Innovative Women's HealthCare Solutions
Patient centered. Patient driven. Patient empowered.

Today's Date:	PCP:

PATIENT INFORMATION

Patient's Legal Last Name: First:	Middle:	DOB:
Address:		
Social Security no.:	Home phone no.:	Cell phone no.:
Preferred Pharmacy & Address:	Pharmacy Phone:	
Occupation:	Employer:	Employer phone no.:
Other family members seen here:		

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: | Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: | Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: | Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

Patients who are self-pay or have nonstandard health insurance should remember that professional services are rendered and charged to the patient, not the insurance company, and will be due **at the time of service.** The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Innovative Women's Healthcare Solutions or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

Melinda Miller-Thrasher, MD
LaShawn Sumlin, Aesthetician

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3200 Highlands Pkwy SE Suite 420
Smyrna, GA 30082
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New Patient to Practice Questionnaire

1. Name:_____ DOB: _____ Date: _____
2. Pharmacy Name & Location : _____ Phone: _____
3. Chief reason for today's visit: Cosmetic Request □ _____
4. First day of last menstrual period: _____
5. Have you had a mammogram? **Y** **N** Date & result of last mammogram: _____
6. Bone Density Test? If yes, date: _____ Colonoscopy? If so, date: _____
7. Type of birth control currently using: _____
   - (including none, vasectomy, tubal ligation, condoms, withdrawal, IUD, abstinence, Oral Contraceptive Pill, Nuvaring, Nexplanon, female partner, or natural family planning methods)
8. Were you referred to our office? If so, please tell us by who. _____
9. Have you been diagnoses or treated for any of the following conditions: uterine fibroids, uterine polyps, endometriosis, ovarian cysts, PCOS, infertility, breast cyst/mass, other?

   _____

OBSTETRICAL HISTORY

1. Are you currently pregnant? **Y** **N** If so, on what date was first positive pregnancy test? _____
2. How many pregnancies have you had? _____ How many miscarriages? _____ Abortions? _____
3. Please list **all** pregnancies, including miscarriages, abortions, and ectopic pregnancies. Please include full birthdate if applicable.

Date	Weeks	Length of Labor	Baby's Weight	Sex	Type of Delivery (vaginal, c-section, VBAC)	Complications (abortion, miscarriage, ectopic, early fetal demise)

GYNECOLOGICAL HISTORY

1. Age at first period: _____ How many days do your periods last? _____
2. How often do your periods come? □ Every 28-30 days □ More frequently □ Less frequently
3. How heavy is your menstrual flow? □ Light □ Moderate □ Heavy □ Extremely Heavy
4. Do you have bad cramps? **Y** **N** Do you have any PMS symptoms? **Y** **N**
5. Any bleeding between periods? **Y** **N** Any bleeding after intercourse? **Y** **N**
6. Any problems with urination (loss of urine while coughing, sneezing, etc.)? **Y** **N**
7. Check any of the following problems that you have had either in the past or currently:

□ Gonorrhea □ Pelvic Inflammatory Disease (PID) □ Herpes □ Vaginal Infections

□ IUD Related problems □ History of physical abuse, sexual abuse, domestic abuse? _____

□ Abnormal pap smears (what abnormality and when)? _____

MEDICAL HISTORY

1. Do you use medication on a regular basis, **including Medications/Supplements/Vitamins**? Please list name and dose of medication: _____

_____

2. Smoking History: Never smoker _____ Current smoker _____ Past smoker _____
   How much? _____ packs per day How many years? _____ When did you quit? _____
3. Do you drink alcohol? **Y** **N** How many alcoholic beverages do you have in a week? _____
4. Social drug use? **Y** **N** If so, what type of drugs do you use? _____
5. Have you ever been diagnosed with a MEDICAL or PSYCHOLOGICAL condition? If so, what was the diagnosis and when?

   _____
6. Have you ever been hospitalized for a medical illness? If so, please explain: _____

_____

7. Do you have any allergies to medications? **Y** **N** Do you have any other allergies? **Y** **N**
Please List: _____ Please list: _____

_____ _____

8. Do you have any history of a bleeding disorder? **Y** **N** Had a blood transfusion? **Y** **N**

9. What surgeries have you had? (please give year of surgery, including cosmetic):

Date	Procedure Type	Physician and/or location

SOCIAL HISTORY

Marital status: **M S D W P** Sexual Orientation? □ **Heterosexual** □ **Homosexual** □ Other: _____

Occupation: _____ Religion: _____

FAMILY HISTORY (Please check if anyone in your family has any of these conditions)

ILLNESS	Mother	Father	Brother	Sister	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Other relative
Cancer (type)									
Diabetes (type)									
DVT									
Heart Disease									
Osteoporosis									

REVIEW OF SYSTEMS- circle if you are having any of the following problems:

Skipping periods Heavy vaginal bleeding Bleeding between periods Bleeding after menopause
Bleeding after intercourse Anemia Abnormal vaginal discharge Vaginal odor Recurrent vaginal infections
External genital itching External genital lump/lesion Pelvic pain Painful periods Painful intercourse
Pelvis mass Difficulty getting pregnant Urinary frequency Urinary leakage Pain with urination
Recurrent UTI Blood in your urine Pelvic pressure Pelvic bulge or prolapse
Bothersome menopause symptoms Significant hot flashes Vaginal dryness Breast pain Breast mass
Nipple discharge Chronic constipation Chronic diarrhea Persistent nausea or vomiting
Blood in your stools Depressed mood Increased anxiety Irritability Unexplained weight changes
Fever or chills

Innovative Women's HealthCare Solutions

FINANCIAL RESPONSIBILITY STATEMENT

(Please read carefully)

Thank you for choosing Innovative Women's HealthCare Solutions (IWHCS)! We are committed to successfully managing your healthcare needs. It is important to us that you fully understand your financial responsibility, as well as other helpful information, to ensure that you have a completely satisfying experience.

Self-Pay Patient

You are a self-pay patient, if you do not have insurance or have a plan that we cannot file or elect for us not to file your insurance. As such, you will benefit from special pricing for all services, including surgery, maternity care, screening tests, diagnostic tests, and lab-work.

Insurance

Please understand that services are rendered and charged to you, our patient, and NOT the insurance company. Therefore, you are ultimately responsible for all charges incurred. As a courtesy to you, we will attempt to file an insurance claim on your behalf. Please be aware of the following:

- It is your responsibility to provide a copy of your current insurance card.
- All co-pays, un-met deductibles, and your percentage (co-insurance-if applicable) are payable at the time of check-in.
- We only file insurance to plans that we participate with (in their network). It is your responsibility to make sure that we are in your plan's network. If a claim is denied for being out of network, you will be responsible for the charges incurred.
- All insurance plans have a limited time to file claims. If the information that you provided is incorrect, and that time limit is missed, you will be obligated to pay for the services in full.
- It is your responsibility to make sure that your insurance processes your claim(s) in a timely manner. The balance of any claim filed for you is your responsibility whether your insurance pays or not. If your insurance company does not pay within 45 days, you will receive a bill from this office. You will be responsible for payment of the bill within 30 days from the date on the bill.
- All services that your healthcare Provider recommends may not be covered by your insurance. It is your responsibility to know your benefits and what your plan covers. Benefits and coverage will vary based on an Employer's selection for coverage. Plan benefits can differ, even within the same insurance carrier.
- If your insurance company denies a charge for a service as "deemed not medically necessary" after your Provider of service determined that is medically necessary, you may be balance billed for the service. However, we will attempt to appeal on your behalf.
- If you have multiple insurance plans, we will file only your primary and a secondary plan.

- For lab work, we only use LabCorp laboratory. It is your responsibility to let us know if they are not in your network.
- In some cases, both LabCorp and our office will bill your insurance for labs. Some tests fall under our contract and we will bill insurance directly. Those that do not will be billed by LabCorp directly. So, it is not unusual for you to get one lab bill from LabCorp and one from our office.

- A $10 charge will be added to all office visits to cover the significantly increasing cost of Personal Protective Equipment (PPE) and other supplies due to the Federally mandated COVID-19 virus regulations and rules of compliance.
- A scheduled appointment is time reserved just for you. You will incur a fee for missed appointments: Dr. Miller-Thrasher $150, Other Advanced Care Providers, i.e. NPs and PAs $75 for established patients and $150 for new patients. Unfortunately, we will not be able to waive this fee in the absence of an emergency. Please notify the office 48 hours in advance for non-emergent cancellations to avoid this charge. Three (3) missed appointments may result in you being relinquished as a patient.
- Please be aware that some insurance plans require prior approval for your visit here. It is your responsibility to be aware of this requirement and to initiate the process by contacting your insurance company for instructions. If not obtained your claim will be denied and you will be responsible for the charges.

Wait Times

Here at IWHCS, we understand and respect that your time is valuable. We promise to do our best to get you through your visit as expeditiously as possible, without compromising care. Sometimes, due to unforeseen situations, your visit may be delayed, but we will keep you informed, allowing you the option to wait or reschedule.

However, if you are tired of waiting, we have options to speed up your wait time!

Concierge Services. Dr. Miller-Thrasher is excited to offer you Innovative Concierge Services! For a $300 fee, in addition to what we bill to your insurance company, you will enjoy priority scheduling with her and zero wait time! If you choose the annual membership program, you will enjoy exclusive appointments with her throughout the 365 day enrollment (includes 6 visits), a fully devoted concierge team, mobile phone access, tele-medicine visits, and best of all, NO wait time! For more information ask us about or visit our website at www.iwhcs.com!

By signing this form, you acknowledge that you have read, understand, and accept the policies, guidelines, and information herein.

_____	_____	_____
(Legible Signature)	(Date)	(Chart ID by Office)

INNOVATIVE WOMEN'S HEALTHCARE SOLUTIONS, INC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Patient Chart ID #: _____ Last 4 of SSN#: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read out Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of your Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of Notice, at any time by contacting:

Contact Person: Janet Handy
Telephone: 404.549.1327
Email: info@IWHCS.com
Address: 3200 Highlands Pwky Suite 420, Smyrna, GA 30080

_____ **I would like to request a copy** _____ **I decline to receive a copy**

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency prevented us from obtaining acknowledgement**
- ☐ **Other (please specify):** _____

_____

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Blood and Specimen Consent Form

- **I give Innovative Women's Healthcare Solutions consent to collect my blood and any required cultures for STD testing.** I understand if I have any questions regarding my laboratory coverage, I can contact my insurance company *and* that Innovative Women's Healthcare Solutions cannot do this on my behalf. I understand that the laboratory will process and bill my insurance company for any test, and that all bills related to labs are subject to my insurance coverage. I understand that Innovative Women's Healthcare Solutions is a spate entity and is not responsible for any bills that I incur from the laboratory. If I should have any questions regarding my bill, **I will contact my insurance company and/or the laboratory regarding this matter**. I understand that Innovative Women's Healthcare Solutions ***cannot*** perform any adjustments to my laboratory bill of any sort.

- I give Innovative Women's Healthcare Solutions consent to send all specimens, not limited to bloodwork, pathology, and/or cytology to the laboratory for processing. I understand if I have any questions regarding my laboratory coverage, I can contact my insurance company in that Innovative Women's Healthcare Solutions cannot do this on my behalf. I understand that the laboratory will process and bill my insurance company for any testing, and that all bills related to labs are subject to my insurance coverage. I understand that ***Innovative Women's Healthcare Solutions is a separate entity and is not responsible for any bills that I incurred from the laboratory*** and that if I should have any questions regarding my bill, I will contact my insurance company and/or the laboratory regarding this matter. I understand that Innovative Women's Healthcare Solutions ***cannot*** perform any adjustments to my laboratory bill of any sort.

Patients Name (Please Print): _____

Patients Signature: _____ Date: _____

Melinda Miller-Thrasher, MD, FACOG ▪ Janice Hull, NP ▪ Sonya Wallace, NP ▪ Wilhamina Bailey, PA
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CONSENT FOR WELL WOMAN EXAM

As your OB/GYN, we take pride in providing you with the best possible care. Therefore, it's important that you understand what your annual gynecological exam consist of.

Annual GYN Exam typically included:

- Breast Exam
- Pelvic Exam
- CBC Bloodwork
- Urinalysis
- Cholesterol Testing (Patient 35 and over)
- Fecal Occult (Patient 50 and over to screen for blood in stool)
- PAP Smear (Test performed in the office)
- HPV Testing (Patient 35 and over)
- STD Screening (Upon request)

I, _____, understand that the above is typically covered as preventative care, but that coverage may vary based on my plan coverage. Any Additional services/tests to evaluate gynecological problems such as abnormal bleeding, vaginal infections, or request for pregnancy test are **NOT** covered as routine services. Due to this, I may incur a charge for these test and payment will be due today if services are performed. I also understand that *Innovative Women's Healthcare Solutions* is not responsible for any bills I may receive from the laboratory in the event my insurance company did not cover any test. I understand that it's my responsibility to contact my insurance company or laboratory to discuss any bill received and that *Innovative Women's Healthcare Solutions* is **NOT** responsible, ***nor will they adjust any bill received from the laboratory.***

Patients Name (Please Print): _____

Patients Signature: _____ Date: _____

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