Kristin Miller Obstetrics & Gynecology PLC

CHART # _____ **PLEASE COMPLETE FRONT AND BACK**

PATIENT HISTORY INFORMATION
(Please Print – Answer All Questions) Date _____

Patient _____ Date of Birth _____ Age _____ Social Security No. _____
Full Name of Patient

Address _____ Home Phone ( ) _____
Street and Number City State Zip Code Area Code

E-Mail Address _____ Cell and/or Pager # _____

Married ____ Single ____ Divorced ____ Widow ____

EMPLOYMENT INFORMATION

Spouse / Parent Name_____
(If minor or on parent's insurance, please give parent's information)

Patient's Employer or school _____

Address _____

_____

Soc. Sec. No._____
Employer_____

Address_____

_____

Work Phone#_____

Work Phone # _____ Position _____

Relationship _____

INSURANCE INFORMATION – We also need a copy of your insurance card.

Primary Ins. _____

Insurance Co. Address _____

Name of Policy Holder _____ Date of Birth _____

ID or SS# _____ Group Number _____

Policy Holder's Address if Other than Pt. _____

Hospital Affiliation _____

Does this insurance require a referral? __ Yes __ No

Secondary Ins._____

Insurance Co. Address_____

Name of Policy Holder _____ Date of Birth _____

ID or SS# _____ Group Number _____

Policy Holder's Address if Other than Pt. _____

Hospital Affiliation _____

Does this insurance require a referral? __ Yes __ No

……

In case of Emergency – Not Living With You _____
Name Relationship

Address _____ Phone ( ) _____
Street and Number City State Zip Code Area Code

Referred By _____
If physician, give address, if known, or at least the city and state.

Address _____
Street and Number City State Zip Code

KRISTIN MILLER OBSTETRICS & GYNECOLOGY, PLC (KMO) – FINANCIAL & ADMINISTRATIVE POLICIES

RECEIPT OF PRIVACY PRACTICES

- I acknowledge that I have received or been allowed to view a copy of KMO's Notice of Privacy Practices as required by HIPAA. This notice describes how KMO may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Initial _____

NON-PARTICIPATION IN TENNCARE OR MEDICAID PLANS

- KMO does not participate in any TennCare or other Medicaid plans and will not submit claims to these plans. If you elect to have services provided by KMO, you acknowledge that any patient balance will be owed at time of service. Otherwise, you should contact your TennCare or Medicaid plan in order to determine an appropriate provider other than KMO for your medical services.

Initial _____

DISCLOSURE OF TENNCARE/MEDICAID COVERAGE

- By initialing you are certifying **one** of the following: ☐ **NO**, **I do NOT have** active or pending TennCare or Medicaid coverage
  ☐ *YES, I DO have* active or pending TennCare or Medicaid coverage

Initial _____

PATIENT PAYMENT POLICY AND COVERED SERVICES

- It is the policy of KMO to collect all patient balances, co-pays, and deposits due from patients at the time of service.
- If you are being seen for maternity care or for certain other surgical or medical procedures, our office may contact your insurance carrier to verify your insurance coverage and benefits. An estimation of your financial responsibility will be determined according to the contractual agreement between KMO and your insurance company for these services. Our office will review your benefits with you to explain your financial obligations to KMO, and you may be required to pay a deposit prior to these services being rendered.
- If your insurance claim is denied due to incorrect personal information or incorrect insurance information that you have provided, you will be billed for any unpaid claims for your services, and payment in full will be due immediately.
- If your account or any account for which you are responsible is sent to a collection agency due to non-payment of any patient balance, you may be dismissed from KMO for any future care and services, which includes all providers at KMO. Additionally, you will be responsible to pay for the reasonable collection costs and/or attorney fees associated with the collection of your account.
- Your health insurance plan **may not** provide coverage for all medical services, tests, and/or procedures that our providers may offer or recommend for your treatment. It is your responsibility to know and understand the services covered by your insurance, and if your insurance does not cover these services, you will be responsible for payment.
- If you do not have medical coverage and insurance through a carrier with which KMO participates, or if you are a new patient and cannot supply your valid insurance card, or if your coverage cannot be determined, you must pay in full at the time of service.
- Certain labs collected in this office may be sent to an outside lab for testing. As such, you may be billed by that reference lab for these.
- If you are required to have a referral or other prior authorization for medical services, it is your responsibility to obtain this.

Initial _____

RETURNED CHECK CHARGE

- KMO will charge the patient account $25.00 for any returned checks to cover KMO's cost for any related bank charges.

Initial _____

CANCELLATION POLICY

- KMO requires a 24 hour cancellation notice for any scheduled medical appointment or surgery/procedure.
- No shows and cancellations without a 24-hour notice may receive a $35.00 charge for missed office visits and $150.00 for missed surgeries or procedures. This charge will be the patient's responsibility and will not be billed to or reimbursed by your insurance.
- If a patient repeatedly misses or cancels appointments, the patient may be dismissed from the practice.

Initial _____

WELLNESS/ANNUAL VISITS WITH OTHER PROBLEMS

- If during your annual/well-woman preventive care exam, you have or need treatment for a problem, if the problem is addressed during the visit in lieu of scheduling a separate appointment, in addition to the preventive exam it may be necessary that a problem/E&M visit be billed along with other labs, testing, and/or procedures, which may be subject to copays and/or deductible.

Initial _____

PERSONAL INFORMATION VERIFICATION

- It is our policy to verify your demographic and insurance information **at every visit** to help insure that claims are processed timely and accurately. Although it may seem unnecessary at the time, this is extremely important to our billing process. Please bring your insurance card with you to **EVERY VISIT**. Additionally, a photo ID will be requested from all patients.

Initial _____

FORMS AND PAPERWORK

- There is a minimum fee of $20.00 for the release of medical records which is the responsibility of the patient to pay prior to receiving the records. For records that exceed twenty (20) pages, there may be an additional charge of $0.50 per page for all pages exceeding the first twenty (20) pages. A $20.00 fee will be charged to complete up to two (2) forms for FMLA and standard disability. An additional fee of $25.00 will be charged for submitting subsequent forms.

Initial _____

Patient Signature _____ Patient Printed Name _____

Date _____ Patient Chart #_____ KMO Initials_____ eff: 8/01/13

PATIENT MEDICAL HISTORY

Date _____
_____ NEW _____REPEAT

NAME: _____ AGE: _____ BIRTH DATE: _____ RACE: _____
ADDRESS: _____ TEL.# (HME) _____ (OFC) _____
OCCUPATION: _____MARITAL STATUS _____ RELIGIOUS BACKGROUND _____
HEIGHT _____ WEIGHT _____
EMERGENCY CONTACT: _____ RELATION _____ TEL.# _____

Please describe your chief medical complaint and duration: _____
_____
_____

Please list current medications: _____
_____

Please describe your immediate family history: (S) self (F) family

GYNECOLOGICAL
___ Breast problems
___ Chlamydia
___ Endometriosis
___ Gonorrhea
___ Herpes
___ Ovarian Cyst
___ Pelvic Infection
___ Vaginitis, recurrent
___ Syphilis
___ Abnormal Pap Smear
___ Genital Warts
___ Cancer (please specify)
_____

GENERAL MEDICAL
___ AIDS
___ Anemia
___ Arthritis
___ Asthma
___ Auto Immune Disease
___ Diabetes
___ Epilepsy / seizures
___ Heart Disease
___ Hepatitis
___ High Blood Pressure
___ Hirsutism (excess Hair Growth)
___ Kidney Disease
___ Liver Problems
___ Lung Disease
___ Measles: German
___ Blood Clots in Leg or Lung
___ Obesity
___ Thyroid Problems
___ Ulcers
___ Urinary Infection

OTHER
___ Alcohol use _____ How much
___ Blood Transfusion
___ Drug use (recreational)
___ DES Exposure
___ Smoke _____ How much
___ Other _____
_____
___ Exercise (how much)
_____
___ Caffeine use _____ How much
___ Vitamins / Diet Pills / Herbals
___ Immunizations Date
Tetanus _____
Hep B series _____
Varicella _____
MMR _____
Influenza _____
Pneumococcal _____

Please list any previous surgeries and dates: _____
_____
_____

Please describe your gynecological history:
Menstruation began at _____ years of age.
Type: (circle one) regular irregular heavy prolonged clots none
First date of last menstrual period: _____
How many days does your period last? _____
How many days pass between your periods? _____
Do you experience pain during your period? Y N
Do you experience pain during intercourse? Y N
Please list your number of children: _____
Age of youngest child? _____
Please list your number of miscarriages / abortions _____
When was your last Pap Smear? _____
When was your last mammogram? _____
Please list your methods of contraception: Current _____ Past _____

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome and Lynch syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

		COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50			
Y	N	Colorectal cancer before age 50			
Y	N	Ovarian, stomach, kidney/urinary tract, brain or small bowel cancer			
Y	N	Two or more Lynch syndrome cancers*			
		BREAST AND OVARIAN CANCER	**SELF**	**FAMILY MEMBER**	**AGE AT DIAGNOSIS**
Y	N	Breast cancer at age 50 or younger			
Y	N	Ovarian cancer			
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y	N	Male breast cancer			
Y	N	Triple negative breast cancer† (ER-, PR-, HER2- pathology)			
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			
Y	N	Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain:			

Patient's Signature Date

FOR OFFICE USE ONLY

- ☐ Candidate for further risk assessment and/or genetic testing
- ☐ Information given to patient to review
- ☐ Follow-up appointment scheduled Date: _____
- ☐ Patient offered genetic testing:
  - ☐ Accepted
  - ☐ Declined

Healthcare Professional's Signature Date

*Lynch syndrome-related cancers include ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas

† For a better understanding of triple negative breast cancer, please ask your healthcare provider.

Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.myriadtests.com/patient_guidelines

WHRA/07-11

MYRIAD®

KRISTIN MILLER OBSTETRICS AND GYNECOLOGY, PLC

I hereby authorize this office to release information regarding my PHI-Protected Health Information, to include account status, test results, scheduled appointments and information regarding my healthcare to the persons I have listed below:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Any person who is not listed above will not be able to obtain any information whatsoever. Unless the information has to do with your healthcare condition as it relates to this office, you must also list any other physician that you would like to have access to your records.

PatientSignature:_____Date:_____

Printed Patient Name:_____

Staff Witness:_____