √ | | √ |
|---|---|---|---|---|---|
| **Cancer**- Breast | | **GI**- Crohn's/ Ulcerative Colitis | | **Orthopedic**- Fractures | |
| **Cancer**- Colon | | **GI**- Hemorrhoids | | **Psychiatric**- ADD/ ADHD | |
| **Cancer**- Gynecology | | **GI**- Liver Disease/ Hepatitis | | **Psychiatric**- Eating disorder | |
| **Cancer**- Skin | | **GI**- Reflux/ Stomach Ulcers | | **Psychiatric**- Anxiety Disorder | |
| **Cancer**- Lung | | **GYN**- Abnormal Paps/ Dysplasia | | **Psychiatric**- Bipolar Disorder | |
| **Cancer**- Genetic screening | | **GYN**- Fibroids | | **Psychiatric**- Depression | |
| **Cardiac**- High blood pressure/ hypertension | | **GYN**- Infertility | | **Psychiatric**- PMS/PMDD | |
| **Cardiac**- High Cholesterol | | **GYN**- PCOS | | **Pulmonary**- Asthma | |
| **Cardiac**- Heart Attack | | **Hematology**- Anemia | | **Pulmonary**- COPD | |
| **Cardiac**- Heart disease | | **Hematology**- Bleeding disorder/clotting disorder/ Factor V Leiden | | **Pulmonary**- Emphysema | |
| **Cardiac**- Mitral valve prolapse/ murmur/arrhythmia | | **Hematology**- Blood Clots/ Pulmonary Embolism/ DVT | | **Pulmonary**- Sleep Apnea | |
| **Dermatology**- Acne | | **Infectious Disease**- Tuberculosis (TB)/ Positive PPD | | **Rheumatology**- Autoimmune Disease | |
| **Dermatology**- Eczema/Psoriasis | | **Infectious Disease**-Chicken Pox/ Shingles | | **Rheumatology**- Fibromyalgia | |
| **Ears/ Nose/Throat (ENT)**- Hearing loss | | **Infectious Disease**- HIV | | **Rheumatology**- Chronic Pain | |
| **Ears/Nose/Throat (ENT)**- Seasonal allergies | | **Infectious Disease**- MRSA | | **Urology**- Frequent Urinary Tract Infections | |
| **Endocrine**- Diabetes/ History of GDM | | **Nephrology**- Renal Disease | | **Urology**- Urinary Incontinence/ Overactive Bladder | |
| **Endocrine**- Osteoporosis/ Osteopenia | | **Neurology**- Migraines | | **Urology**- Kidney Stones | |
| **Endocrine**- Thyroid Problems | | **Neurology**- Dementia | | **Urology**- Interstitial Cystitis | |
| **Endocrine**- Glucose intolerance/ Insulin resistance | | **Neurology**- Multiple Sclerosis | | **Urology**- Hematuria (Blood in urine) | |
| **Eyes**- Glaucoma/ Vision loss/ Macular Degeneration | | **Neurology**- Seizures/ Epilepsy | | **Vascular**- Aneurysm | |
| **GI**- Colon Polyps | | **Neurology**- Stroke/ TIA | | **Weight Management**- Obesity | |
| **GI**- Gallbladder Disease | | **Orthopedic**- Arthritis | | **Other Not Listed**- | |
| **GI**-IBS | | **Orthopedic**- Chronic Back Pain | | | |

# Unified Premier Women's Care
## Receipt of Notice of Privacy Practices Written Acknowledgement Form

I have received a copy of the Notice of Privacy Practices for this office.

Signature _____ Date _____

**Consent for Release of Information, for Treatment, Payment and Healthcare Operations**
*(For Insurance Purposes)*

I consent to the use and disclosure of my protected health information by Unified Premier Women's Care; Drs. Street, Robbins, Cauthen, Goh and Epps, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Drs. Street, Robbins, Cauthen, Goh and Epps.

I have the right to revoke this consent in writing at any time, except to the extent that Drs. Street, Robbins, Cauthen, Goh, and Epps has taken action in reliance on this consent.

My "protected health information" is defined as any health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Signature _____ Date _____

## Electronic Health Records

Our practice, Unified Premier Women's Care, utilizes electronic medical records to make sure we are in compliance with all federal laws. We utilize pharmacy interface which allows us to obtain your medication history from your pharmacy to keep us up to date on your current medications. We utilize a patient portal to have a more secure way to transfer and receive information with our patients. Lastly, we utilize an interface with the Georgia Department of Public Health to keep your vaccination record up to date.

Please sign that you understand and consent for treatment in our office.

Signature of Patient or Parent/Guardian _____ Date _____