Dr. McSwain

Dr. Ingvoldstad

Dr. Dozier

Dr. Roberts

Dr. Knoer

Peachtree Women's Specialists

Today's date _____ Referred by _____

Please print and fill out completely. Account #_____

Legal **Name** _____ Date of birth _____

Name we should use (Nickname) _____ S.S # _____

Home address _____ Apt # _____

City _____ State _____ Zip code _____ Home phone _____

Occupation _____ Cell phone _____

Employed by _____ Work phone _____

SPOUSE's name _____ Marital status S M D W Your email _____

Spouse's occupation _____ Employer _____ Work phone _____

Person with whom we may leave results (name / relation) _____

Emergency contact's name, rel, phone (not living with you) _____

Primary care physician _____ PCP's phone _____

Referring physician _____ Ref phys phone _____

If **MINOR**, responsible adult / relationship _____

Address _____ City, state, zip _____ Phone _____

Occupation _____ Employer _____

Primary Insurance Ins Name _____ Effective Date _____ Phone _____

Policy holder's name _____ Date of birth _____

ID # _____ Group number _____

Type of plan (circle one) HMO POS PPO EPO Indemnity Commercial

Secondary Insurance Ins Name _____ Effective date _____ Phone _____

Policy holder's name _____ Date of birth _____

ID # _____ Group number _____

Type of plan (circle one) HMO POS PPO EPO Indemnity Commercial

Authorization for Treatment:

I consent to examination, treatment and procedures, which may be performed during office visits including emergency treatment considered necessary by the physician and / or his designated provider.

Assignment of Insurance Benefits:

I hereby assign payment directly to Peachtree Women's Specialists for services covered by insurance or other health benefit plans.

Authorization for Release of Information:

I authorize Peachtree Women's Specialists to release to my insurance carrier and its designated agents any medical information, including information related to psychiatric care, drug or alcohol abuse, and HIV / AIDS, necessary to process any healthcare related utilization review or quality assurance activities. I further authorize the release of any medical information to other healthcare providers to whom or from whom I have been referred for healthcare services or who provide consultative services regarding my medical care. This authorization shall remain in effect until revoked by me in writing. I know that I have a right to receive a copy of this authorization upon request and agree that a photocopy of same is as valid as the original.

SIGNATURE OF PATIENT OR GUARDIAN: _____ **Date** _____

Peachtree Women's Specialists

Family History of Cancer Questionnaire

Name_____ Date of Birth _____ Date_____

Please circle Y to those that apply to **YOU and/or YOUR FAMIL Y** (on both **MOTHER** and **FATHER'S** side.)
Please list your relationship to the individual diagnosed and the age at cancer diagnosis.

Consider parents, siblings, grandparents, aunts, uncles, children, nieces, and nephews.

HEREDITARY BREAST and OVARIAN CANCER SYNDROME

		Relationship	Age at Diagnosis
Breast cancer before age 50	Y N		
Ovarian cancer at any age	Y N		
Breast cancer in both breasts or multiple primary breast cancers at any age	Y N		
Male breast cancer at any age	Y N		
3 or more breast cancers on the same side of the family at any age	Y N		
Ashkenazi Jewish with a personal or family history of breast or ovarian cancer at any age	Y N		

LYNCH SYNDROME / HEREDITARY NONPOLYPOSIS COLORECTAL CANCER

		Relationship	Age at Diagnosis
Endometrial (uterine) cancer before age 50	Y N		
Colorectal cancer before age 50	Y N		
Colorectal or endometrial cancer at any age AND another family member on the same side of the family with any cancer listed below at any age:	Y N		

Colorectal, Endometrial, Ovarian, Stomach, Kidney/ Urinary Tract, Brain, or Small Bowel

If you circled yes to one or more statements on the Family History Questionnaire, you may be appropriate for a blood test to help determine if you have an inherited risk of cancer.

FOR OFFICE USE ONLY

O Patient offered genetic testing
O **Accepted** O **Declined**

O Information given to patient for review
O Follow up appointment scheduled for date _____

Provider's Signature_____ Date_____

PEACHTREE WOMEN'S SPECIALISTS
PATIENT MEDICATION & PHARMACY INFORMATION

Patient Name:_____

Drug Allergies:_____

Pharmacy Name:_____

Pharmacy Address:_____

City, State, ZIP: _____

Pharmacy Phone Number:_____

Medication Name?	**Dose?**	**Frequency?**	**What is the medication for?**	**Who prescribes the medication?**

PEACHTREE WOMEN'S SPECIALISTS

Vaccination History Questionnaire

Date: _____

Patient Name: _____ DOB: _____

- Every hour a woman is diagnosed with cervical cancer in the United States.
- Over 600,000 adults each year are diagnosed with pertussis (whooping cough) in the U.S.
- Over 30% of people with Hepatitis A and over 50% of people with Hepatitis B have not signs or symptoms. There is no medication to treat acute Hepatitis.

Are you current on your vaccinations?

If you are like most of our patients, you don't know. If you can't remember the last time you were vaccinated or which ones you previously received, it's time to get vaccinated! Please ask your health care provider about getting vaccinated today.

If you would like more information about your vaccines, please ask us for a copy of the Vaccine information sheet or go to www.immunize.org.

Vaccinations / Boosters

Have you ever been vaccinated for Hepatitis A?	○ Yes	○ No	○ Unsure
Have you ever been vaccinated for Hepatitis B?	○ Yes	○ No	○ Unsure
Have you had pertussis (whooping cough) booster?	○ Yes	○ No	○ Unsure
Have you had a recent tetanus booster?	○ Yes	○ No	○ Unsure
Have you had a flu shot this year?	○ Yes	○ No	○ Unsure
If under 26, have you had cervical cancer vaccinations?	○ Yes	○ No	○ Unsure

I decline updating my vaccinations. _____

Signature

Atlanta Women's Healthcare Specialists, LLC

275 Collier Road, NW Atlanta, Georgia 30309

FINANCIAL POLICY

Patient Name:_____

(Please print)

Atlanta Women's Healthcare Specialists' providers are committed to meeting your health care needs! We are pleased that you have chosen us! Listed below are our financial policies. If you have any questions, please discuss them with our financial team.

Patient Responsibility

1. All co-payments are due at the time of visit. Post dated checks are not accepted.
2. Co-insurance and unmet deductibles are due prior to scheduled office visits, ultrasounds, surgeries, and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date.
3. You are ultimately responsible for payment of charges for services you receive from our office.
4. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
5. It is your responsibility to ensure that our physicians are in your insurance network.
6. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider.
7. It is your responsibility to notify the office of any change in your mailing address and phone number(s).
8. Cancellations for appointments and procedures must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time.
9. Payment is due for rendered services 7 days from receipt of your billing statement. Unpaid previous balances must be paid in full prior to any additional visit unless arrangements have been made with our financial counselor.

Fees

1. The returned check fee is $30.00.
2. There will be an additional charge of 25% of the balance owed for any past due balance that is submitted to an outside agency for collections.
3. Patients who fail to keep and fail to cancel a scheduled appointment may be charged a $50.00 No Show Fee. There is a $200.00 cancellation fee for scheduled surgeries that are cancelled less than 5 business days from the date and time of surgery unless cancellation is due to insurance denial or medical necessity.
4. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Georgia. Fees must be received prior to record delivery. No more than 5 pages may be faxed. *We strongly discourage faxing medical records unless the recipient has a dedicated and personal fax for delivery.*
5. When a physician treats you via telephone after hours it is for emergencies only. Therefore, for routine problems that require history, diagnosis, and treatment (i.e., calling a prescription or refill into a pharmacy), the provider **may** bill a $50 or $75 service fee. There is no charge for labor related calls, OB problems, and emergent medical issues.

Administrative Services

There is a fee for patient Administrative Services. Our office collects an **OPTIONAL** Administrative Service Fee of $5.00 per office visit for Gynecologic visits and $75.00 per pregnancy for Obstetrical visits (payable at the beginning of the Prenatal Care) which covers **all** forms that need to be completed during your pregnancy. **YOU ARE NOT REQUIRED TO PAY THIS FEE**; however, if you choose not to pay the fee there is a $20.00 charge for **each** required Administrative Service payable prior to service completion.

This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative item not covered by insurance.

_____ **(Initial)** **I accept the Administrative Service Fee. I will pay $5.00 per visit. (GYN)**

_____ **(Initial)** **I accept the Administrative Service Fee. I will pay $75.00 today. (OB per pregnancy)**

_____ **(Initial)** **I decline the Administrative Service Fee. By declining the Administrative Service Fee, I understand that I will be charged $20.00 for each Administrative Service requested.**

My signature authorizes Atlanta Women's Healthcare Specialists, LLC, to file insurance claims on my behalf to Medicare or other insurance plans and for payments of any benefits due under my insurance plan to be made to Atlanta Women's Healthcare Specialist, LLC when insurance is filed on my behalf.

By my signature below, I acknowledge that I have read and understand this Financial Policy.

Patient Signature _____ Date _____