

Center for True Harmony Wellness & Medicine

GYNECOLOGY INTAKE

Name _____ Birth Date _____ Today's Date _____

Current health problems/concerns:

Intention for this appointment:

Allergies:

Please list drug allergies, with the reactions you have _____

Please list food allergies, with the reactions you have _____

Please list environmental allergies, with the reactions you have _____

MEDICAL INFORMATION

General Health—Excellent _____ Good _____ Fair _____ Poor _____

Medications _____

Vitamins & Herbals & Homeopathics _____

Have you ever had your cholesterol checked? Date _____ Results _____

Have you ever had a mammogram? Date _____ Results _____

Do you do self-breast exams? _____

Surgeries/Hospitalizations

Date	Hospital	Diagnosis/Surgery	Physician
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Pregnancies (include miscarriage/abortion please)

Date	How far along	Sex of baby	Weight of baby	Problems-
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Advanced Directives (end of life issues)

Do you currently have a living will or advanced Directives: ___yes ___no

Please consult with your health provider with any of life issues, advanced care directives that you desire to put in place or receive information regarding these issues.

Yes, I would like to receive information ___ No, I don't not require any information ___

Current Health Care Providers

Name	Dates	Care Provided
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Would any of these healthcare providers prefer us to follow-up after your visit here?

Name _____ Address _____

Other Medical Conditions (Circle)

Heart problems	High Blood Pressure	Stroke	Varicose Veins
Phlebitis	Clotting defects	Bleeding tendency	Diabetes
Epilepsy	Blood Transfusions	Rheumatic Fever	Jaundice/Hepatitis
Fractures	Cancer	Arthritis Colitis	Asthma
Chronic Fatigue/EBV		Eating Disorder	Fibromyalgia

Childhood diseases such as German measles or chicken pox _____

OTHER: _____

HABITS

Dietary preferences/restrictions: _____

Examples of a day's menu –

Breakfast: _____

Lunch: _____

Dinner: _____

What do you like to do for exercise? _____

How often do you exercise? _____ For how many minutes? _____

Tobacco use: how much? _____ how long? _____ when did you quit? _____

Caffeine use: how much? _____ how long? _____ when did you quit? _____

Alcohol use: how much? _____ how long? _____ when did you quit? _____

Other drug use? _____ how much? _____ how long? _____ when did you quit? _____

Any current or past history of physical abuse? _____ Or sexual abuse? _____

MENTAL/EMOTIONAL

Do you experience or have history of any of the following

Depression Anxiety ADHD Other Behavioral Conditions

If yes, please put dates (past/current), and treatments (past/current)

LIFE STRESSES

Family, work, self, etc.

Family History

Please include diseases, age of person if alive and age/cause of death if deceased.....

Thank you!!

Mother _____

Father _____

Sisters _____

Brothers _____

Maternal Grandmother _____

Maternal Grandfather _____

Paternal Grandmother _____

Paternal Grandfather _____

Aunts _____

Uncles _____

Other _____

GYNECOLOGICAL HISTORY

First day of last period: _____ Date of last pelvic exam: _____

Date of your prior period : _____ Date of last PAP smear: _____

Age first period began : _____ were the above normal? _____

Have you had the HPV vaccine? YES NO If yes, when? _____

Have you EVER had an abnormal PAP? _____ When? _____ Results? _____

Treatment: _____

Are you sexually active? _____ Do you have intercourse? _____ Do you practice safe sex? _____ Are you trying to get pregnant? _____ For how long? _____

Current birth control method- _____ How long? _____

Past birth control methods _____

Problems experienced with any birth control methods: _____

Normally (not on pills) how many days from the start of one period to the start of the next? _____

Number of days of flow _____ Amount of bleeding _____ Amount of cramping _____

Do you experience premenstrual symptoms? _____ When do they start? _____

Are there any current changes to your normal pattern _____

Bleeding between periods? _____ When? _____

Unusual pelvic pain or fullness _____ When & describe: _____

Unusual vaginal discharge/itching? _____ Describe: _____

How long has this occurred? _____ Treatments you have tried? _____

Any sexual concerns to discuss? _____

Past history of tubal infection? _____

Past history of sexually transmitted disease? _____

Any history of DES exposure? _____

Other: _____

REVIEW OF SYSTEMS: any present problems you are experiencing (Circle)

General

Fever Chills Hot flashes Unusual hair growth

Skin eruptions Weight Change

Head

Headaches Dizziness Visual changes Hearing defects

Sinus trouble Fainting

Abdomen

Bloating Heartburn/indigestion Cramps/pain Nausea/vomiting

Diarrhea Constipation Hemorrhoids Bloody/tarry stools

Chest

Chest pain Shortness of breath heart murmur MVP

Palpitations Chronic cough wheezing Other _____

Breasts

Lumps Bleeding Nipple discharge Tenderness Other _____

Bladder

Frequent urination Painful urination Blood in urine Inability to hold urine

Inability to empty bladder Need to get up at night to urinate

OTHER Concerns: _____

Authorization: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for all service rendered on my dependents or my behalf. I consent to/and authorize treatment for the above named patient. I authorize the release of any information requested by health professionals participating in my care.

Name: _____

Signature: _____

Date: _____

How did you hear about us?:

Online search?- what were the keywords you searched?: _____

Website? Friend? Who may we thank? _____ Other?: _____

**PATIENT/CLIENT NOTIFICATION OF PRIVACY PRACTICES
SIGNATURE OF ACKNOWLEDGEMENT FORM**

Dr. Christine Brass-Jones DO, Dr. Denise Grobe ND, Mary Ann Shostek PA-C,
Center For True Harmony Wellness & Medicine, PC

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that **Center For True Harmony Wellness & Medicine, PC** has the right to change its Notice of Privacy Practices and that I may contact the Privacy Officer at any time to obtain a current copy of such practices.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment or health care operations. If restrictions are placed, we **Center For True Harmony Wellness & Medicine, PC**, are not required to agree, but if agreed upon will abide by such restrictions.

Patient/Client Name: _____ DOB: _____

For Minor-
Parent/Guardian

Signature: _____

YES NO I consent to receive calls from Dr. Christine Brass-Jones DO, Dr. Denise Grobe ND, and Center For True Harmony Wellness & Medicine, PC for my protected healthcare and other services at the phone numbers below, including any wireless number provider. I understand I may be charged for such phone calls by my wireless carrier and that such calls may be generated by an automated dialing system.

YES NO I consent to have information regarding my health insurance left on my voicemail

YES NO I consent to have information regarding my lab results left on my voicemail

YES NO I consent to have information regarding my upcoming appointment including; time/date, information requested before appointment, information regarding any prescriptions needing to be taken before appointment, etc. left on my voicemail.

YES NO I consent to have information regarding any private information including; prescriptions, notification of medicinal items I am needing in stock, Center For True Harmony Wellness & Medicine, PC, requesting lab results from other offices, etc. left on my voicemail.

I understand that I am not required to give my consent to do so and that I may revoke this authorization at any time.

Phone Calls at: _____
Phone Number Name of Person

Calls & Voicemails at: _____
Phone Number Name of Person

I authorize _____ to pick up medical records; medicinal; or other medical supplies on my behalf.

Patient Signature

Date

FINANCIAL POLICY

CENTER FOR TRUE HARMONY WELLNESS & MEDICINE; TRUE NATURAL HEALTHCARE INC.

Thank you for choosing us as your health care provider. We are committed to providing quality medical care. We have adopted the following Financial Policy to reduce confusion regarding your treatment and require you to read and sign it prior to services being performed.

INSURANCE

- Deductible, Co-Payment and Co-Insurance

Your insurance policy is a contract between yourself and the insurance plan. *It is your responsibility to verify your benefits with your insurance company, we do so as an added courtesy to you.* Your insurance plan determines your annual deductible, your visit co-pay and your visit co-insurance. (For example, your annual deductible may be \$500, your co-pay \$25 and your co-insurance 90/10%. This means at every year, you're required to pay \$500 cash before your 90/10 co-insurance will take effect. Upon reaching your deductible you will only be required to pay your co-pay and co-insurance amount for each visit.) You will also be responsible for any and all **deductibles, co-insurance, co-pays, and all balances at the time of service. You may still receive a bill if your insurance plan adjusts its coverage from what they dictated to us.**

Initial _____

- Billing – Office Visits

We must bill your insurance with current and valid information (i.e., ID #'s, copy of card, etc.). **We will bill insurance for those plans with which we have a contract.** Not all health plans have coverage for certain procedures, benefits, and in the event your insurance company deems services “non-covered,” you will be responsible for the bill.

You may also be required to get pre-authorization for certain procedures and visits. It is *always best* for you to call your insurance plan to verify coverage and determine any pre-authorizations needed or any requirements and restrictions in your plan. If these requirements are not followed correctly you may be financially responsible for all or part of the services rendered.

Initial _____

- Billing - Lab work

Lab work and imaging, ie ultrasounds et al. may be recommended by your provider. It is *your responsibility* to confirm that all lab work will be covered by insurance and what if any costs you may be responsible for paying. Each individual lab and imaging center bills out for your lab work that is ordered. **The Center for True Harmony is not responsible for lab costs which are not covered by insurance.**

Initial _____

-Requirements and Restrictions

It is your responsibility to notify our office of insurance changes and to know your own coverage. This includes co-pays, labs, radiology & hospital coverage. **If we are not contracted with your insurance, you** will be expected to pay for services at the time they are rendered. All payments are due at the time of service. If you have any questions about your insurance billing, call our billing office that handles insurance billing at 480-539.6646.

Initial _____

MINORS- A parent or legal guardian must accompany a minor patient on their first visit, so as to obtain a legal signature for treatment and billing purposes. The minor may receive treatment on subsequent visits, unaccompanied, with parental permission at initial visit.

APPOINTMENTS – If you cannot keep your scheduled appointment, you must call our office to cancel or reschedule. There will be a cancellation fee charged to you without proper notification. **This \$25 fee will be charged to you regardless of insurance and/or private pay patients/clients.**

BILLING STATEMENTS/FEES/COLLECTIONS –I understand that billing statements may be emailed or mailed to me. I understand that the billing statement date constitutes when all charges are due, not when I open and read the emailed/mailed billing statement.

Initial _____

I understand and promise to pay all outstanding balances within 30 days of the billing statement date. I understand that I if I do not pay within 30 days, and a followup call/statement is sent I will owe extra fees and interest as outlined below. **Initial** _____

Outstanding Balance Fees/No response within 30days	Payment Plan Fees
2% monthly interest for Outstanding Balances	1% monthly interest for Payment Plans
30% fee for Balances sent to Collections	\$3 Monthly Payment Plan Processing Fee
	Other Fees
	\$25 Late Cancellation/No Show Fee

I hereby authorize **Center For True Harmony Wellness & Medicine, P.C.** to release any information that may be necessary to my insurance carrier for payment and processing of my claims for medical/treatment charges, or to review information related to my health care providers participation with my health plan. I assign to **Center For True Harmony Wellness & Medicine, P.C.** any and all benefits to which the patient/client or insured party is entitled for medical services. **I have read the Financial Policy. I understand and agree to the above Financial Policy.**

Signature Patient/Client or Responsible Party

Date

Patient Demographics Information Sheet



(Please Print)

SS# _____ - _____ - _____

Patient's Name: _____
Last Name First Name Middle Initial

Permanent Address: _____ Apt # _____

City: _____ State: _____ ZIP: _____

Local Address: _____ Apt # _____

City: _____ State: _____ ZIP: _____

Date of Birth: ____/____/____ Sex: F / M Marital Status: S / M / W / D

Phone #: (____) _____ - _____ Work Phone #: (____) _____ - _____

Other #: (____) _____ - _____

Primary Care Physician: _____ PCP Phone #: _____
Last Name First Name

Patient Employer: _____

Primary Insurance

Secondary Insurance

Ins Company Name: _____ Ins Company Name: _____

ID/Policy #: _____ ID/Policy #: _____

Group #: _____ Group #: _____

Primary Policy Holder's Name: _____ Primary Policy Holder's Name: _____

Primary Policy Holder's Date of Birth: _____ M / F Primary Policy Holder's Date of Birth: _____ M / F

Policy Holder's Relation to Patient: _____ Policy Holder's Relation to Patient: _____

Policy Holder's Employer: _____ Policy Holder's Employer: _____

Primary Policy Holder's SSN# _____ - _____ - _____ Primary Policy Holder's SSN# _____ - _____ - _____

Who may receive information regarding your protected health information? (Check all that apply)

Spouse: _____ Name: _____ Date of Birth: _____

Children: _____ Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Parent/Guardian: _____ Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Significant Other/Friend: _____ Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

May we leave messages regarding test results and appointments on your answering machine? Yes _____ or No _____

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

Date: _____ Signature of Patient or Guardian: _____

IF YOU HAVE TWO INSURANCE COMPANIES, PLEASE PRESENT BOTH CARDS SO THAT WE MAY FILE WITH YOUR SECONDARY CARRIER FOR ANY BENEFITS DUE.

Billing Statement Options for

Center for True Harmony Wellness & Medicine PC

True Natural Healthcare Inc



Email Billing Statement Option

I, _____, DOB _____, request that my billing statements be emailed to me at _____.

_____ I understand that my Name, Address, Appointment date, CPT codes and descriptions, and details of charges will be on the billing statement.

_____ I release the Center for True Harmony Wellness & Medicine, and True Natural Healthcare Inc from all responsibility of potential identity or medical identity theft through the use of this email.

_____ I understand it is my responsibility to change my email address with this office if my email address becomes compromised or I choose not to receive billing statement emails anymore.

_____ I understand that this is the form of communication I choose to receive my billing statements, and I understand that the billing statement date constitutes when all charges are due, not when I open and read the emailed billing statement.

Mailed Billing Statement Option

I, _____, dob _____, request that my billing statements be mailed to me via post at _____.

_____ I understand that this is the form of communication I choose to receive my billing statements, and I understand that the billing statement date constitutes when all charges are due, not when I open and read the mailed billing statement.

Patient Signature

Date

Appointment Confirmation Preference:

Please Number the order of your preference #1, #2, #3 and list the phone number or email we should use.

#__ Phonecall @ ___-___-_____

#__ Text message @ ___-___-_____ Reply STOP to cancel, HELP for help. Msg&data rates may apply

#__ Email message @ _____@_____

Patient Signature

Date