Patient Demographic Form

MRN | Date

PATIENT INFORMATION

Last Name | First Name | Middle Initial | Nickname/AKA

Date of Birth | Social Security Number | Gender ◎ Male ◎ Female

Marital Status ◎ Married ◎ Single ◎ Divorced ◎ Life Partner ◎ Separated ◎ Widowed ◎ Other | Language other than English

Race ◎ Black ◎ American Indian/ ◎ Hispanic ◎ Asian/Pacific ◎ White ◎ Other

Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone ◎ Cell ◎ Pager ◎ Fax

Email Address

Employer | Employer Phone

PHYSICIAN REFERRAL/PHARMACY INFORMATION

Primary Care Physician | Referring Physician

How did you hear about us? | Pharmacy Information

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ◎ Self (If self, skip to Emergency / Next of Kin) ◎ Spouse ◎ Parent ◎ Other

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number

Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone ◎ Cell ◎ Pager ◎ Fax

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | First Name | Relationship to Patient

Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone ◎ Cell ◎ Pager ◎ Fax

Last Name | First Name | Relationship to Patient

Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone ◎ Cell ◎ Pager ◎ Fax

New Patient Obstetrics & Gynecology Form

This will become part of your medical record. Today's Date: ____

Name: ____ Date of Birth: ____ Age: ____

Primary Care Physician: ____ Telephone: ____

Pharmacy: ____ Pharmacy Address: ____

Menstrual History:

First day of last menstrual period ____

Age at first menstrual period ____ years

Number of days from the start of one period to the start of the next ____ days

Number of days that you bleed ____ days

Describe the amount of menstrual flow (circle one) light / moderate / heavy / clots

How many tampons or pads do you use on your heaviest day? ____

Describe the amount of menstrual discomfort (circle one) none / mild / moderate / severe

Do you bleed in between your periods? Yes ☐ No ☐

Do you bleed after intercourse? Yes ☐ No ☐

If you stopped menstruating, at what age did you stop? ____ years

Have you had bleeding or spotting since your periods stopped? Yes ☐ No ☐

Contraceptive and Sexual History:

Present birth control method: ____

Birth control methods used in the past: ____

METHOD	LENGTH OF USE	REASON FOR DISCONTINUATION
1)		
2)		

Have you ever been sexually active (had intercourse)? Yes ☐ No ☐

Have you had a new sexual partner in the past three months? Yes ☐ No ☐

How many sexual partners have you had in the past 3 months? ____

Is/Are your partner(s) male, female, or both? Male ☐ Female ☐ Both ☐

Do you experience pain or discomfort with sexual intercourse? Yes ☐ No ☐

Would you like to discuss sexual activity or birth control today? Yes ☐ No ☐

Gynecological History:

Have you been vaccinated for Human Papilloma Virus (HPV) – Gardasil Yes ☐ No ☐

Last Pap Smear ____

Last Mammogram ____

Last Bone Density (DEXA) ____

Last Colonoscopy ____

Have you ever been on hormone therapy (estrogen / progesterone)? Yes ☐ No ☐

Any personal history of:

- Abnormal Pap Smears Yes ☐ No ☐
- Sexually transmitted diseases Yes ☐ No ☐
  - List:
- Fibroids Yes ☐ No ☐
- Endometriosis Yes ☐ No ☐
- Infertility Yes ☐ No ☐
- Urinary Incontinence Yes ☐ No ☐

Obstetrical History: Please record the number of:

Pregnancies________ Vaginal Births________ Ectopics________ Abortions________
Living Children________ C-Sections________ Miscarriages________

List any complications of pregnancies ________

Medical History: Please check if you or a blood-relative have had any of the following:

	MYSELF	FAMILY		MYSELF	FAMILY		MYSELF	FAMILY
Anemia	☐	☐	Mental Illness	☐	☐	Liver Disease / Hepatitis	☐	☐
High Blood Pressure	☐	☐	Depression	☐	☐	Gall Bladder Disease	☐	☐
High Cholesterol	☐	☐	Anxiety	☐	☐	Blood clots in veins/lungs	☐	☐
Heart Disease	☐	☐	Eating disorder	☐	☐	Blood Transfusion	☐	☐
Stroke	☐	☐	Migraine Headaches	☐	☐	Breast Cancer	☐	☐
Diabetes	☐	☐	Urinary Tract Infection	☐	☐	Colon Cancer	☐	☐
COPD / Emphysema	☐	☐	Lupus	☐	☐	Uterine Cancer	☐	☐
Asthma	☐	☐	Arthritis	☐	☐	Ovarian Cancer	☐	☐
Seizures	☐	☐	Back Injury	☐	☐	Other Cancer, specify:		
Thyroid problems	☐	☐	Osteoporosis	☐	☐			

Other Medical Problems (list all):

Surgical History: Please list any operations, including the year, or your age when you had it:

____

Personal / Social History:

Occupation ________ Marital Status ________

Do / Did you use tobacco products? Yes ☐ No ☐ How much? ________

Do / Did you drink alcohol? Yes ☐ No ☐ How many drinks per week? ________

Do / Did you use illicit/street drugs? Yes ☐ No ☐ Which drugs? ________

Have you ever been tested for HIV? Yes ☐ No ☐ Year and result: ________

Have you ever been a victim of physical, verbal, emotional or sexual abuse? Yes ☐ No ☐

Medications: Please list any medications you take, including over-the-counter medicines

MEDICINE	DOSE	HOW OFTEN	MEDICINE	DOSE	HOW OFTEN

Please list any allergies to medications ________

Current Medical Concerns: Please circle if you have had any of the following this week: ________

Weight change	Yes ☐	No ☐	Nausea / Vomiting	Yes ☐	No ☐	Trouble sleeping	Yes ☐	No ☐
Abnormal bleeding	Yes ☐	No ☐	Bowel changes	Yes ☐	No ☐	Night sweats / Hot flashes	Yes ☐	No ☐
Abnormal hair growth	Yes ☐	No ☐	Anxiety / Panic	Yes ☐	No ☐	Breast problems	Yes ☐	No ☐
Problems with urination	Yes ☐	No ☐	Depression	Yes ☐	No ☐			

How did you hear about us? ________

Is there any other information you feel we should have?

____

Patient Signature ________ Date ________ Provider Signature ________ Date ________

CONSENT FOR HIV ANTIBODY BLOOD TEST AND RELEASE OF INFORMATION

I give my permission for Georgia Center for Women. and to order one or more blood specimens from me in order to detect whether or not I have antibodies in my blood to the Human Immunodeficiency Virus (HIV). This is the virus which has been associated with Acquired Immune Deficiency Syndrome (AIDS).

1. INFORMATION ABOUT THE TEST

These tests will be performed by withdrawing one or more samples of blood from a vein in my body (as with normal blood tests) and by testing such blood samples in a laboratory. In general, there is an initial screening test which indicates I may have been exposed, and then other tests may be performed to confirm this result. I understand a positive blood test result does not mean I have or will develop AIDS, but it does mean it is likely the HIV is in my blood. In order to diagnose AIDS, other means must be used in conjunction with these blood tests.

2. SOME INFORMATION ABOUT THE HIV VIRUS

It is thought by scientists that whether or not a person develops AIDS or gets sick from the virus, a person with the virus can still transmit the virus to other people who might become sick. Therefore, knowledge that I do or do not have the virus is important in protecting those people close to me.

3. RELEASE OF INFORMATION

I consent to the laboratories release of the results of these blood tests to those health care practitioners responsible for my care and treatment or as may otherwise be in accordance with applicable law. I consent to the placement of these test results in my record.

4. CONSENT

By my signature below, I acknowledge:

- I have received the information pamphlet published by the Department of Human Resources.
- I have been given all the information I desire concerning the propose blood tests and the release of their results.
- I have had all of my questions answered to my satisfaction.
- I consent to the performance of these blood tests.
- I consent to the release and the use of the test results as set forth above.

Consent for HIV antibody blood test and release of information

______________________________	______________________________
Signature of Patient	Signature of Witness
______________________________	______________________________
Date	Physician giving informed consent

BHRT Checklist For Women

Name: ______________________ Date: ______________

E-Mail: ______________________

Symptom (please check mark)

Symptom	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

Patient's Name ____________________

Date of Birth: ____________________

Hereditary Cancer Questionnaire

Today's Date: ____________________

Instructions: This is a screening tool to help your healthcare provider determine if you would benefit from hereditary Cancer genetic testing. Your provider will review this form looking for any risk factors for hereditary cancer syndrome such as similar types of cancer running in the family, cancers diagnosed at young ages, or multiple cancer diagnosis in the same person.

DOES CANCER RUN IN YOUR FAMILY? CHECK THOSE THAT APPLY.

Please fill this form out to the best of your ability. Please only consider family members related to you by blood, such as your parents, grandparents, children, siblings, aunts, uncles and cousins.

	Type of Cancer	Yourself, Mother, Father, Siblings, Children	Age at Diagnosis	Maternal Extended Family Grandparents, Aunt, Uncle, Cousin (mother's side)	Age at Diagnosis	Paternal Extended Family Grandparents, Aunt, Uncle, Cousin (father side)	Age at Diagnosis	
☑	**Example:** Colorectal Cancer	Mother	38			Aunt	44	
☐	Breast Cancer (women or men)							
☐	Ovarian Cancer (peritoneal / fallopian tube)							
☐	Uterine (Endometrial Cancer)							
☐	Colorectal Cancer							
☐	Prostate Cancer							
☐	Kidney Cancer (Renal)							
☐	Pancreatic Cancer							
☐	Other Cancer Type: ________							
☐	Other Cancer Type: ________							
☐	Other Cancer Type: ________							
☐	Colorectal Polyps (more than 10)							

☐ My Family heritage is Ashkenazi Jewish decent.

☐ I have a family history of positive BRCA gene

If so, please explain who:

Dear Patient,

We are honored that you have chosen us as your Obstetrics and Gynecological provider. Today we have exciting news regarding your health management!

As we continue in our efforts to provide our patients with the highest quality of care, we are constantly looking for methods of working together with you to ensure that you are not only aware of, but also involved in the management and improvement of your health.

We are proud to inform you that our practices now offer the opportunity to use the power of the web to track the most important aspects of your healthcare through our offices.

The Patient Portal enables our patients to interact with our offices securely *via* the Internet. You will be able to:

1. View your lab, imaging studies, and procedures once your provider has reviewed them.
2. View your medical history
3. Request Refills

Participating patients will be sent an email from **IQHealth**; given secure User IDs and passwords, enabling them to access the Portal to view their personal health record, to see their appointments and examine their current and past statements all from the comfort of their home, whenever it is convenient for them!

Begin today to take an active role in managing your healthcare! If you are interested, please provide us with your email address and last four digits of your SSN.

Email Address: ______________________________________ Last 4digits SSN: ______

Yours truly,

Offices of GACFW

PATIENT RESPONSIBILITY FORM

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral or prior authorization, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable"; I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.
- Services filed and not paid within 90 days, will become the responsibility of the patient. Patients will be reimbursed if the insurance subsequently pays.

1. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Georgia Center for Women on my behalf for any services furnished to me by the providers.

2. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Georgia Center for Women to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

3. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Georgia Center for Women. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

____ ________________

Signature of Patient, Authorized Representative or Responsible Party | Date

____ ________________

Print Name of Patient, Authorized Representative or Responsible Party | Relationship to Patient

Dr. Tracey Lemon-Sams * Dr. Julia Samaddar * Dr. Wendell O. Hackney * Hyacinth Crooks, NP

Cancellation/Missed Appointment Policy

Our goal at Georgia Center for Women is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/missed/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call GACFW promptly if you are unable to attend your appointment. This time will be reallocated to someone who is in need of treatment that day. If it is necessary to cancel your scheduled appointment, we require that you call at least **24 hours** in advance. Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care.

How to Cancel Your Appointment:

To cancel appointments, please call **AMC** at 404-265-6888, **Midtown** at 404-581-0307 and **Morrow** office at 770-961-2508 at least 24 hours prior to your scheduled appointment. If you do not reach the medical secretary, leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave us your phone number and we will return your call as soon as possible. Late cancellations will be considered as a "no-show".

No-Show Policy

A "no-show" is a missed appointment without 24 hours notice. "No-shows" inconvenience other patients who may need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment without adequate notice will be recorded in the patient's chart as a "no-show". There will be no charge to the patient for the first event. Any additional "no-shows" will result in a fee of $25.00 charged to the patient and **must be paid prior to your next appointment**. Any further "no-show" appointments may result in the termination of the patient from the practice.

I have read the above policy completely. I agree to all of the terms and understand that if I violate this policy it may result in the termination of my doctor/patient relationship.

Signed: ____________________________ Date: ____________________________

Print Name: ____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE:_________________

I acknowledge that I was provided with a copy of the Georgia Center for Women Notice of Privacy Practices.

___________________________ ___________________________

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

___________________________ ___________________________

For GACFW use only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of GACFW Notice of Privacy Practices but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Other

___________________________ ___________________________

Employee Name Date

This form should be placed in the patient's medical record

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect __01__/_03___/__2011__, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $_35___ for each page, $______ per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: __________Sabrina Wright, Practice Manager______________________________

Telephone: _____404-265-6746__________________________Fax: ____________404-880-0807__________________

E-mail: _________________swright@gacfw.com____

Address: ____

____

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