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's Signature Patient/Legal Guardian Signature

Patient Name____ Date_____________________________

Prenatal Genetic Screening and Infection History

Are any of these present in the families of the Patient or Father of the Baby?

please state if patient or father of the baby

Thalassemia (common in Italian, Greek, Mediterranean or Asian Background)	Yes No	________________
Neural Tube Defect (myelomeningocele, spina bifida or anencephaly)	Yes No	________________
Congenital Heart Defect	Yes No	________________
Down Syndrome	Yes No	________________
Tay-Sachs (common in Jewish, Cajun, French-Canadians)	Yes No	________________
Canavan Disease	Yes No	________________
Sickle Cell Disease or Trait (common in African descendents)	Yes No	________________
Hemophilia or Other Blood Disorders	Yes No	________________
Muscular Dystrophy	Yes No	________________
Cystic Fibrosis	Yes No	________________
Huntington's Chorea	Yes No	________________
Prior GBS-infected child	Yes No	________________
Bloom Syndrome	Yes No	________________
History of HIV	Yes No	________________
Deafness / Blindness	Yes No	________________
Familial Dysautonomia	Yes No	________________
Hemochromatosis	Yes No	________________
Galactosemia	Yes No	________________
Bone/Skeletal Defects	Yes No	________________
History of Hepatitis	Yes No	________________
Developmental Delay	Yes No	________________
Marfan Syndrome	Yes No	________________
Niemann-Pick Disease	Yes No	________________
Color Blindness	Yes No	________________
Fanconi Anemia	Yes No	________________
Gaucher Disease	Yes No	________________
Dwarfism	Yes No	________________
Learning Problems	Yes No	________________
Polycystic Kidney Disease	Yes No	________________
Autism	Yes No	________________
Mental Retardation (if yes, was person tested for Fragile X?)	Yes No	________________
Other inherited Genetic or Chromosomal Disorder?	Yes No	________________
Patient or baby's father had a child with any birth defects not listed above?	Yes No	________________

Recurrent pregnancy loss, or a stillbirth	Yes No	________________
Patient or Baby's Father using illicit/recreational drugs	Yes No	________________
If Yes, Agent(s) and Strength/Dosage ____		
Do you live with someone with Tuberculosis or exposed to Tuberculosis?	Yes No	________________
Patient or partner has a history of genital herpes	Yes No	________________
Rash or viral illness since last menstrual period	Yes No	________________
History of STD, Gonorrhea, Chlamydia, HPV, Syphilis?	Yes No	________________
Other infection history	Yes No	________________
If so, please elaborate ____		

Women for Women

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.
8. Pregnant patients: You will receive a letter in the mail after your initial prenatal visit; the information will be based on your insurance type and/or if you are a cash paying patient. We request that your final payment be made by the seventh month of your pregnancy. Please note that we do not back-bill Medicaid insurance. We only bill from time of acceptance.

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.

_______________________________________ ____________________________

Patient’s Signature Date

Total Prenatal Care and Delivery for Cash-Paying Patients

Initial Visit - Confirmation of Pregnancy

New Patient office visit:	$286.19 ($505.00 with a 43.33% discount)
New Patient ultrasound:	$227.00 ($400.50 with a 43.33% discount)
New Patient pregnancy test:	$14.74 ($26.00 with a 43.33% discount)
Amount due: $527.93	

Established Patient office visit:	$187.02 ($330.00 with a 43.33% discount)
Established Patient ultrasound:	$227.00 ($400.50 with a 43.33% discount)
Established Patient pregnancy test:	$14.74 ($26.00 with a 43.33% discount)
Amount due: $428.76	

Delivery

Vaginal Delivery:	**$3,725.49** ($6,574.00 with a 43.33% discount)
Cesarean Section:	**$4,775.59** ($8,427.00 with a 43.33% discount)

*Does not include hospital charges

Frequency of Prenatal Visits

Initial Visit → 28 Weeks Gestation	Every 4 weeks
28 Weeks → 36 Weeks Gestation	Every 2 weeks
36 Weeks → Delivery	Every week

Test Done at the Time of Your Visits:

Initial Visits	Routine Obstetrical Bloodwork, Infection Screening, Genetic Testing, Pap Smear
Weeks 15 - 20	AFP Screen (Test for Neural Tube Defects)
Weeks 24 - 28	CBC, 1-Hour Glucose Test
35-37 Weeks	CBC, HIV, Syphilis, GBS

*Certain tests and imaging are performed by a third party

Risks of Vaginal Delivery & Cesarean Section

Hemorrhage possibly requiring blood administration and/or hysterectomy and/or artery ligation. Injury to bladder and/or rectum, including a hole (fistula) between bladder and vagina and/or rectum and vagina. Injury to tube (ureter) between kidney and bladder. Sterility. Injury, brain damage, or even death to the fetus before or during labor and/or delivery whether or not the cause is known. Uterine disease or injury requiring hysterectomy.

_______________________________________ _________________________

Patient's Signature Date

____

Print Name of Patient

Consent for Cystic Fibrosis Carrier Testing

Cystic Fibrosis is one of the most common genetic disorders, the gene that causes the disorder is found in approximately:

1 in 3,200 White Americans	1 in 15,000 Black Americans
1 in 10,000 Hispanic Americans	1 in 30,000 Asian Americans

In couples where each is found to carry the cystic fibrosis gene there is an increased risk (1 in 4) of delivering a child with the disorder. Cystic Fibrosis can cause lung and digestive problems of varying severity, but most cystic fibrosis cases are associated with substantial illness, shortened life spans, and require lifelong medical care. If your testing would be reported as positive, testing for your partner would be recommended. Further education and counseling for any couple found to be an increased risk for cystic fibrosis would be made available.

I have been informed by my doctor, or nurse, that cystic fibrosis carrier testing is a screening to determine if I am a carrier. I understand this screening test may not be covered by my insurance and I agree to take full financial responsibility for the cost if it is a non-covered service. I give my consent for Northeast OB/GYN Associate to proceed cystic fibrosis carrier testing

Consent for HIV Testing

Human Immunodeficiency Virus (HIV) is the cause of Acquired Immunodeficiency Syndrome (AIDS), which is a viral illness that is spread by contact with blood or bloody fluids of an infected person. The test may give a false-positive result and a confirmation test is done on all positive results. A positive test does not predict whether someone has or will develop AIDS. Patients have the opportunity to ask questions concerning this blood test and counseling concerning the meaning of the test results and its implications are available. Test results will be kept confidential to the full extent required by law; tests will not be released to any other parties without consent.

Please inform your doctor if you do not want one or all of these test performed.

_______________________________ _______________________________

Patient's Signature Date

_______________________________ _______________________________

Print Name of Patient Date