Name: _____ **Date:_____**

Thibodaux Women's Center

In order to best serve you, please provide this important information which will be reviewed by your doctor. Complete the form to the best of your ability. We want to assure you that your health information will always be confidential.

Reason for Visit

- Ĭ Wellness Exam
- Ĭ Follow Up
- Ĭ Pregnancy
- Ĭ Problem Visit: What would you like to address today? _____

_____

Medications/dose/frequency (Include vitamins, birth control):

(1) _____ **(9)** _____
(2) _____ **(10)** _____
(3) _____ **(11)** _____
(4) _____ **(12)** _____
(5) _____ **(13)** _____
(6) _____ **(14)** _____
(7) _____ **(15)** _____
(8) _____ **(16)** _____

YOUR Medical History: Please check off past/present medical history:

Ĭ High Blood Pressure Ĭ Stroke Ĭ Blood Clot (DVT) Ĭ Constipation Ĭ High Cholesterol

Ĭ Arthritis Ĭ Hormone Therapy Ĭ Depression Ĭ Diabetes Ĭ Cancer Ĭ Asthma Ĭ Anxiety

Ĭ Acid Reflux Ĭ Thyroid Disease Ĭ Osteopenia Ĭ Urinary Tract Infections Ĭ Osteoporosis

Ĭ Migraines Ĭ Other (Please specify): _____

Allergies: _____

GYN History

When was your **last** (month/year): Annual Exam:_____ Pap Smear:_____
Mammogram: _____ Bone Density Scan: _____

Have you ever had an abnormal pap smear? ____No ___Yes: (when)_____

If yes, did you require biopsies or surgery? ___No ___Yes: (explain) _____

Have you ever had an abnormal mammogram? ___No ___Yes: (when) _____

How old were you when you had your first period? _____ years old

How many days from the start of one period to the next? _____days

How many days of bleeding? _____days How many heavy days? _____days

Describe your menstrual cramps? _____None _____Mild _____Moderate _____Severe

Do you have PMS (Premenstrual Syndrome)? _____None _____Mild _____Mod _____Severe

If menopausal, how old were you when it began? _____ years old

Do you have any problems with urination _____No
(burning, leaking when you cough or strain?) _____Yes: (explain) _____

SEXUAL History
How old were you when you first had intercourse? _____years old

How many sexual partners have you had: Ĭ 0 Ĭ 1-5 Ĭ 6-10 Ĭ 11-20 Ĭ >20

Are you using any type of contraception? _____No _____Yes: (specify) _____

Do you have pain or bleeding with sexual intercourse? _____No _____Yes

Have you ever been treated for STDôs? ____No ____Yes (type): _____

Have you ever been sexually or physically abused? _____No _____Yes

OB History
How many times: have you been pregnant? _____ Total Living Children: _____
have you had a miscarriage?_____ still birth?_____ elective abortion?_____
have you had a vaginal delivery?_____ Cesarean Section?_____

Did you have any complications with any of your pregnancies (ex: diabetes, high blood pressure, early delivery, blood clots, post partum hemorrhage): _____No _____Yes: (explain)_____

SURGICAL History (Note date if known):
Ĭ Tonsillectomy/Adenoidectomy Ĭ Breast Biopsy Ĭ Breast Surgery (Cosmetic) Ĭ Mastectomy

Ĭ Hernia Repair Ĭ Gallbladder Ĭ Oophorectomy (Ovaries removed) Ĭ Hip/Knee

Ĭ Hysterectomy: if so, reason for surgery: _____

Ĭ Other Surgeries: _____

_____

FAMILY Medical History
Please list any known illnesses in the following (particularly cancers or female problems):

Mother: _____ Father: _____

Sister(s):_____ Brother(s):_____

Your motherôs side: Grand Mother:_____
Grand Father: _____
Aunt(s):_____
Uncle(s):_____

Your fatherôs side: Grand Mother:_____
Grand Father: _____
Aunt(s):_____
Uncle(s):_____

SOCIAL History
Marital Status: Ĭ Single Ĭ Married Ĭ Divorced Ĭ Widowed

Do you smoke? Ĭ No Ĭ Yes Ĭ Former Smoker _____packs per day

Do you drink alcohol? Ĭ No Ĭ Yes _____drinks per day

Do you use recreational drugs? Ĭ No Ĭ Yes, list _____

Do you exercise regularly? Ĭ No Ĭ Yes: _____ (how often, type)

Thank you for providing this information. Please notify your physician if you would like to address a particular part of your medical history.
We hope you are satisfied with your visit and welcome feedback to improve the patient experience!

Thibodaux Regional Physician Network

LOC: CV EN FAM IM NL NS OR PM PU RA TWC

Acct #: _____ ❑ Request for Confidential Communications Attached Completed Date: _____

P-INS Code: _____ S-INS Code: _____

PATIENT INFORMATION

Prefix:
Mr./Mrs./Other: _____ Patient*⇳: _____ (Last) _____ (First) _____ (Middle)

Suffix: Jr./Sr./Other: _____ Previous Name: _____

Mailing Address 1*: _____ (If PO Box, complete Street Address Below) _____ (City) _____ (State) _____ (Zip)

Street Address 2: _____ _____ (City) _____ (State) _____ (Zip)

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Circle the preferred phone #/email contact. Leave message at what phone number? ☐ Home ☐ Work ☐ Cell ☐ None

Email*: _____ Gender*: ☐ Male ☐ Female Other: _____

Marital Status*: ☐ Married ☐ Single
Date of Birth*: _____ ☐ Widowed ☐ Divorced Social Security#: _____

Employer: _____ Occupation: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired _____ (MMDDYY) ☐ Military Active ☐ Unknown

Student Status: ☐ Full Time ☐ Part Time ☐ N/A Patient & Responsible Party are the same*? ☐ Yes ☐ No (complete below)

Race*: ☐ African American ☐ Caucasian/White ☐ Other: _____

Ethnicity*: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino Preferred Language*: ☐ English ☐ Spanish ☐ Other: _____

☐ Provide copy of insurance card(s) to be scanned⇳ (if not, complete below) Do you have wellcare/preventative coverage for annual exams: ☐ Yes ☐ No

Primary Insurance: _____ Secondary Insurance: _____

Primary Ins Policy #: _____ Secondary Ins Policy #: _____

Group #: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____ SS#: _____

RESPONSIBLE PARTY INFORMATION

ONLY COMPLETE IF OTHER THAN PATIENT (NOT SELF), THIS IS WHERE STATEMENT/BILL IS SENT AFTER INSURANCE DISPOSITION

Prefix: Mr./Mrs./Other: _____ Responsible Party: _____ (Last) _____ (First) _____ (Middle)
(Employer Info if work related)

Suffix: Jr./Sr./Other: _____ Relationship to Patient: _____ Social Security #: _____

Mailing Address: _____ (If PO Box, complete Street Address Below) _____ (City) _____ (State) _____ (Zip)

Street Address: _____ _____ (City) _____ (State) _____ (Zip)

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Date of Birth*: _____ Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Email: _____ Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Employer: _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Disabled ☐ Retired ☐ Military Active ☐ Not Employed

Thibodaux Regional Physician Network

LOC: CV EN FAM IM NL NS OR PM PU RA TWC

Acct #: _____ ❑ Request for Confidential Communications Attached Completed Date: _____

How were you referred to our practice: ☐ Friend/Relative ☐ Newspaper ☐ Radio ☐ Healthsource ☐ Other: _____

☐ Referring Physician: _____ Phone #: _____

Primary Care Provider (PCP): _____ Address: _____ Phone: _____

Preferred Pharmacy: _____ Address: _____ Phone: _____

Preferred Lab: _____ Address: _____ Phone: _____

Do you have an Advanced Directive (living will, durable power of attorney)? ☐ Yes ☐ No → If 'Yes', provide copy:

Rec'd by: _____ Date: _____

By signing this form, I verify all above information is true and accurate as of the below indicated date.

TRND & TRMC Covered Entities:

Anesthesia, Heart & Vascular Center of Thibodaux Regional, EKG, Endocrinology Clinic, Family Medical Center – Paincourtville, Family Medical Center – Pierre Part, Geri-Psychology, Hospitalists, Internal Medicine Clinic, Maternal Fetal Women's Center of Thibodaux Regional, Neurology Clinic, Brain and Spine Clinic of Thibodaux Regional, Cancer Center of Thibodaux Regional, Orthopaedic & Sports Medicine Clinic of Thibodaux Regional, Pediatric Cardiology, Pain Center of Thibodaux Regional, Pathology, Pulmonology & Critical Care Specialists, Radiology/Radiology Wellness, Rheumatology Clinic, Thibodaux Women's Center.

When receiving services at any of the above covered entities, you may receive a separate bill and/or statement from each provider and a separate bill and/or statement from the facility.

_____ (Initial) I hereby acknowledge Thibodaux Regional Network Development Corporation (TRND) has an organized healthcare arrangement (OHCA) with several different covered entities (CE), i.e., practices representing different specialties/clinics, which are legally separate but are clinically/operationally integrated and participate in joint activities to share protected health information (PHI) about their patients in order to manage and benefit their joint operations. TRND has the right to use and disclose PHI between these CE's for Treatment, Payment and Health care Operations, and that I have received the HIPAA Notice of Privacy Practices for Protected Health Information (NOPP). I understand I have the right to restrict how my PHI is used or disclosed *outside* of the HIPAA permitted uses of PHI, and that TRND is not required to agree to any restriction, but if an agreement is reached, TRND is bound by the agreement.

_____ (Initial) I hereby acknowledge that all TRND and Thibodaux Regional Medical Center (TRMC) covered entities (CE) may transfer funds due to an overpayment/credit from any specialty office/clinic/hospital account to another specialty office/clinic/hospital account. I understand this is done in an effort to reduce collection costs and prevent accounts with outstanding balances being transferred to outside collection agencies.

_____ (Initial) I hereby acknowledge that I have received a copy of the Notice of Privacy Practice (NPP).

_____ (Initial) I hereby authorize Thibodaux Regional Network Development Corporation (TRND) Practitioners to evaluate and recommend any testing and/or additional treatment and send my lab work to TRMC or other referenced lab; who will in turn bill me for their services. I understand I have the right to refuse any such recommendations/treatment.

_____ (Initial) I understand that charges **not covered** by Medicare, Medicaid or Managed Care will be the patient's responsibility and that TRND is an Out of Network provider for Ochsner Plans and all services will be the patient's responsibility.

_____ (Initial) I hereby authorize all of my insurance companies to pay directly to Thibodaux Regional Network Development Corporation (TRND) benefits due on my behalf, if any, as provided in the above provided unexpired policy.

_____ (Initial) I understand that any payment(s) made by me to TRND in the form of a check will be processed as an electronic check transaction; therefore, the funds will be debited immediately from my checking account.

_____ (Initial) I agree that TRND may contact me via any means that I have provided including but not limited to land lines, cell phones (text and mobile applications), and email, etc.

_____ _____

Signature ☐ Patient ☐ Responsible Party Date

Thibodaux Regional Physician Network

LOC: CV EN FAM IM NL NS OR PM PU RA TWC

Acct #: _____ ❑ Request for Confidential Communications Attached Completed Date: _____

OFFICE USE ONLY

TRND Staff: Scan to patient demographics 'eCW/INS' folder

** = Required for eCW ⇳ = Interfaces to MEDPM*

Provide ABN for all potentially non covered services.

Patient Name: _____ Date of Birth: _____

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

*Note: If request initiated, assign Account Status: R - HIPAA Restricted (in **MED**PM); send copy to MEDDATA.*

Please list any person(s) other than yourself, and their relationship to you, that we may discuss your medical information with:

Person:	Relation:	Phone #:
1)		
2)		
3)		
4)		
5)		

EMERGENCY CONTACT*: _____ Relationship: _____

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

Email: _____

Any special instructions: _____

Are you currently a Hospice or Home Health Care patient or are you in a Nursing Home or Skilled Nursing Facility? ☐ Yes ☐ No

If 'Yes', office staff to assist in completing a Hospice/HHA/NH/SNF Facility Information Form.

❑ Hospice/HHA/NH/SNF Facility Info Form

Patient Signature: _____ Date: _____

Thibodaux Regional Physician Network

Acct # _____ Completed Date: _____

HOSPICE/HHA/NH/SNF FACILITY INFORMATION FORM

PATIENT INFORMATION

Prefix: Mr./Mrs./Other: _____ Patient: _____ Suffix: Jr./Sr./Other: _____
(Last / First / Middle)

If Hospice/HHA/NH/SNF patient and answered 'Y'es on Demographics Intake Form, TRND staff to assist patient in completing the below data and ask about an ABN Form.

FACILITY INFORMATION

Type: ☐ Hospice ☐ Home Health (HHA) ☐ Nursing Home (NH) ☐ Skilled Nursing Facility (SNF) ☐ Other: _____

Facility Name: _____ Contact Name _____
(Last / First / Middle)

Mailing Address: _____ _____ _____ _____
(City / State / Zip)

Phone: _____

Completed By: _____ Date: _____

OFFICE USE ONLY

Provide ABN form for all services.

If currently a Home Health patient, all charges must be paid for prior to receiving services by the facility or the patient must be redirected to the HHA facility for care.

Refer to **User Guide: SNF/Home Health/Hospice Billing Medicare & LA Medicaid**

Confirmation of Above Facility Information: *(must be confirmed prior to each visit)*

Date:	Confirmed by:	Updates/Additions:

Thibodaux Regional Physician Network

Acct # _____ Completed Date: _____

ACCIDENT/INJURY INFORMATION FORM

PATIENT INFORMATION

Patient: _____ Title: Mr./Mrs./Other: _____ Suffix: Jr./Sr./Other: _____
Last First Middle

If patient has had an accident or injury and answered 'Y'es *to same* on Demographics Intake Form, complete below data. Please ask if you have any questions.

ACCIDENT/INJURY INFORMATION

Type: ☐ Accident ☐ Injury

Date of: _____ Date symptoms began: _____

Motor Vehicular Accident (MVA): ☐ Yes ☐ No If 'Yes', State Code: _____

Give details of accident/injury (Description/Reason): _____

Slip & Fall: _____

Prior Physicians Seen (Treated by, date and Treatment Place): *(List)* _____

❑ Release Form Needed *(Provide Physician Address)* _____

Prior Tests with approximate date: *(List)* _____

❑ Patient is Providing Results OR ❑ Release Form Needed *(Provide Facility and Address)* _____

Prior Surgery (Treated by, date and and Treatment Place): *(List)* _____

WORKERS' COMP INFORMATION

Resp Employer: _____ Work Ph.: _____

Mailing Address: _____ _____ _____ _____
City State Zip

Workers' Comp Ins Co.: _____ Phone: _____

Mailing Address: _____ _____ _____ _____
City State Zip

Adjuster: _____ Approved: _____

Phone: _____ Spoke with: _____

Claim #: _____ Any testing: _____

Patient's Attorney: _____ Phone: _____

Mailing Address: _____ _____ _____ _____
City State Zip

Completed By: _____ Date: _____

OFFICE USE ONLY

Refer to **User Guide: Workers' Compensation Accounts and Claims.**

Thibodaux Regional Network Development Corporation

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION

Prefix: Mr./Mrs./Other: _____ Patient: _____
(Last / First / Middle)

Suffix: Jr./Sr./Other: _____ Date of Birth: _____ SS#: _____

Mailing Address: _____ _____ _____ _____
(City / State / Zip)

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

MEDICAL RECORDS

Records requested for further medical treatment from: _____

Purpose for the release of information: _____

Consent will expire on the following date/event. Expiration Date: _____ or Expiration Event: _____

RELEASE AUTHORIZATION

I hereby authorize _____
to disclose records obtained in the course of my evaluation and/or treatment to:

Name: _____ Phone#: _____ Fax#: _____

Mailing Address: _____ _____ _____ _____
(City / State / Zip)

Name: _____ Phone#: _____ Fax#: _____

Mailing Address: _____ _____ _____ _____
(City / State / Zip)

I ☐ consent ☐ do not consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV (AIDS) testing and/or results, or such disclosure shall be limited to the following specific types of information: _____.

This consent is subject to written revocation by the undersigned at any time and the practice is required to honor and abide by that written request, except to the extent that actions relying on your authorization have already occurred.

I understand that:

- I may refuse to sign this authorization and it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- Information disclosed by this authorization may be re-disclosed by the recipient of your PHI. Such re-disclosure will no longer be protected by this authorization.
- I have the right to receive a copy of this authorization.

By signing below, I agree to all above and agree to abide by all policies of PRACTICE. I agree that I have read the above or have had it read to me and I authorize the disclosure of the PHI as stated.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient (if other than patient signing): _____

NOTE: Authorized representative must submit copies of legal documents supporting his/her authority to act on the patient's behalf.

Witness Signature: _____ Date: _____

Witness Printed Name: _____

RECIPIENT OF MEDICAL RECORDS: This information has been disclosed to you from records whose confidentiality may be protected by state and/or federal law. Certain regulations prohibit you from further disclosing it without specific written consent of the patient or otherwise as permitted by state/federal laws. A general authorization for the release of such information is not sufficient for this purpose. Fees will be charged for the unauthorized release of information in accordance with state/federal laws.

THIBODAUX REGIONAL WOMEN'S CLINIC

Agreement to Accept Responsibility

(No Insurance Card)

I have presented for services without a current insurance card. I understand that it is my responsibility to provide the full name, address, and phone number of the insurance company along with the insured's full name, date of birth, policy ID number, group number, relationship to insured and employer name and address. I will assume full responsibility for today's services if the information is not provided, provided incorrectly, or if a claim is denied to the information provided.

_____ _____

Patient Signature **Date**

_____

Print Name

FINANCIAL AND BILLING POLICY FOR:
THIBODAUX REGIONAL WOMEN'S CLINIC

COPAY'S WILL BE COLLECTED UPON ARRIVAL.

CO-INSURANCE WILL BE COLLECTED AT TIME OF CHECK OUT.

INSURANCE: We will file your claim to your insurance company for office visits, surgical procedures and established patient's obstetrical services. Insurance cards must be presented with every visit.

OBSTETRICAL SERVICES: All "OB" patients will be set up on a payment plan for their private responsibilities and must be completely paid by the 7th month of pregnancy. You will meet with a representative from our insurance department to review benefits, estimated cost and financial arrangements will be determined. Once an "OB Payment Plan" become delinquent, the payment plan is voided and full private responsibility is due.

ROUTINE ANNUAL WELLNESS SERVICES ** Important – Please Read Carefully**

With the continued changes in Manage Care and Insurance benefits, a specific code was developed by American Medical Association to help identify these services. Preventive Medicine Services – "Routine Annual Check-ups" or "Wellness Care" – is described as:

"Preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive exam, counseling/anticipatory guidelines/risk factor reduction intervention and ordering appropriate laboratory procedure. If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and if the problem/abnormality requires additional services, this service should be reported with the appropriate problem – oriented level of service."

These are Federal Standards mandated by the HCFA and the physician is held responsible to code the visit specific to services rendered without regard to insurance benefits or coverage. In OB/GYN, this creates a difficult task as the general public feels that if they come in once a year to see the physician, they are free to discuss or address problems they may be experiencing and this total service will be considered in their "Wellness Benefit" visit covered by insurance. Unfortunately, the description of preventive medicine is limited and in most cases, will not cover problem oriented services.

This document is to assist our patients in understanding the coding and billing policies of this office:

> If the reason for the appointment is described as your routine annual (wellness) visit, the physician will perform a complete exam and pap smear. If a problem is discovered or discussed, the physician will address the problem and treat appropriately. This additional service does not fall in the description of service associated with "wellness" care and will require the physician to document this service with an additional code and fee.
>
> As the patient, there are options you need to consider:
>
> 1. If you have a problem to discuss, you may wish to see the physician for the problem only and return for your annual visit to maximize your insurance coverage.

2. The physician will be happy to see you for both your annual comprehensive exam and also discuss a problem. The proper codes and fees for the annual visit will be charged along with the appropriate office visit for the problem focused service.
3. Your physician may recommend you have wellness blood work. It is the patient's responsibility to check their "wellness benefits" coverage as some test may not fall under your wellness benefit. Any testing not covered under "Wellness Benefit" will be the patient's responsibility.

   **It is important to understand that some insurance companies will process these charges according to their guidelines which is completely out of our control. The physician is responsible to code for services as described and mandated by HCFA. Insurance companies have the flexibility to develop benefit packages and interpret these packages in a variety of ways. The physician must code for services rendered without consideration to individual insurance benefits.

It is your responsibility to advise the staff and physician of your wishes if you have a problem to discuss at the time of your annual routine, wellness visit.

I have read and understand the policies described above.

Patient Signature:_____ Date:_____