Patient Demographic Form

avina women's care™

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Preferred Name: _____ Maiden Name: _____ Pronouns: _____

Date of Birth: ____ /____ /____ Social Security Number: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: (___)_____ Cell Phone #: (___)_____ Work Phone #: (___)_____

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Other Circumstance: _____

Employer Name: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Other Circumstance: _____

Race: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Are you adopted? ☐ Yes ☐ No Please provide more information if needed: _____

Preferred Language: _____

Preferred Pharmacy: _____ Phone #: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

How did you hear about Avina? ☐ Google (search engine) ☐ Social Media ☐ TV ☐ Other _____

Primary Insurance Information

Name of Insurance: _____ Effective Date: ____ /____ /_____

Policy Holder's Name: _____ Relation to Patient: _____ Policy Holder's D.O.B.: ____ /____ /_____

Policy Holder's S.S. #: _____ Policy #: _____ Group #: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance Information (if applicable)

Name of Insurance: _____ Effective Date: ____/____/_____

Policy Holder's Name: _____ Relation to Patient: _____ Policy Holder's D.O.B.: ____/____/_____

Policy Holder's S.S. #: _____ Policy #: _____ Group #: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

I authorize Avina Women's Care and any entity authorized by my healthcare provider to contact me by using any telephone number, email address and mailing address provided. I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to Avina Women's Care. By signing this form, I agree to be fully responsible for payment of services deemed medically unnecessary or are not covered by my insurance carrier.

Patient Signature: _____ Date: _____

(Parent/Guardian Signature, if applicable)

Authorization for Use and Disclosure of Health Information

Avina Women's Care can contact me with detailed information and leave a message at

Phone #: (_____)_____ Type (cell, home, work): _____

Avina Women's Care has permission to contact and disclose my medical condition and/or treatment with

Name: _____ Relationship: _____ Phone #: (_____)_____

Name: _____ Relationship: _____ Phone #: (_____)_____

I understand that I may request a copy of the information used or disclosed under this authorization.

I understand that if the person or entity who receives my protected health information is not covered by Federal Health Care Privacy regulations, the personal health information disclosed may be re-disclosed to another person or entity and it will no longer be protected by Federal Health Care Privacy rules.

I understand that I may refuse to sign this authorization and that this refusal will not affect my ability to obtain health care treatment from Avina Women's Care, payment for this treatment, my ability to enroll in a health care plan or be eligible for health care plan benefits.

I understand that I have the right to revoke this authorization at any time, in writing, by notifying the Avina Women's Care Privacy Officer.

Patient Name (Printed): _____ Date of Birth: _____ /_____ /_____

Patient Signature: _____ Date: _____

(Parent/Guardian Signature, if applicable)

Medical History Questionnaire

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Date of Visit: ____ /____ /____ Patient Name: _____ Date of Birth: ____ /____ /____

Primary Care Physician: _____ Patient Type: ☐ New Patient ☐ Current Patient (seen in past 3 years)

Reason for Visit: ☐ Annual/Preventative Exam ☐ OB Exam ☐ GYN Exam Problem: _____

☐ Other: _____

Pregnancy History

Number of: Pregnancies _____ Full Term Deliveries _____ Premature Deliveries _____

Miscarriages _____ Ectopics: _____ Abortions _____ Living Children _____

1. Delivery Date (year): _____ Gender (circle): M / F Birth Weight: _____ Weeks at delivery: _____
   Delivery Type (circle): Vaginal / C-section Complications: _____

2. Delivery Date (year): _____ Gender (circle): M / F Birth Weight: _____ Weeks at delivery: _____
   Delivery Type (circle): Vaginal / C-section Complications: _____

3. Delivery Date (year): _____ Gender (circle): M / F Birth Weight: _____ Weeks at delivery: _____
   Delivery Type (circle): Vaginal / C-section Complications: _____

Additional Pregnancies: _____

Menstrual History

Age of first menstrual period: _____ Regular monthly cycles? (circle): Yes / No / N/A

First day of last period : _____ /_____ /_____ Current Method of contraception: _____

History of STDs: _____

Preventative Care

Last Pap Smear: _____ /_____ /_____ Previous Abnormal Pap? (circle): Yes / No Gardasil Vaccine? (circle): Yes / No

Last Mammogram: _____ /_____ /_____ Where_____ Previous Abnormal Mammo? (circle): Yes / No

Last Cholesterol Test: ____ /____ /____ Last Colonoscopy: ____ /____ /____ Last DEXA (Bone Density): ____ /____ /____

Current Medications (Including Over-the-Counter and Vitamins)

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Allergies (Drugs and/or Food)

Type: _____ Reaction: _____

Type: _____ Reaction: _____

Type: _____ Reaction: _____

Pharmacy Name and Address _____

Surgeries and/or Major Injuries

Type: _____ Year: _____

Type: _____ Year: _____

Type: _____ Year: _____

Social History

Regular Exercise? (circle): Yes / No Times per week: _____

Caffeine Intake? (circle): Yes / No Servings per day: _____ Alcohol use? (circle): Yes / No Drinks per week: _____

Tobacco Use? (circle): Yes / No If yes, describe: _____ Recreational drug use? (circle): Yes / No

Medical History

Check box if you have a history of:

- ☐ Blood Clots
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Health Disorder
- ☐ Mitral Valve Prolapse
- ☐ Neurologic Disorder
- ☐ Ovarian Cyst
- ☐ Pelvic Inflammatory Disease
- ☐ Polycystic Ovarian Disease
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Uterine Fibroids

Family History

Check box and list relation (e.g. mother, father, brother, sister, etc.):

- ☐ Alcoholism _____
- ☐ Autoimmune Disorder _____
- ☐ Birth Defects _____
- ☐ Blood Clots _____
- ☐ Breast Cancer _____
- ☐ Cerebral Palsy _____
- ☐ Cervical Cancer _____
- ☐ Colon Cancer _____
- ☐ Cystic Fibrosis _____
- ☐ Diabetes _____
- ☐ Endometrial Cancer _____
- ☐ Epilepsy _____
- ☐ Genetic Disorder _____
- ☐ Heart Disorder _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Kidney Abnormalities _____
- ☐ Liver Disease _____
- ☐ Mental Health Disorder _____
- ☐ Osteoporosis _____
- ☐ Ovarian Cancer _____
- ☐ Pancreatic Cancer _____
- ☐ Sickle Cell Disease _____
- ☐ Stroke _____
- ☐ Thyroid Disease _____
- ☐ Uterine Cancer _____
- ☐ Other _____

Symptoms

Check box if you have any of these symptoms:

<u>Reproductive & Urinary Symptoms</u>

- ☐ Abnormal Bleeding
- ☐ Bleeding After Sex
- ☐ Bleeding Between Periods
- ☐ Bleeding Post-Menopause
- ☐ Blood in Urine
- ☐ Burning Urination
- ☐ Hot Flashes
- ☐ Menstrual Cramps
- ☐ Night Sweats
- ☐ Painful Intercourse
- ☐ Pelvic Pain
- ☐ Sexual Difficulties
- ☐ Urinary Incontinence
- ☐ Urination Frequency/Urgency
- ☐ Vaginal Discharge
- ☐ Vaginal Dryness

<u>General Symptoms</u>

- ☐ Blood in Stool
- ☐ Breast Mass/Discharge
- ☐ Chest Pain/Palpitations
- ☐ Constipation
- ☐ Cough
- ☐ Depression/Anxiety
- ☐ Diarrhea
- ☐ Dizziness/Fainting
- ☐ Easy Bruising
- ☐ Fatigue
- ☐ Fever/Chills
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Jaundice/Liver Disease
- ☐ Muscle/Joint Pain
- ☐ Nasal Drainage
- ☐ Nausea/Vomiting
- ☐ Numbness/Tingling
- ☐ Shortness of Breath
- ☐ Swollen Legs
- ☐ Varicose Veins/Clots
- ☐ Weight Changes
- ☐ Wheezing
- ☐ Other Symptoms _____

_____

_____

_____

Financial Policy

Thank you for choosing Avina Women's Care for your obstetric and gynecologic care. The following is a summary of our financial policy. Please take the time to understand this document and agree to our guidelines.

It is your responsibility to understand your health insurance policy, its benefits and limitations. It is a requirement of your insurance carrier that you present your insurance card at every visit. If you have any questions about your policy, please contact your agent or employer.

Our office will file your charges to your insurance carrier. It is your responsibility to pay all co-pays, deductibles, coinsurance and any balances not covered by your insurance plan(s). Co-pays and past due balances are due at the time of your appointment. If you are a self-paying patient, we also expect full payment at the time of your visit.

Self-paying maternity patients are required to establish a payment plan prior to being seen and must make an initial payment at their first obstetrical visit. The remaining delivery charges are to be paid, in full, by the 24th week of pregnancy. If you do carry insurance, you are required to pay your co-insurance or deducible (if applicable) also prior to your 24th week of pregnancy. It is your responsibility to pay all balances not included in the delivery charge, such as all laboratory work, ultrasounds and non-stress tests.

By signing this form, I acknowledge that I have read and understand the above statements.

Patient Name (Printed): _____ Date of Birth: _____ /_____ /_____

Patient Signature: _____ Date: _____

(Parent/Guardian Signature, if applicable)

Patient Advocacy and Mediation Program

At Avina Women's Care, it is our goal that our providers and patients engage in a cooperative approach to ensure quality healthcare. Further, our hope is that any conflicts that may arise will be resolved in the same cooperative style through mediation.

The parties to this agreement agree to pursue a good faith effort to resolve any problems that may arise between them. As a part of entering into the provider/patient relationship, the patient agrees to submit in writing to the Avina Women's Care Mediation Program, any dispute, controversy or disagreement arising out of or relating to the provider/patient relationship and the agreement to provide medical services.

1. After the matter has been presented in writing to the Avina Women's Care Mediation Program the parties will use negotiation in an attempt to reach a voluntary resolution of their differences.

2. If the dispute, controversy or disagreement is not resolved in a reasonable time, then the matter will be submitted to mediation.

The ultimate goal of mediation is to resolve any issues or concerns between the provider and patient through a neutral third party. Either party is entitled to seek legal representation at any time, but Avina Women's Care wishes to provide the patient with this opportunity to settle concerns without incurring additional costs and fees.

Summary of Mediation:

- The patient is not required to reach a resolution in mediation.
- The mediator (or co-mediators) will be a neutral third party who is trained in mediation.
- The costs of the mediation will be paid by Avina Women's Care.
- The date, time and place of any mediation session will be scheduled by the mediator in consultation with the parties.
- The use of mediation does not preclude either party from pursuing any other remedies that may be available to them.
- Any agreements reached by the parties will be in writing and signed by both parties.
- All parties agree to make a good faith effort at mediation before pursuing litigation.
- Mediation is not a substitute for legal advice. Parties should consult with their legal counsel for any questions regarding legal rights.

By signing this form, I acknowledge that I have read and understand this Patient Advocacy Program.

Patient Name (Printed): _____ Date of Birth: _____ /_____ /_____

Patient Signature: _____ Date: _____

(Parent/Guardian Signature, if applicable)

Notice of Privacy Practices Acknowledgement Form

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Patient Name: _____ Date of Birth: _____ /_____ /_____

☐ I have received a copy of Avina Women's Care's Notice of Privacy Practices.

☐ I was offered a copy of Avina Women's Care's Notice of Privacy Practices, but declined it.

Patient Signature: _____ Date: _____

(Parent/Guardian Signature, if applicable)

For Office Use Only:

An effort was made to provide a copy of Avina Women's Care's Notice of Privacy Practices to this patient and to obtain her acknowledgment of the same.

The patient:

☐ Accepted

☐ Declined the Notice and refused to sign this acknowledgment.

Avina Women's Care Representative Name: _____

Avina Women's Care Representative Signature: _____ Date: _____

Prenatal Genetics Screen

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Name: _____ Date of Birth: _____ /_____ /_____

This form is intended to simply learn more about you and your family's history to better understand how it may influence your pregnancy. Your provider will be with you through your entire pregnancy and will answer any questions that arise along the way.

1. Will you be 35 years or older when the baby is due? ☐ Yes ☐ No

2. Have you, the baby's father or anyone in either of your families had any of the following? List relation (e.g. me, baby's father, relative)

☐ Birth Defect _____
☐ Canavan Dysautonomia _____
☐ Chromosomal Abnormality _____
☐ Cystic Fibrosis _____
☐ Developmental Disabilities _____
☐ Downs Syndrome _____
☐ Familial Dysautonomia _____
☐ Fragile X Syndrome _____
☐ Heart Defect _____
☐ Hemophilia or Other Blood Disorders _____
☐ Huntington's Disease _____
☐ Muscular Dystrophy _____
☐ Neural Tube Defect (Spina Bifida, Anencephaly) _____
☐ Phenylketonuria (PKU) _____
☐ Spinal Muscular Atrophy (SMA) _____
☐ Other: _____

3. Indicate if the following questions apply to either you or the baby's father:

- Jewish Ancestry? ☐ Yes ☐ No
  Tested for Tay-Sachs Disease? ☐ Yes ☐ No
- African-American? ☐ Yes ☐ No
  Tested for Sickle Cell Trait? ☐ Yes ☐ No
- Philippine or Southwest Asian background? ☐ Yes ☐ No
  Tested for A-Thalassemia? ☐ Yes ☐ No
- Italian, Greek or Mediterranean background? ☐ Yes ☐ No
  Tested for B-Thalassemia? ☐ Yes ☐ No

4. Since being pregnant or since your last menstrual period, have you taken any:

- Medications, excluding iron and vitamins ☐ Yes ☐ No
- Recreational drugs ☐ Yes ☐ No

5. Do you have a litter box in your home? ☐ Yes ☐ No

6. Have you had chicken pox? ☐ Yes ☐ No

7. Have you had the rubella vaccine? ☐ Yes ☐ No

8. Have you had any x-rays during the pregnancy? ☐ Yes ☐ No

9. Have you been exposed to infectious diseases during the pregnancy? ☐ Yes ☐ No

10. Have you traveled outside of the country in the last three months? ☐ Yes ☐ No

Patient Signature: _____ Patient Name (Printed): _____

Provider Signature: _____ Date: _____

Obstetrical Fees

Your first OB visit, Pap smear (if applicable), labs, ultrasounds and non-stress test are billed at the time of service. The below represent charges billed by our office or the outside labs performing your tests. If you are a self-pay patient, the below represents the expected charges. If you have insurance, the costs are dependent upon your insurance provider's contract with our practice.

The global package is billed after the delivery or after any change of insurance. It is the patient's responsibility to notify our office of any insurance changes so that proper authorization may be obtained from the NEW insurance for payment of your delivery.

The charges stated below are the physician's fees only. You will receive separate bills from the hospital and anesthesiologist. In addition, if you have an amniocentesis, there is a separate fee for reading the fluid. If you are seen for a reason not related to your pregnancy, you will be subject to standard office charges.

Global Fees: Includes routine OB visits, delivery and postpartum visits

Vaginal Delivery	$4,600
Vaginal Delivery – Twins	$6,600
Cesarean Section	$5,000
Cesarean Section – Twins	$7,400
Vaginal Birth After Cesarean	$4,800
Attempted VBAC resulting in C-Section	$5,300

Ultrasounds:

< 14 weeks gestation (76801)	$365
< 14 weeks each additional gestation (76802)	$250
> 14 weeks single gestation (18-20 weeks) (76805)	$450
> 14 weeks each additional gestation (76810)	$395
Transvaginal Scans (76817)	$350
Amniocentesis	$650

Common Additional Services:

First OB Visit	$250-$338
Non-Stress Test (NST)	$250
NST each additional gestation	$250

Labs: Billed by outside labs

Pap Smear	CBC (24-28 weeks)
Prenatal Profiles (5-8 weeks)	Beta Strep Culture (36-40 weeks)
Urine Culture (5-8 weeks)	Venipuncture
Gonorrhea/Chlamydia Profile (8-10 weeks)	Cystic Fibrosis
AFP Profile (16 weeks)	Genetic Testing
Glucose Screen (24-28 weeks)	

- I acknowledge that the above fee information has been discussed with me and I understand the fees listed above are subject to change.
- I agree to make the office aware of any insurance coverage changes.
- I understand and agree that I am responsible for charges not covered by my insurance, including any non-authorized HMO services.

Patient Signature: _____ Date: _____

Staff Name: _____ Date: _____