GynoFit MD
Women's Health & Medical Weight Loss Expert

Patient Demographic Information

PATIENT INFORMATION

*Fields with * are required*

*Last Name: _____ *First Name: _____ Middle Initial: _____

If minor, name of responsible parent: _____

Name you would like to appear on your health records: _____

*DOB: _____ Social Security #: _____ Driver's License #: _____

*Home Address: _____ APT/Suite #: _____

*City: _____ *State: _____ *Zip: _____

*Pick one: Home #: ☐ _____ Mobile #: ☐ _____ (Checkmark the best number to use)

*Email Address: _____

Occupation: _____

*Pharmacy Name: _____ Phone: _____ Cross Streets: _____

RX BIN #: _____

EDUCATION, LANGUAGE & DEMOGRAPHICS

Preferred Language: _____ Do you need and interpreter? _____

Ethnicity: _____ Race: _____

IF APPLICABLE, NAME OF SPOUSE / DOMESTIC PARTNER

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

CONTACT INFORMATION FOR RESPONSIBLE PARTY / SPOUSE / PARENT

If some info same as above, leave blank

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

Social Security #: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home #: _____ Cell #: _____ Email Address: _____

*Patient's Primary Care Provider: _____ Phone: _____

Specialist Provider: _____ Phone: _____

How did you hear about our office? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Billing Information & Responsible Party/Insurance Information

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

PRIMARY INSURANCE INFORMATION

Primary Insurance Name: _____

Claims Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Effective Date: _____

ID/Policy #: _____ Group #: _____

Policyholder's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Policyholder's SSN#: _____ Phone: _____

Policyholder's Employer: _____

OTHER INSURANCE INFORMATION

Primary Insurance Name: _____

Claims Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Effective Date: _____

ID/Policy #: _____ Group #: _____

Policyholder's Name: _____ Relationship to Patient: _____

Date of Birth: _____ Policyholder's SSN#: _____ Phone: _____

Policyholder's Employer: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payments of medical benefits to the provider for the services rendered, or to be rendered in the future, without obtaining my signature on each claim submitted, and understand the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary; I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policies and procedures.

Patient Signature: _____ Date: _____

Patient Representative/Parent: _____ Date: _____

For patients requiring translation or verbal reading of the document, the reader of translator may document and sign below.

Reader/Translator: _____

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Gynecology Medical History Form

Name:_____ DOB:_____ Age:_____

Race:_____ Marital status: **Never Married / Married / Divorced /Legally Separated / Widowed**

Reason for your visit:_____

Other concerns:_____

MENSTRUAL HISTORY

1. Last menstrual period:
2. Number of days between cycles:
3. Age of first menstrual period:
4. Flow amount:
5. Current birth control:
6. Have you had a tubal ligation?:

PREGNANCY HISTORY

Total Pregnancies	Full Term Deliveries	Premature Deliveries	Elective Terminations	Miscarriages	Ectopics	Multiples	Living

SURGICAL HISTORY

Surgery Type: _____ Date: _____

SOCIAL HISTORY

Occupation: _____

Have you ever been or currently are sexually active?	☐ Yes	☐ No	
Did you have more than one sexual partner in the last year?	☐ Yes	☐ No	
Have you ever smoked or currently smoke cigarettes or tobacco?	☐ Yes	☐ No	Amount per day: If former smoker, age quit:
Do you use recreational or illicit drugs?	☐ Yes	☐ No	Type: Frequency:
Do you drink alcohol?	☐ Yes	☐ No	Amount per day: If former drinker, age quit:
Have you ever been physically or sexually abused?	☐ Yes	☐ No	

GYNECOLOGY MEDICAL HISTORY

Last Pap Smear: _____	Result: _____	
Have you ever had an abnormal pap smear? _____	Date: _____	Treatment received: _____
Last mammogram: _____	Result: _____	Performed at: _____
Last bone density: _____	Result: _____	

ALLERGIES

Allergy	Reaction

If you have no known allergies, please circle: **NO ALLERGIES** Latex Allergy: **YES / NO** Iodine Allergy: **YES / NO**

MEDICATIONS

Medication Name	Dose	Frequency	Taken For	Date Started

NUTRITION & PHYSICAL ASSESSMENT

Check your current experiences (check all that apply):

Late night snacking Food cravings Large portions Emotional eating

Exercise: Circle YES OR NO

Yes: Type of exercise: _____ How many times per week: _____

No: What keeps you from exercising?_____

Rate your willingness: On a scale of 0-10, rate your willingness to make dietary and lifestyle changes for weight loss? (0 = 0% willing and 10 = 100% willing)

0 1 2 3 4 5 6 7 8 9 10

Rate your confidence: On a scale of 0-10, rate your confidence in your ability to make changes required for weight loss? (0 = 0% willing and 10 = 100% willing)

0 1 2 3 4 5 6 7 8 9 10

PAST MEDICAL HISTORY

Check all that apply:

Condition	Age of Diagnosis	Date of Treatment	Treatment
Heart Disease			
Hypertension			
Heart Disease			
Neurological Disorders			
Stroke			
Respiratory			
Asthma			
Sleep Apnea			
Hematologic			
Clotting Disorders/Blood Clot Leg/Lung			
Bleeding Disorders			
Anemia (Thalessemia, Sickle Cell)			
Endocrine/Metabolic			
Diabetes			
Thyroid Disease			
Cancer			
Gynecological Infections			
History of STI:			

Condition	Age of Diagnosis	Date of Treatment	Treatment
Gynecological Conditions			
☐ Abnormal bleeding			
☐ Uterine fibroids			
☐ PCOS			
☐ Endometriosis			
☐ Ectopic pregnancy			
☐ Ovarian cyst			
☐ Infertility			
Auto Immune Disorders			
☐			
Mental Health			
☐			

FAMILY HISTORY (Please list family members diagnosed, if any:)

Condition	Family Member/Relative	Age of Diagnosis	Treatment
Heart Disease			
☐ Hypertension			
☐ Heart Disease			
Neurological Disorders			
☐ Stroke			
Hematologic			
☐ Clotting Disorders/Blood Clot Leg/Lung			
☐ Bleeding Disorders			
Endocrine/Metabolic			
☐ Diabetes			
☐ Thyroid Disease			
Cancer:			
Gynecological Infections			
☐ No infections			
☐ History of STI			
Gynecological Conditions			
☐ Uterine fibroids			
☐ PCOS			
☐ Endometriosis			
Auto Immune Disorders			
☐			
Mental Health			
☐			

Patient Name (print): _____

Patient Signature: _____ Date: _____

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Medical Information Authorization

Last Name: _____ First Name: _____ DOB: _____

I understand that information will only be shared with those involved with the maintenance of my care and individuals that I provide the office permission to speak with regarding results or my medical information.
Please list all names and phone numbers of individuals you allow our office to release information to if needed:

Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:

This authorization is valid from _____ to _____
(Start Date) *(End Date)*

☐ I decline to list any authorized individuals to receive information about my care/results.

Please indicate which information can be disclosed:		
☐ All Records	☐ Operative Reports	☐ Mammograms
☐ Lab/Pathology Reports	☐ Progress Notes	☐ Medication Log
☐ H&P	☐ Ultrasounds	☐ Pap Smears
☐ Other:		

Patient or authorized representative signature: _____ Date: _____

GynoFitMD Staff Witness: _____ Date: _____

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Authorization for Release of Medical Records

PATIENT INFORMATION

Last Name: _____ First Name: _____ DOB: _____

Address: _____

RELEASE INFORMATION

Please check the appropriate box:

☐ I authorize GynoFitMD to release photocopies of my medical records to the recipient listed below.

☐ I authorize the provider listed below to release photocopies of my medical records to GynoFitMD.

PLEASE NOTE: THIS REQUEST WILL PROCESSED WITHIN 7 BUSINESS DAYS

Doctor of hospital name: _____ Fax #: _____

Address: _____

Any information about my health and health care, including the diagnosis, treatment, or examination rendered to me during the period from _____ to _____

I expressly authorize and consent to the disclosure of my health information related to:
Medical records shall include all confidential AIDS/HIV, alcohol, drug, and mental health related information, unless otherwise specified.

☐ All Records
☐ Lab/Pathology Reports
☐ Pap Smears
☐ Operative Reports
☐ Progress Notes
☐ Ultrasounds
☐ Mammograms
☐ Other: _____

Please circle reason for request:

Moving ○ | Transferring Care ○ | Patient's Request ○ | Continuation of Care ○ | Other: ○

CONFIDENTIALITY POLICY

Medical records are maintained to serve the patient and the health care team in accordance with all applicable legal and regulatory requirements. The information contained in medical records is considered highly confidential. All patient care information shall be regarded as confidential and available only to authorized users. The phrase "medical records" includes any protected health information (PHI), which includes test results, any medical reports, the medical record itself, claim files, and any correspondence relating to the care of a patient. Any disclosure of my protected health information to a different name, class of person, address, or fax number will require a separate authorization.

I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization. For the revocation of this authorization to be effective, the above name(s) or class of person(s) must receive the revocation in writing.

This authorization shall expire one year from the date signed. After one year, a new authorization form is needed to continually disclose my PHI. I understand this authorization is voluntary and may refuse to sign it.

I fully understand and accept the terms of this authorization. A copy of this authorization is valid as an original.

Personal requests for duplicate copies of records will be subject to a $35 fee, it is suggested that you make an additional copy of all records before giving them to other providers outside of GynoFitMD.

Patient or authorized representative signature: _____ Date: _____

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Practice Insurance & Financial Policy

Thank you for choosing GynoFitMD as your health care provider. We are committed to building a successful physician-patient relationship and providing quality care and service to all our patients. Your understanding of our Practice Insurance and Financial Policy and payment for services are important parts of this relationship and we require that you read and agree to prior to any treatment.

1	All copayments, deductibles, patient responsibility amounts, and past-due balances are due at the time of check-in unless previous arrangements have been made with Practice Administrator/Billing Department. We accept cash, check, credit cards and pre-approved insurance for which we are a contracted provider. We cannot waive deductibles, coinsurances, or copays that are required by your insurance. This is a violation of insurance rules.
2	It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy and any pre-authorization requirements of your insurance company.
3	We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.
4	Your insurance card and insurance verification must be on file for your insurance to be billed. If we do not contract with your insurance company, you will be expected to pay for all services rendered before your visit.
5	Proof of payment and photo ID are required for all patients. You must present your insurance card at every visit. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company. Without your insurance card or if we are unable to verify your eligibility for benefits, your appointment may be rescheduled, or you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If you are not prepared to make your co-pay or other patient responsibility amount, your visit will be rescheduled.
6	If your insurance card is furnished after the visit, we may file a claim with your insurance if it is provided prior to the timely filing requirements of your insurance company. If the claim is paid in full by your insurance company, you will be reimbursed the amount you paid as a self-pay patient.
7	You will receive a billing statement via the patient portal that you will be required to pay within 30 days. This can be paid online via the patient portal, via mail by check/cash or in person at our office. It is our office policy that all accounts with pending balances be sent two statements, each one month apart. If payment is not made on the account, a single phone call will be made to try and make payment arrangements. Accounts with unpaid balances for 90 calendar days or more will be sent to an external collection agency. You hereby agree to pay any imposed collection charge fee up to 33% of the past-due amount owed in the event the account is referred to our outside collection agency. Unpaid bills can also lead to possible discharge from the practice. If you are 18 years old or older and are receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

8	If your insurance company requires a referral from your primary care provider for your appointment, you must contact their office prior to your appointment. **We cannot see you without a valid referral for your appointment.**
9	If you are unable to keep your appointment, please notify our office as soon as possible. We would like to offer an available appointment to another patient. A **"No-Show"** appointment will be subject to a **$50** fee. If you are going to be more than 15 minutes late, we must receive a phone call to confirm we can keep your appointment, otherwise your appointment will need to be rescheduled.
10	If your physician recommends surgery, your surgery will be scheduled by your physician's staff. The staff member can answer specific questions about the surgery scheduling process, discuss the paperwork, tests involved, and assist with completing all prior authorization your insurance company might require. Our office will require a pre-surgical deposit equal to the amount of your copayment/deductible to go toward your surgery copayment, deductible, or any other amount your insurance carrier deems to be the patient's responsibility. After your insurance company has processed your surgery claim, any amount remaining as a credit will be refunded to you.
11	Procedure cancellations require **72 hours' notice** (3 days). If notice is not provided, a **$100** fee will be charged.
12	Requests for medical records, for personal use, to/from other physicians, insurance companies etc. can take up to two weeks to process. There will be a $25 fee for additional copies after the first request. To avoid this fee, patients will need to make additional copies for their personal file.
13	A non-sufficient (NSF) fee of $40 will be applied to each returned check.

I have read, understand, and agree with the above Insurance and Financial Policy. I understand my financial responsibility to make payments for services provided to me and the courtesy extended by GynoFitMD to simplify insurance reimbursement for the services provided to me. Once I have signed this agreement, whether by original, facsimile, or electronic (PDF) signature, I agree to all the terms and conditions contained herein and this agreement shall be in full force and effect.

Patient or authorized representative signature: _____

Patient or authorized representative printed name: _____

Date: _____

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Patient Office Policy Agreement

Patient's Name: _____ DOB: _____ Date: _____

We, at GynoFitMD strive for excellent patient care in a positive and caring environment. We want to maintain a healthy atmosphere for both staff and patients that is safe, clean and enjoyable. ***Please read the following office policies and initial each indicated line, acknowledging your compliance.***

(initial) _____

Cell Phones

Please be courteous of other patients and staff. Please turn off all cell phones and/or pagers during your visit with the doctor. Individual uninterrupted attention is very important when it comes to your health.

(initial) _____

Treatment of Staff

Any inappropriate treatment of staff will be a cause for discharge from our practice, this includes but is not limited to aggressive or threatening behavior towards the staff, use of foul/bad language towards staff and/or any other behavioral, verbal, or written communication, which is deemed inappropriate towards staff.

(initial) _____

Good Communication/Appointment Reminder

Good communication is crucial between patient and doctor. We have an automated courtesy reminder system that will send a text, email or call via the method you selected on your demographics. ***Do not depend on the automated reminder system; you are still responsible for keeping your appointments when scheduled.***

(initial) _____

Constructive Criticism

Constructive criticism of our practice is welcome. We do reserve the right to discharge anyone from the practice in the event of patient non-compliance of care, the breakdown in communication and/or willful slander/putting derogatory comments about our practice in person or on social media.

(initial) _____

Office Appearance

Please be courteous when in the lobby, using the restrooms or while in an exam room to be sure all trash is thrown away in a receptacle. Please don't leave a mess, leave it as tidy as it was before.

By signing this form, you acknowledge that you are aware of this policy and understand your responsibilities.

Patient Name *(print)*: _____

Signature of Patient/Authorized representative: _____ Date: _____

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Lab Preference Form

Patient Name: _____ Date: _____

Please mark what lab company you prefer to use or are mandated to use by your insurance company.

Please note: if a lab preference is **NOT** marked, our office will default to send labs to Sonora Quest. We do our best to verify the insurance requirements, however it is your responsibility to know your benefits and the requirements needed for your healthcare.

PLEASE MAKE A SELECTION BELOW:

☐ LabCorp

☐ Sonora Quest

☐ No Preference

By signing below, I acknowledge that my selection is my choice, and I understand that if I receive a bill from the lab, GynoFitMD is not responsible for charges incurred due to an incorrect lab choice.

Patient Signature: _____