Northeast OB/GYN Associates
Patient Personal History:

Julie Bernell, M.D. Carlos Garcia-Jasso, M.D. Tayler Stephens, P.A.-C.
Our Physicians operate and deliver only at HCA Healthcare Kingwood Hospital

All information here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided here will be used by your doctor/physician assistant in decisions regarding your care.

Please Circle one: Married Single Divorce Widowed Live-in Partner

Last Name:_____ First Name:_____

Date of Birth:_____ Age:_____ Height:_____ Weight:_____

Race: (Please circle one)

African American American Indian Asian Hawaiian/Pacific Islander Hispanic White
other:_____

Language Spoken: English Spanish other:_____

Reason for visit today:_____

Age of 1st menstrual period_____ Date of 1st day of last menstrual period_____

Are your periods monthly?_____ How many days does it last?_____ Cramps?_____
If so, are your cramps**: Mild Moderate Severe**

Are your sexually active? Yes or No Number of Partners (lifetime)_____

Are your currently using contraception?_____ If so, what are you using?_____

Date of last Pap Smear_____ Ever had an abnormal pap smear?_____

If yes, please give year and any procedures_____

Date of last Mammogram_____ Ever had an abnormal Mammogram?_____

Date of last Bone Scan_____ Date of last Colorectal Screen_____

How many times have you been pregnant?_____ Number of living children_____

List # of Miscarriages_____ Voluntary terminations_____ Ectopic Pregnancies_____

Date of Delivery	How far along # of weeks	Baby's weight	Type of Delivery (Csection/Vaginal/Miscarriage)	Sex	Any complications:

Are you experiencing any of the following: Circle all that apply

Difficulty getting pregnant	Loss of sex drive	Painful periods	Pelvic pressure
Frequent urination	Hot flashes	Nipple discharge	Irregular periods
Heavy periods	Painful urination	Pelvic pain	Vaginal dryness
Painful intercourse	Problems w/bowel movements		
Spotting between periods	Loss of Urine (with cough, sneeze, or laugh)		

Past Medical History
Do you have, or have you ever had, any of the following

Anxiety	Depression	High cholesterol
Arthritis	DVT and/or PE	Migraines
Asthma	GERD / Stomach Ulcers	Seizures
Bleeding tendency	Heart Disease	Stroke
High blood pressure	Thyroid Disease	Diabetes
Heart attack / failure		

Cancer (type)_____Other_____

List all surgeries and the year they were performed
1._____
2._____
3._____
4._____

Have any relatives had or have (Name relative) mother, father, grandmother, grandfather, brother/sister

Stroke_____	Heart Attack_____	DVT &/or PE _____	Diabetes_____
High Blood Pressure_____	Breast Cancer_____	Thyroid Disease_____	Arthritis_____
High Cholesterol_____	Colon Cancer_____	Depression_____	Asthma_____
Bleeding Tendency_____	Stomach Ulcers_____	Heart Failure_____	Seizures_____
Gynecologic Cancer (Ovary/Uterus/Cervix)_____		Congenital Heart Defect_____	

Other Cancer (Types)_____

Do you have allergies to medications or latex? Yes or No
If yes list here:_____

List all medications you are taking, with dose and how often (include vitamins)
1._____
2._____
3._____
4._____
Do you smoke? Yes or No (Cigarettes/Pipe/Cigar/Vape) (Regular/Occasional) # of years_____
Have you ever smoked? Yes or No
Do you Drink Caffeine? Yes or No (Heavy / Moderate / Occasional)
Do you Drink Alcohol or Wine? Yes or No (Regularly/Occasional)

Pharmacy Name_____ Phone #_____

_____ _____
Patient Signature Patient/Legal Guardian Signature

Well Woman Exam Notification

Northeast OB/GYN Associates would like to inform you that if you are here for your well woman exam and have an additional problem/concern, your insurance company may require a diagnostic visit to be filed, which will incur and additional co-pay, and or co-insurance after your deductible has been met, this will be due at the time of service

Thank you,
Northeast OB/GYN Associates

_____ _____
Patient Signature Date

_____ _____
Patient Name (printed) Date of Birth

_____ _____
If Patient is under 18-Parent/Legal Guardian Signature Date

Recommended Annual Testing

Effective as of January 2005, the American College of Obstetrics and Gynecology recommend that any female under 26 years of age should be tested for two of the most common sexual transmitted diseases known as: Chlamydia and Gonorrhea at the time of her yearly well woman exam and pap smear. They also recommend patients 30 + be screened for Human Papillomavirus (HPV) which may cause abnormal pap smears and possible genital warts. Please let your healthcare provider or assistant know if you do not approve of this screening.

I acknowledge that no warranty or guarantee has been made as to the results that may be obtained from such treatment and care, that I understand the nature and purpose of the above authorized treatment, and that I have fully informed myself of the contents and effects of the above Consent and Authorization and do hereby freely give my consent thereto. **THERE IS NO GUARANTEE OF ANY PAYMENT FROM YOUR MEDICAL INSURANCE AND MAY RESULT IN YOU BEING FINANCIALLY RESPONSIBLE FOR SERVICES**

_____ _____
Signature of Patient Date

I WISH TO <u>DECLINE</u>: (Please circle) HPV CHLAMYDIA GONORRHEA

Northeast OB/GYN Associates

Patient Demographic Form

Julie Bernell, M.D. Carlos Garcia-Jasso, M.D. Tayler Stephens, P.A.-C.

Patient Information:

Patient's Name:_____ Today's Date:_____

Marital Status: Single Married Divorced Separated Widowed

Race: Caucasian African American Hispanic Asian Other:_____

Primary Language:_____ **Secondary Language:_____**

Former or Maiden Name(s)_____

SSN:_____ Date of Birth:_____ Age:_____

Home Address:_____ Apt#_____

City:_____ State:_____ Zip:_____

Mobile #:_____ Home #:_____

Employer:_____ Work#:_____

Email Address:_____

Billing Address (if Different)_____

City:_____ State:_____ Zip:_____

Emergency Contact:

Name:_____ Relationship:_____

Address:_____

City:_____ State:_____ Zip:_____

Mobile #_____ Home #_____

Preferred Communication:
The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

Patient Name: _____ Date of Birth: _____

I prefer to be contacted in the following manner (check all that apply):

- **Send all communications through my Patient Portal.**

- **Home Telephone: _____**
  - OK to leave message with detailed information
  - Leave message with call-back number only
- **Cell Phone: _____**
  - OK to leave message with detailed information
  - Leave message with call-back number only

- **Work Telephone: _____**
  - OK to leave message with detailed information
  - Leave message with call-back number only
- **Written Communication: _____**
  - Please send all of my mail to my home address on file
  - Please send all mail to THIS address:

_____
_____

- **Other: _____**

My Preferred Contacts:

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results. **You** have the ability to control access to your patient portal.

Please indicate the person(s) with whom you prefer we share your information below. **Please update this information in writing promptly if your preferences change.**

Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Note that we generally do not share your information via email; if you wish, you can give another individual access to your secure patient portal. You can set this up yourself through the portal or contact our Patient Experience team at 1-888-774-8428 - Monday – Friday 8am – 6 pm ET.

Name:_____ Telephone: _____ Relationship: _____
Email: _____

Name:_____ Telephone: _____ Relationship: _____
Email: _____

Name:_____ Telephone: _____ Relationship: _____
Email: _____

ACKNOWLEDGMENT: I understand that HIPAA may permit my provider to share my information with other persons **not** named on this form as needed for my care or treatment or to obtain payment for services provided.

Patient Signature: _____ Date: _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agreed to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its healthcare providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agreed to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being; however I may refuse any particular treatment or procedure.

If I request or initiate a telehealth visit (a "virtual visit"), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also cover the carrying outs of the orders of my treatment provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my providers staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

HIPPA. I understand that my provider's Privacy Notice is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient: _____ Email: _____

Signature: _____ Date: _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

Name and Relationship of Person Signing, if not Patient: _____

***Note: If you do not want to participate in Health Information Exchange (HIE), it is <u>your</u> responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.**

Privia Financial Policy & Notice of Privacy Practices Effective February 2022

Authorization for Treatment

I hereby grant permission to authorize and direct the authorities of Northeast OB/GYN Associates to perform such medical and/or surgical procedures on me (him or her) as they deem their judgment advisable or necessary for the treatment or care of (1) any conditions now recognized or contemplated and (2) any conditions not now recognized or contemplated, which are revealed or arises during the course of such treatment or care. I understand that I retain the right to refuse any or all advice or treatments. I hereby acknowledge that no guarantees have been made to me as the effect of any examinations or treatment plan.

Billing Policy

Thank you for choosing Northeast OB/GYN Associates as your health care provider. We are committed to providing you the best available medical care. Our personnel will be pleased to discuss our fees and this policy with you at any time. We ask that all patients read and sign our financial policy as well as complete our patient information form prior to seeing the physician.

Payments for service is due at the time services are rendered. We accept cash, check, Visa, Discover, and MasterCard.

We will be happy to help you process your insurance claim or your reimbursement.

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" charges. We are, however, contracted with certain managed care and preferred provider plans; we will follow the guidelines for patient care, reimbursement, and submission of claims for services rendered.
2. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for these services, along with unpaid deductibles and co-payments, are due at the time of treatment.
4. If your insurance company does not pay your claim within 30 days, is it your responsibility to contact your insurer to expedite payment. You will be responsible for any unpaid claims.
5. If your insurance company does not pay in full within 45 days, we require you to pay the balance by cash, check, Visa, Discover or MasterCard.
6. Lab Billing – Please remember, your lab billing is separate from our physician's billing and you may receive a separate itemized bill from the laboratory, for which you are responsible. Please verify that you are being directed by our office to a lab that is a participating provider with your insurance plan.
7. Returned checks and balances older than 45 days may be subject to collection placement and collection fees.

We will be happy to meet with you and discuss any charges or insurance questions upon request.

Again, thank you for choosing Northeast OB/GYN Associates as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

_____ _____

Patients Signature Date