PATIENT INFORMATION SLIP

AMIGS, LLC
105 Collier Rd., Ste 1010
Atlanta, GA 30309

DATE _____

PLEASE PRINT CLEARLY

TO BE COMPLETED BY PATIENT

( ) Single ( ) Married ( ) Widowed ( ) Partnered ( ) Divorced Race _____

PATIENT NAME _____ DATE OF BIRTH _____

MAILING ADDRESS _____ SOCIAL SECURITY NUMBER _____

CITY _____ STATE _____ ZIP _____ BUSINESS PHONE _____

HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____ HOW DID YOU HEAR ABOUT US? _____

EMPLOYED BY _____ OCCUPATION _____

SPOUSE/PARTNER'S NAME _____

SPOUSE/PARTNER'S PHONE NUMBER _____

EMPLOYER _____ OCCUPATION _____

RELATIVE TO CALL IN CASE OF EMERGENCY _____ RELATIONSHIP _____

ADDRESS _____ PHONE NUMBER _____

GIVE NAME OF ANOTHER LOCAL RELATIVE _____ RELATIONSHIP _____

ADDRESS _____ PHONE NUMBER _____

WHO IS RESPONSIBLE PARTY? _____ RELATIONSHIP _____

ADDRESS _____ PHONE NUMBER _____

EMPLOYER OF RESPONSIBLE PARTY _____

ADDRESS _____ PHONE NUMBER _____

NAME OF INSURANCE COMPANY _____ NAME OF POLICY HOLDER _____

NAME OF INSURED _____ SS# _____ POLICY NUMBER _____

NAME OF INSURANCE COMPANY _____ NAME OF POLICY HOLDER _____

NAME OF INSURED _____ SS# _____ POLICY NUMBER _____

NAME OF INSURANCE COMPANY _____ NAME OF POLICY HOLDER _____

NAME OF INSURED _____ SS# _____ POLICY NUMBER _____

MEDICARE NUMBER * _____ MEDICAID NUMBER * _____

**PLEASE PROVIDE CARD FOR RECEPTIONIST TO MAKE COPY BEFORE LEAVING OFFICE*

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS INSURANCE. I AUTHORIZE PAYMENT OF BENEFITS TO BE PAID DIRECTLY TO AMGIS, LLC. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY INSURANCE.

_____
Signature of Patient or Authorized Person

WPC 22-950 • Walker Printing • 1-800-423-0003

Atlanta Minimally Invasive Gynecologic Surgery Center
Gyn Appointment Form

Today's Date: ___/___/_____
Circle one: Established patient Referral Self-referral
Referring Provider's Name/Contact #: _____
Primary Care Provider's Name/Contact #: _____

Name: _____ Age: _____ DOB: ___/___/_____

Reason for today's visit? _____

GYN History

Age period began: _____ How often do you get your periods: _____
How long do they last: _____ 1st date of last period: ___/___/_____
Menstrual flow: __ Spotting __Light __ Moderate __ Heavy
What do you use: __ Pantyliner __ Pads __ Maxi/Overnight Pads __ Tampons __Menstrual Cup
How often do you change by the hour: _____ Pain/Cramping/Other with periods: __ Yes __No
Pain level: __ Mild __ Moderate __ Severe/Incapacitating

Date of last pap smear: ___/___/_____ Results: _____ Date of last pelvic exam: ___/___/_____
Have you ever had an abnormal pap smear: __ Yes __ No If yes, when: ___/___/_____
Have you ever tested positive for HPV: __ Yes __ No If yes, when: ___/___/_____
Have you had any treatments on your cervix: __ Yes __ No
If yes, which one: __ LEEP __ Freezing __ Colposcopy __ Other biopsies: _____

Are you interested in sexually transmitted disease testing today: __ Yes __ No
If yes, please check: __ Gonorrhea __ Chlamydia __ Trichomonas __ HIV __ Syphilis
__ Hepatitis __ Herpes 1 __ Herpes 2
Have you ever had any sexually transmitted diseases: __ Yes __No
If yes, list type of STD and date: Type: _____ Date: ___/___/_____
Type: _____ Date: ___/___/_____ Type: _____ Date: ___/___/_____
Are you sexually active: __ Yes __ No __ Never
Current sex partner(s) is/are: __ Male __ Female __ Both
Birth control method: __ Condom __ Pills __ IUD __ Injection __ Ring __Patch __ Withdrawal
__ Implant __ Sterilization (female or male) __ None

List all GYN Surgeries

Type: _____ Type: _____ Type: _____
Date: ___/___/_____ Date: ___/___/_____ Date: ___/___/_____
Hospital: _____ Hospital: _____ Hospital: _____

Pregnancy

__ Never Been Pregnant
#of pregnancies: ___ #of full term: ___ #of pre-term: ___ #of miscarriages: ___ #of abortions: ___
#of ectopic: ___ #of multiple: ___ #of live births: ___ #of living: ___ #of vaginal: ___ #of c-section: ___

Are you <u>currently</u> experiencing any of the following symptoms: circle and answer all

Heavy bleeding during your periods: Yes / No / N/A
Bleeding in between your periods: Yes / No / N/A
Significantly painful periods: Yes / No / N/A
Postmenopausal bleeding: Yes / No / N/A
Bleeding after intercourse: Yes / No
Significantly painful intercourse: Yes / No
Chronic pelvic pain: Yes / No
Significant hot flashes: Yes / No
Significant vaginal dryness: Yes / No
Abnormal vaginal discharge: Yes / No
Loss of urine when cough or sneeze: Yes / No
Loss of urine when you feel urgency: Yes / No
Frequent abdominal bloating: Yes / No
Have bowel movements at least 3x week: Yes / No
Blood in urine or stools: Yes / No
Chronic diarrhea: Yes / No
Recent significant weight changes: Yes / No
Fever/Chills/Nausea/Vomiting: Yes / No

For Office Staff Only
Vitals: BP: ____/____ Ht: ____ Wt: ____ BMI: ____ Temp: ____ Pulse: ____ Resp: ____
Tobacco use past or present: __ Yes __ No If yes, quit date: ___/___/_____

Atlanta Minimally Invasive Gynecologic Surgery Center

Name: _____ DOB: ___/___/_____

PERSONAL HEALTH HISTORY

Childhood illness: circle all that apply

Measles / Mumps / Rubella / Chickenpox / Rheumatic Fever / Hepatitis A / Hepatitis B

Immunizations and Most Recent Dates:

Influenza: ___/___/_____ Measles: ___/___/_____ Tetanus: ___/___/_____ Rubella: ___/___/_____
Hepatitis A: ___/___/_____ Hepatitis B: ___/___/_____ Other: _____

Surgeries

Type: _____ Type: _____ Type: _____
Date: ___/___/_____ Date: ___/___/_____ Date: ___/___/_____
Hospital: _____ Hospital: _____ Hospital: _____

Hospitalizations (Do not list childbirth)

Reason: _____ Reason: _____ Reason: _____
Date: ___/___/_____ Date: ___/___/_____ Date: ___/___/_____
Hospital: _____ Hospital: _____ Hospital: _____
Have you ever had a blood transfusion: __ Yes __ No If yes, when: ___/___/_____

List the name(s) of your prescribed drugs and over-the counter-drugs, such as vitamins and inhalers: (attach additional sheet if needed)

Name of Drug	Strength	Frequency Taken

Pharmacy Name/Address/Phone #: _____
_____

Drug/Environmental Allergies and Reactions

___ No Known Allergies

Allergy	Reaction(s)

Have you ever had cancer: __ Yes __ No If yes, type(s) and age of diagnosis: _____
_____

PERSONAL HEALTH HISTORY

Anemia	___ Yes	___ No	Blood Clots	___ Yes	___ No
Ovarian Cysts	___ Yes	___ No	Tuberculosis	___ Yes	___ No
Endometrioma	___ Yes	___ No	Diabetes	___ Yes	___ No
Fibroids	___ Yes	___ No	Heart Disease	___ Yes	___ No
Endometriosis	___ Yes	___ No	High Blood Pressure	___ Yes	___ No
PCOS	___ Yes	___ No	High Cholesterol	___ Yes	___ No
Genital Warts	___ Yes	___ No	Stroke	___ Yes	___ No
Infertility	___ Yes	___ No	Epilepsy	___ Yes	___ No
Fibrocystic Breast	___ Yes	___ No	Kidney Failure/Disease	___ Yes	___ No
Anxiety	___ Yes	___ No	Dementia/Alzheimer's	___ Yes	___ No
Depression	___ Yes	___ No	Thyroid Disease	___ Yes	___ No
Other:					

Atlanta Minimally Invasive Gynecologic Surgery Center

Name: _____ DOB: ____/____/_____

FAMILY HEALTH HISTORY

___ Adopted

	Maternal	Who	Paternal	Who
Tuberculosis				
Diabetes				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Stroke				
Epilepsy				
Suicide				
Mental Illness				
Dementia/Alzheimer's				
Kidney Failure/Disease				
Thyroid Disease				
Other:				

Cancer: (check, specify who, and age of diagnosis)

__ Colon: __ Ovarian: __ Uterine:

__ Cervical: __ Breast: __ Other Types:

Health Habits and Personal Safety

Exercise

What kind of exercise?

If you do not exercise, why?

__ Sedentary (No exercise)

__ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)

__ Occasional Vigorous Exercise

Diet:

How do you rate your diet?

__Good __Fair __ Poor

Caffeine:

__ None
__ Coffee: ____ cups/day
__ Tea: ____ cups/day
__ Cola: ____ /day
__ Chocolate: ____ oz./day

# of meals you eat in an average day.

Do you drink 4 large glasses of milk daily or take calcium supplements?

__ Yes __ No

Do you take supplements?

__ Yes __ No

Drugs:

Any past or present recreational or street drug use? ___ Yes, currently
___ Yes, not currently
___ Never

If yes, what Kind?

Have you ever given yourself street drugs with a needle?

___ Yes __ No

Alcohol:

Do you drink alcohol?
__ Yes __ No __ Never

If yes, what kind and how many per week?

__ Wine
__ Beer
__ Liquor

Is your alcohol use a concern for you or others?
___ Yes ___ No

Tobacco:

Do you use tobacco? __ Yes __ No __ Former

If former, Year Quit: _____

If yes, check all that apply:
__ cigarettes: Packs/day ____ or Cigs/day ____# of Years ___
__ snuff: times/day ____ # of Years ____
__ chew: times/day ____ # of Years ____
__ vape: times/day ____ # of Years ____

AMIGS, L.L.C.

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have received a copy of the Notice of Privacy Practices of AMIGS, L.L.C. on the date indicated below.

I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of AMIGS, L.L.C.

I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact:

FREEDOM MITCHELL
OFFICE MANAGER
105 COLLIER ROAD, NE SUITE 1010
ATLANTA, GA 30309
(404) 355-4885 OR Toll Free (866) 355-8364
(404) 355-2210 FAX

_____
Signature of Patient

PRINT NAME:_____

DATE:_____

THIS SPACE TO BE USED BY PRACTICE ONLY.

DATE ACKNOWLEDGEMENT DENIED BY PATIENT: _____

REASON DENIED BY PATIENT: _____

NAME OF PERSON REVIEWING DENIAL: _____

DATE: _____

Financial Policy

Thank you for choosing A.M.I.G.S as your healthcare provider. We are committed to providing the best medical care possible. The following statement explains our Financial Policy, which we ask that you read, sign, and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior are due at the time of service.
- We accept cash, check, American Express, Visa and MasterCard

Regarding Insurance

We must emphasize that as physician our relationship is with you, not your insurance company. We file the insurance claim as a courtesy to our patients, but all charges are your responsibility from the date the services are rendered. All services are not necessarily a covered benefit in every contract. So, it is important that you read and understand your health insurance policy and its requirements for coverage. We currently send claims to hundreds of plans and it is impossible for us to know the coverage or requirements of your specific plan. Our office participates with the majority of managed care plans.

Late Arrival

Any patient who is 15 minutes late to their appointment will be asked to reschedule, or if the physician time allows may be worked back into the physician schedule. Atlanta, as you know is a congested area, so please allow extra time for traffic and parking.

Missed Appointments

Unless canceled at least 24 hours in advance, it is our policy to charge $25 for a missed appointment. Please help us to serve you better by keeping scheduled appointments. This fee is not covered by insurance, so it will be your personal responsibility.

There is a $100 cancellation fee for scheduled surgeries that are cancelled less than 5 business days from the date and time of surgery, unless cancellation is due to insurance denial or medical necessity.

Returned Checks

For checks returned to us unpaid by your bank, we will charge a $30 fee. If a second check is returned to us unpaid, you will not be permitted to write any more checks to A.M.I.G.S as a form of payment.

Collection Accounts

Any patient balance that is not resolved, by this office, will be forwarded to our collection agency. A thirty percent (30%) fee will be attached to your bill and forwarded to the collection agency. Our collection agency will reserve the right to attach your account to any or all credit reporting agencies.

I have read and understand the financial policy for A.M.I.G.S

Printed Name	Signature	Date

Atlanta Minimally Invasive Gynecological Surgical Center, LLC
105 Collier Road, N.W., Suite 1010
Atlanta, GA 30309
Phone: (404)355-4885
Fax: (404)355-2210
NATHAN MORDEL, M.D.

PATIENT:_____

Birthdate: _____ **Date:** _____

Insurance issues, requirements and coverage are ever changing, and we are making every effort to eliminate payment denials before they occur. Your insurance plan may or may not cover routine (preventive) care. We are legally obligated to assign procedure codes based on the service provided to you, whether it be an "annual physical", a visit to take care of problems, or both. *Based on the kind of coverage you have, SOME (OR ALL) of this cost may have to be billed to you.*

Please keep in mind, while the appointment may have been just for the physical or just for problems, if we do both kinds of service on the visit, then both services may be billed.

Billing is based on the intent of the visit up front; consequently, we cannot change the coding later to cause the insurance company to pay for a non-covered service.

Please indicate below the purpose of your visit as you understand it. We thank you for taking the time to complete this form. We are making every effort to comply with governmental rules, and the rules of all insurance plans, for claims submission. We appreciate the help of our patients in this endeavor.

_____**Annual Physical** _____**Problem(s)** _____**Both**

_____
Patient's Signature

Specializing in
Women's Health Care

Atlanta Minimally Invasive Gynecologic Surgical Center, LLC
A.M.I.G.S, LLC

Routine Procedures

REQUEST AND INFORMED CONSENT

Important: Do not sign this form without reading and understanding its contents.

Patient's Name: _____ Date of Birth: _____

During the course of my care and treatment, I understand that various types of tests, diagnostic or treatment procedures ("Procedures") may be necessary. These Procedures may be performed by physicians, nurses, technologists, technicians, physician assistants or other healthcare professionals ("Healthcare Professionals").

While routinely performed without incident, there may be material risks associated with each of these Procedures. I understand that it is not possible to list every risk for every procedure and this form only attempts to identify the most common material risks and the alternatives (if any) associated with the procedures. I also understand that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative Procedures

The Procedures may include, but are not limited to the following:

1. **Needle Sticks**, such as shots, injections, intravenous lines, or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.
2. **Physical test, assessments and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks and similar procedures. The material risks associated with these types of procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.
3. **Administration of Medications** whether orally, rectally, topically or through your eye, ear or nose. The material risks associated with these types of Procedures include but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.
4. **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding or loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.
5. **Insertion of Internal Tubes** such as bladder catheterizations, nasal gastric tubes, rectal tubes, drainage tubes, enemas etc. The material risks associated with these types of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.

I understand that:

- The physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure or treatment, which has been explained.

- The practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the results of this procedure.
- During the course of the procedure or treatment described above it may be necessary or appropriate to perform additional procedures or treatments that are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures and treatments. I also consent to and authorize the performance of such additional procedures and treatments, as they deem necessary.
- Results or outcomes of my procedure(s) may be presented in scientific meetings or published research or used for teaching purposes, but that the physicians and medical staff will safe guard my personal privacy.
- I also consent that any tissue, specimens, organs or limbs removed from the patient's body in the course of any procedure or treatment may be tested or retained for scientific or teaching purposes and then disposed of within the discretion of the physician, facility or other health care provider.

By signing this form:

- I acknowledge that I have read or had this form read and/or explained to me
- That I fully understand its contents
- That I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. All blanks or statements requiring completion were filled in and all statements I do not approve of were stricken before I signed this form.

I hereby voluntarily request and consent to the performance of the procedures or treatments described or referred to herein by Dr. _____ and any other physicians or medical personnel who may be involved in the course of my treatment.

_____	_____	_____
Signature of Patient (Or person giving consent)	Relationship	Date
_____	_____	
Patient unable to sign because	Witness	

Additional materials used, if any, during the informed consent process for this procedure included:

_____

Person disclosing information for consent: _____

06/07 revised