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

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Return Patient to Practice Questionnaire Gynecology

Welcome back to Innovative Women's HealthCare Solutions!

Patient Name: _____ Age: _____ DOB: _____ Date: _____

Reason for visit: Annual exam Problem visit _____

Dr. Miller-Thrasher successfully completed a cosmetic surgery fellowship. Please check any concerns and procedures or products of interest to you so that we can better serve you today.

<input type="checkbox"/> Liposuction/Liposculpture	<input type="checkbox"/> Scar Revision/ Beautification	<input type="checkbox"/> Micro-dermabrasion
<input type="checkbox"/> Panniculectomy (removal of excess skin)	<input type="checkbox"/> Snapback Package	<input type="checkbox"/> Hyperpigmentation
<input type="checkbox"/> Tummy Tuck	<input type="checkbox"/> Injectable Fillers/Botox	<input type="checkbox"/> Chemical Peels
<input type="checkbox"/> BBL ("Booty Pop")	<input type="checkbox"/> Gynecomastia (man boobs)	<input type="checkbox"/> Uneven Skin Tone
<input type="checkbox"/> Vaginoplasty/Labiaplasty	<input type="checkbox"/> Wrinkles	<input type="checkbox"/> Mole Removal
<input type="checkbox"/> Vaginal Tightening	<input type="checkbox"/> Skin Care Products	<input type="checkbox"/> Enlarged Pores/ Acne Scarring
<input type="checkbox"/> Breast Augmentation	<input type="checkbox"/> Laser Hair Removal	<input type="checkbox"/> Hair Loss Treatment
<input type="checkbox"/> Fat Transfer (face/breasts)	<input type="checkbox"/> Microneedling	<input type="checkbox"/> Botox/Fillers
<input type="checkbox"/> Mommy Makeover	<input type="checkbox"/> Weight-loss	<input type="checkbox"/> O Shot/P Shot
<input type="checkbox"/> Scarless Breast Lift/Reduction	<input type="checkbox"/> Split Earlobe Repair	<input type="checkbox"/> Other

MENOPAUSAL SYMPTOM CHECKLIST- (circle if you are having any of the following problems):

- *Decreased sex drive
- *Increased anxiety
- *Vaginal dryness
- *Difficulty achieving orgasms
- *Irritability/mood changes
- *Hair loss/thinning
- *Depressed mood
- *Weight gain/loss
- *Dry & wrinkled skin
- *Sleep Problems
- *Hot flashes/night sweats
- *Memory loss/confusion



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Return Patient to Practice Questionnaire - Gynecology

Last Menstrual Period _____

Do cycles come monthly? Yes No If not, how often? _____ Cycles last _____ # days

Have you been pregnant since your last visit? Yes No

Current birth control: None, Condoms, Withdrawal, Birth Control Pills, IUD, Nuvaring, Nexplanon, Tubal sterilization, Vasectomy, Female Partner, Other:

Current Medications: _____

Which medications need refills? _____

Are you interested in testing for Sexually Transmitted Infections today? (STDs/STIs) Yes or No

Have you ever had an abnormal pap test? Yes No When? _____

What was follow-up? Repeat testing, colposcopy (with biopsy), LEEP/conization procedure, cryotherapy

Have you recently been treated for a Sexually Transmitted Disease (STD)? Yes No When? _____

If yes, circle/fill in: HPV, Genital warts, Chlamydia, Gonorrhea, Herpes, HIV, Syphilis, Hepatitis C

Have you had gynecologic surgery since your last visit? Yes No

Please list surgery: _____

Have you ever received the Gardasil Vaccine (to prevent HPV and cervical cancer)? Yes or No ___ # doses

Review of Systems: Circle if you are currently having any of the following problems?

Skipping periods, heavy vaginal bleeding, bleeding in between your 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, pelvic mass, difficulty getting pregnant, urinary frequency, urinary leakage, pain with urination, recurrent urinary tract infections, 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.

Last Pap _____ Mammogram _____ Bone Density _____ Colonoscopy _____

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!

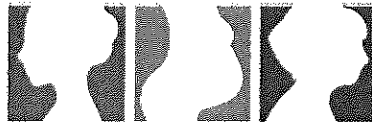
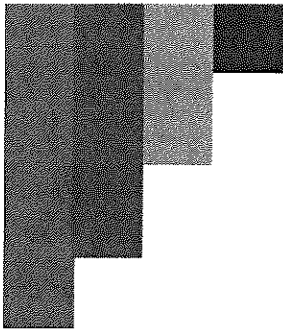
Concierge Services. Dr. Miller-Thrasher is excited to offer you Innovative Concierge Services! For a \$300 fee, in addition to what we bill to your insurance company, you will enjoy priority scheduling with her and zero wait time! If you choose the annual membership program, you will enjoy exclusive 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)



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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: _____



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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: _____