Balcones Gynecology

3705 Medical Parkway, Ste 540
Austin, Texas 78705

PATIENTS NAME: ____
LAST FIRST M

ADDRESS: ____

CITY: ____________________ **STATE:** ______________ **ZIP:** ________

PRIMARY PHONE: ______________ **SECONDARY PHONE:** ____________

SOCIAL SECURITY #: ________________ **DATE OF BIRTH:** ____/_____/____

MARITAL STATUS: S, M, D, W DRIVER'S LICENSE #: ____________________

EMPLOYER: __________________ **OCCUPATION:** __________________

EMERGENCY CONTACT: ________________ **CONTACT #** ______________

EMAIL ADDRESS: ____

PRIMARY INSURANCE ***<u>PLEASE COMPLETE THIS SECTION AND PRESENT YOUR CARD TO THE FRONT DESK</u> *****

INSURANCE COMPANY: ______________________ **PHONE #:** ________________

POLICY #: ____________________________ **GROUP #:** ________________

POLICY HOLDER'S NAME: ______________________ **DATE OF BIRTH:** ____________

POLICY HOLDER'S SS#: __________________ **RELATIONSHIP TO PATIENT:** ____________

SECONDARY INSURANCE
INSURANCE COMPANY: ______________________ **PHONE #:** ________________

POLICY #: ____________________________ **GROUP #:** ________________

POLICY HOLDER'S NAME: ______________________ **DATE OF BIRTH:** ____________

POLICY HOLDER'S SS#: __________________ **RELATIONSHIP TO PATIENT:** ____________

I acknowledge that I have been read, understand and been offered a copy of the HIPAA policies of Balcones Gynecology.

I authorize qualified staff to perform upon me, rehabilitation, therapy and/or any other care including treatment necessary to improve my well being. I acknowledge that no guarantees can be made to me as to the outcome of treatment.

I authorize my insurance benefits to be paid directly to Balcones Obstetrics & Gynecology, PA realizing I am responsible to pay non-covered and/or denied services. In the event that my insurance carrier denies payment for any reason, I acknowledge that I am responsible for payment of services provided to me.

I authorize the release of information to my insurance carrier named above concerning my medical condition and for the purpose of claims processing. I also authorize the release of medical information to my referring physician and any physician I am recommended to see for continuation of care. I understand that the release of information will only consist of medical records belonging to Balcones Obstetrics & Gynecology, PA.

PATIENT SIGNATURE: ____ **DATE:** ______________

Balcones Gynecology Patient Information

Nancy Binford, MD

The intent of this handout is to provide you with concise information regarding the conditions, expectations, and procedures of our office and staff. The policies and procedures listed below have been instituted due to the many continuing changes in healthcare, our growing practice, and our desire to respond to these changes in a way that will continue to provide you with the utmost care.

APPOINTMENTS:

We will make every effort to schedule your appointment in an appropriate time frame. Yearly well-woman exams will be scheduled within one to three months of calling. Scheduling these routine exams in that time frame is important to allow patients with urgent medical needs to be seen in a shorter time frame.

If you are due for your well-woman exam and have an urgent problem, we will make two appointments for you—an earlier appointment for the problem, and a later appointment for the well-woman exam.

For women who are due for their annual mammogram before a well-woman appointment, we will not mail you an order in advance of that appointment. It is important to examine the breasts each year in advance of the mammogram so that we may order the proper type of testing. If you believe that there is a breast problem requiring immediate attention, we will make two appointments for you—an earlier appointment for the breast problem, and a later appointment for the well-woman exam.

LAB TESTING AND RESULTS:

For all testing done with a blood sample, you may have the labs drawn in our office. Most labs have multiple lab locations for your convenience and operate on a walk-in basis if you choose to have them drawn elsewhere. We send all labs and specimens to Clinical Pathology Laboratories. Please let us know prior to getting your blood drawn if your labs must be sent to a different lab that is required by your insurance company.

Pap smear results and other screening labs will be reported to you by mail within two weeks of testing if normal. All abnormal results will be called to you in the same time frame. Mammogram results will be reported to you by mail by the radiology facility whether normal or abnormal. We will be sent a report, and we will call you within two weeks if the report shows abnormal findings.

NURSE CALL-BACKS:

If you have a medical question that cannot wait until your appointment, you may leave a message for our nurse. Your call will be prioritized relative to all calls received by the nurse. Problems of an urgent nature will be attended to first. Calls of a less urgent nature may be returned later the same day or the following day.

MAIL-ORDER PRESCRIPTIONS AND MEDICATION REFILL REQUESTS:

Mail-order pharmacy use by our patients has greatly increased. It is our policy that our nursing staff cannot fax or call in medication orders to mail-order pharmacies. Our intention is that their time may be dedicated to responding to your phone calls about your medical concerns rather than spent on the inordinate amount of paperwork and lengthy phone calls required by the mail-order pharmacies. We will provide you with a written prescription for your medications and we ask that you mail or fax this in yourself.

If you need a refill of your medication, please do not call the office. We ask that you call your pharmacy and request a refill. The pharmacy will then fax this request to our office. These faxes are checked daily, prioritized by importance and the time received, then faxed back to the pharmacy within 48 hours.

First time reviewed: Signature: ____ Date: _______________________

Balcones Gynecology
3705 Medical Parkway, Suite 540, Austin, Texas 78705
Phone (512)452-8888   Fax (512)452-8889

FINANCIAL POLICY

- **Co-payments, deductibles and/or coinsurance are due at the time of service.** We accept Cash, Personal Check, Care Credit, MasterCard, and Visa. If you are not prepared to pay the required amount, we are required to reschedule the appointment. The estimated financial responsibility for scheduled services will be due ***prior*** to these services being provided. Any remaining balance after your health plan pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to the appointment, the account will be notated as private pay and payment will be due in full. *Account balances over 90 days with no payment activity will be reported to the credit bureau(s).* Initials _______

- **Your insurance policy is a contract between you and your insurer. Do not assume your policy covers everything or pays at 100%. It is your responsibility to know what your policy covers and what it does not. We cannot quote your benefits.** Any item deemed "non-covered" by your insurance carrier will be your financial responsibility. This includes lab designation and payment. Any disputes about payment must be resolved between you and your insurer. You are responsible for ensuring a properly dated referral and/or authorization if required by your insurer for services being provided. You are also responsible for payment if your claim denies for lack of referral/authorization. Failure to provide accurate insurance information within 3 days from the date of service will result in the balance becoming your financial responsibility. Initial _______

- As a courtesy to you, we will file primary participating insurance for you with proper assignment. Any additional insurance policies will be yours to file with receipt from our office. Please bring your primary insurance card with you to <u>every</u> visit. I understand that all remaining balances are my responsibility to satisfy prior to additional services being rendered. Initial _______

- This office is not party to legal disputes. The financial responsibility rests with the patient or parent/guardian for patients under 18 years of age. Initial _______

- A $35.00 fee will be assessed for all returned checks. Initial _______

- We confirm appointments 48 hours in advance. Please notify our office within 24 hours before scheduled appointment to avoid a $50.00 cancellation fee. Initial _______

- Payments & credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service. Refunds over $50 will be provided within 30 days from the date all outstanding claims are satisfied. Credit balances less than $50 will be available and processed upon request of the patient. Initial _______

ASSIGNMENT OF BENEFITS

I request payment of the medical benefits, otherwise payable to me, directly to *Balcones Gynecology* for services provided by them.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

____ ______________________

Responsible Party Printed Name (Must be 18 or over) Date

____ ______________________

Responsible Party Signature (Must be 18 or over) Date

New Patient Intake Form

Please complete this brief history to assist me in providing you with the best care possible.
This form will be added to your medical record.

Name: ______________________________ Preferred Name _________________________ Preferred Pronoun(i.e. she/he; her/him) __________

Date of Birth: ______________________ Who referred you? ____

Reason for visit: ____

Sexuality/Gender Identity

What is your sexual orientation?
☐Straight/Heterosexual
☐Lesbian/Gay
☐Bisexual
☐Other ___________
☐Decline to state

What sex were you assigned at birth?
☐Female
☐Male
☐Decline to state

What is your gender identity?
☐Female
☐Transgender woman/Transwoman
☐Male
☐Transgender man/Transman
☐Gender queer/Gender non -conforming
☐Decline to state

Recent Exam

Type of exam	Date of last exam	Location of exam
Pap test		
Mammogram		
Colonoscopy		
Pelvic/Transvaginal ultrasound		
Bone density study		

Gynecologic History

Date of last menstrual period: ___________________

Age (years) at 1st period _____; My period usually occurs every_____ days and lasts for _____days; Age at Menopause_____

Do you have a history of (If yes please provide date and describe):

☐ Ovarian cysts ____

☐ Fibroids ____

☐ Abnormal Pap test ____

☐ Sexually Transmitted Infection ____

Have you ever used oral contraceptives (if so for how many years)? ____

Have you ever used hormone replacement therapy (if so for how many years)? _________________________________

Are you sexually active? ☐ No ☐ Yes Any problems? ____

Total number of pregnancies _____

# of Vaginal deliveries ___; Cesarean sections ___; Miscarriages ___; Abortions ___; Ectopic pregnancies ___;

Pregnancy Complications____

Current Medications (include vitamins, herbs and other supplements)

Please review your attached medication list. Please add/remove medications based on what you currently take.

Name of Medication	Dosage	How Often

Allergies

Are you allergic to any medications? ☐ No ☐ Yes (Please specify the medication and reaction):

Medical History (either now or in the past/detail below with year of diagnosis and treatment given)

☐ Asthma
☐ Cancer
☐ Cardiac disease
☐ Diabetes
☐ Hypertension / high blood pressure
☐ Hyperlipidemia / cholesterol
☐ Irritable bowel syndrome

☐ Inflammatory bowel disease
☐ Lupus
☐ Osteoporosis / osteopenia
☐ Stroke
☐ Thrombotic disorder (blood clots)
☐ Thyroid disease (low / high)
☐ Reflux (GERD)

Psychiatric diagnosis
☐ Anxiety
☐ Depression
☐ Bipolar disorder
☐ Other: ___________________________
____
____

Name: ______________________________ Date of visit: ______________

Surgical History

Name of Procedure	Date of Procedure	Reason for Procedure

Family History

Do you have a family member with any of the following cancers (if yes please list which family member and age of diagnosis)

- ☐ Breast cancer ______________________
- ☐ Ovarian cancer ______________________
- ☐ Uterine/endometrial cancer ______________________
- ☐ Prostate cancer ______________________
- ☐ Pancreatic cancer ______________________
- ☐ Colon cancer ______________________
- ☐ Melanoma ______________________
- ☐ Other cancer (specify) ______________________

Mother: ☐ Living ☐ Deceased (cause) ______________________

Father: ☐ Living ☐ Deceased (cause) ______________________

Siblings: Number living: ______ Number deceased: ________ Cause: ______________________

Social History

Do you exercise? If so what do you do ______________________

Occupation________________________ Marital Status_________________

Do you smoke? _______ How many packs a day? __________ If you quit, when was this? ________

Do you drink alcohol? _____ How many drinks per week? ________ Any other drugs? ________ Which other drugs?_ ____________

Review of Systems: Are you experiencing any of the following symptoms?

Constitutional	☐ No	☐ Weight loss	☐ Weight gain	☐ Fever	☐ Fatigue
Eye Problems	☐ No	☐ Vision Changes	☐ Glasses	☐ Contacts	☐ Other
Ear, Nose, Throat	☐ No	☐ Ulcers	☐ Sinusitis	☐ Headache	☐ Hearing Problems
Cardiovascular	☐ No	☐ Chest pain	☐ Leg Swelling	☐ Palpitations	☐ Other
Respiratory	☐ No	☐ Wheezing	☐ Cough	☐ Shortness of Breath	☐ Other
Gastrointestinal	☐ No	☐ Diarrhea	☐ Constipation	☐ Nausea	☐ Vomiting
Urinary	☐ No	☐ Painful Urination	☐ Urgency	☐ Frequency	☐ Bloody Urine
Skin/Breast	☐ No	☐ Breast Pain	☐ Nipple discharge	☐ Breast Mass	☐ Skin Rash
Neurological	☐ No	☐ Fainting	☐ Seizures	☐ Numbness	☐ Trouble Walking
Psychiatric	☐ No	☐ Depression	☐ Anxiety	☐ Other	
Blood/Lymph	☐ No	☐ Easy Bruising	☐ Abnormal Bleeding	☐ Swollen Glands	☐ Other
Musculoskeletal	☐ No	☐ Weakness	☐ Pain	☐ Other	

Physicians

Medical / primary care physician: ______________________ Phone #__________________

Obstetrician / Gynecologist: ______________________ Phone # __________________

Cardiologist: ______________________ Phone # __________________

Other physician: ______________________ Phone # __________________

Other physician: ______________________ Phone # __________________

GENERAL INFORMATION

Patient Name (please print): ______________________________________

Patient Email: ____

Preferred pharmacy:________________________________ Pharmacy location: _______________________

RELEASE OF INFORMATION

By signing in the spaces below I understand these authorizations will remain in effect until a written change request is received by Balcones Gynecology. I understand I am responsible for updating the office promptly of any changes in the phone numbers and/or home address on file.

I authorize the staff of Balcones Gynecology to leave detailed health information, which may be confidential, at the following phone number(s): ____

Patient Signature: ____ Date: ________________________

I authorize the staff of Balcones Gynecology to send lab results to my current home address on file.

Patient Signature: ____ Date: ________________________

PATIENT AGREEMENT: Choosing Visit Type(s)

This form is to **clarify the type of office visit(s)** that you will have today. A Wellness Visit or Well Woman Visit (Preventive Services) includes coordinating health screening, performing a complete physical exam (including a breast and pelvic exam), obtaining a pap smear (if indicated), and refilling any existing prescriptions such as birth control pills or hormone replacement. A Problem Visit addresses any symptoms, problems, or concerns that you may have (such as pelvic pain, abnormal periods, or menopause symptoms), or anything abnormal in your history or discovered on exam.

Please understand that by government rules, a Problem Visit is a separate service to your Wellness Visit, may fall under different benefits, and may leave you **owing a copay** even if there would not be a co-pay for a Wellness Visit only. And, you will be financially responsible for any additional services provided.

Please understand we are contractually obligated to code your visit and bill your insurance company based on the actual services we provide during your visit. Be aware that we cannot modify these codes later in an effort to get your insurance to pay for non-covered services.

Please indicate the type of visit you wish to have today:

______________ **Wellness Visit only**

______________ **Problem Visit only**

List Problems: ____

____

____

Patient Name: ____ Date: _______________

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ____ Date of Birth: ________________________ Age: ____________
Height: ___________________ Weight: ___________________ Age at First Period: _________ Age at Delivery of First Child: __________
Are you menopausal: YES or r NO Have you ever used hormone replacement therapy: YES or NO
Has anyone in your family had genetic testing for a hereditary cancer syndrome: (Ex: (BRCA or Lynch)? YES or NO

Please mark below if there is a **personal or family history** of any of the following cancers and **indicate family relationship** along with **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

BREAST AND OVARIAN CANCER (BRCA)

		Type	You (age of diagnosis)	Siblings/Children (age at diagnosis) *Ex: Brother 36yrs*	Mother's Side (Who + age at diagnosis) *Ex: Aunt 44yrs*	Father's Side (Who + age at diagnosis) *Ex: Grandfather 65yrs*
Y	N	Breast cancer				
Y	N	Breast cancer in both breasts OR multiple primary breast cancers				
Y	N	Ovarian cancer				
Y	N	Male breast cancer				
Y	N	Are you of Jewish descent				

COLON AND UTERINE CANCER (Colaris)

Y	N	Uterine (endometrial) cancer				
Y	N	Colon cancer				
Y	N	Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer				
Y	N	10 or more colon polyps found in a lifetime				

OTHER CANCERS

Y	N	Prostate cancer (BRCA)				
Y	N	Pancreatic cancer (Col/BRCA)				
Y	N	Melanoma (BRCA)				

Patient Signature: ____ Date: _________________________________

For Office Use Only:

BRCA/Lynch Testing Indicated? YES NO
Patient offered hereditary cancer testing? YES NO If YES: ACCEPTED DECLINED
Follow-up appointment scheduled? YES NO Date of Appointment: ___________________________

Physician Signature: ____ Date: _________________________________

BRCA - Personal or Fam. History	**BRCA - Personal or Fam. History**	**Lunch Syndrome (Colon/Endo)**
One person with (out of 2nd degree) * Breast cancer at 45 or younger * Ovarian cancer at any age * Male breast cancer at any age * Breast cancer + Jewish heritage * Bilateral breast at 50 or younger * Triple Neg Br.Ca at 60 or younger	Two persons with (out to 3rd degree) * 2 Breast cancers, w 1 at age 50 or younger * Breast & ovarian (any age) Three persons with (out to 3rd degree) * Breast and/or ovarian and/or pancreatic (any age)/aggressive Prostate	Personally affected with: * Colon or endometrial at age 50 or younger Family history of Colon, endometrial, or + another Lynch cancer (out of 2nd degree) (gastric, ovarian, brain, kidney, small bowel) * 2 or more Lynch cancers, 1 dx at 50 or younger