Centura Health Physician Group

Centura Health

OB/GYN Supplement
PG-1802 rev. 11/15

Patient Label

Name: _____ DOB: _____/_____/_____

Chief Complaint (reason for visit): _____

Method of Birth Control (if applicable): _____

Menstrual Periods First day of Last Menstrual Period: _____ ☐ N/A Reason: _____

Do you have regular periods? ☐ Yes ☐ No Cycle length (days between periods): _____ Length of bleed: _____ days

Bleeding is: ☐ Light ☐ Moderate ☐ Heavy Bleeding between periods? ☐ Yes ☐ No Pain with period is (0-10): _____

Pregnancy History:

___Total Pregnancies ___Term Birth ___Preterm Birth ___Miscarriages ___Multiples ___Ectopic ___Abortions ___Living Children

#	Month/Day/Year	Gender	Weight	Weeks Pregnant	Delivery Type	Anesthesia	Complications/Notes
1							
2							
3							
4							
5							
6							

Pap Smears Date of Last Pap: _____ Was it normal? ☐ Yes ☐ No

Have you ever had an abnormal Pap? ☐ Yes Date: _____ ☐ No

If yes, what was the treatment? ☐ Colposcopy ☐ Cone Biopsy ☐ Observation ☐ LEEP ☐ Cryosurgery

Menopause Symptoms ☐ Hot Flashes ☐ Irritability ☐ Vaginal Dryness ☐ Other: _____

Have you had any vaginal bleeding since menopause? ☐ Yes ☐ No

Are you currently taking hormone replacement therapy? ☐ Yes ☐ No

Previous hormone replacement therapy? ☐ Yes ☐ No

Breast Health Date of last mammogram: _____ ☐ Never ☐ Other Breast Imaging: _____

How often do you perform self-breast exams? ☐ Never ☐ Monthly ☐ Less than Monthly ☐ Other: _____

History of breast problems? ☐ Yes ☐ No Current: Masses/Lumps, Pain, Skin Changes/Redness? ☐ Yes ☐ No

Colon Health: Date of last colonoscopy: _____

History

Are you currently sexually active? ☐ Yes ☐ No Recurrent vaginal infections? ☐ Yes ☐ No

Have you ever had: ☐ Chlamydia ☐ Gonorrhea ☐ Hepatitis ☐ Herpes ☐ HIV ☐ Human Papilloma virus (HPV) ☐ Syphilis

Have you had the Human Papillomavirus (HPV) vaccine (i.e. Gardasil)? ☐ Yes ☐ No

Did you take the full course? ☐ Yes ☐ No ☐ Uncertain Have you ever used fertility medications? ☐ Yes ☐ No

Please list any medical, surgical, social or family history changes since your last visit: _____

_____

_____

Signature: _____ Date: _____

(Patient or Authorized Representative)

Patient Information
PG-1800 rev. 11/15

Patient Label

AUTHORIZATION TO LEAVE TELEPHONE INFORMATION

Centura Health Physician's Group is committed to ensuring the privacy and confidentiality of your medical/personal information. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To assist us in protecting your privacy, please complete the following information:

Number to best contact you: _____ ☐ Home ☐ Cell ☐ Work

May we leave a clinical message if no answer? ☐ Yes ☐ No

May we leave information with someone other than you regarding your medical care (medication changes, laboratory results, billing issues, appointments, etc.)? If so, please list the name(s) in the space(s) below.

Billing Issues: ☐ Yes ☐ No

Clinical Issues: ☐ Yes ☐ No

Name: _____ Phone: _____ Relation to patient: _____

Name: _____ Phone: _____ Relation to patient: _____

IF PATIENT IS A MINOR (LESS THAN 18 YEARS OLD):

Age of minor: _____ Name of person completing form: _____
Please Print

If Parent or Legal Guardian is unavailable to accompany minor to appointment, please list authorized caretaker(s):

Name: _____
Please Print

Name: _____
Please Print

I am aware that this permission can be revoked by me at any time.

Parent or Legal Guardian Signature: _____ Date: _____

Patient Name: _____ DOB: _____
Please Print

Patient Signature: _____ Date: _____

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Patient Label

Consent for Medical Treatment
PGCT-001 rev. 12/15

1 **CONSENT FOR HEALTH CARE SERVICES.** I authorize physicians(s), therapists(s), their assistants and/or designees to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Centura Health practices. This authorization includes, but is not limited to, medical services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, which my physician or provider considers necessary in person or telehealth. My health care providers will discuss with me the risks, benefits and alternatives to recommended treatments. I understand that health care services may be rendered by students, interns or residents under supervision. I understand that the Centura Health practice may release copies of my medical records to other physicians, practitioners and healthcare facilities for treatment and other purposes, as permitted by law. I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in by the practice.

2 **NON-CENTURA PRACTITIONERS.** I understand that I may receive services from professionals who provide care to me who are not employees or agents of a Centura Health practice. These professionals may include other physicians requested by my physician to participate in my care as well as radiology, pathology and laboratory services. As a result, I understand that I may receive bills for these services that are separate from the bills I receive from the Centura Health practice. **I understand that, in some cases, these non-Centura professionals or facilities may not be participating providers under my insurance plan. I understand it is my responsibility to verify whether professionals providing my care are participating providers under my insurance, and that I may be responsible for any out of network costs incurred due to non-participation.**

3 **MEDICARE and/or MEDICAID CERTIFICATION.** I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the practice on my behalf for the charges for which the practice is authorized to bill in connection with these health care services.

4 **FINANCIAL AGREEMENT.** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I acknowledge full financial responsibility for, and agree to pay, all charges of the practice and of physicians rendering services not otherwise paid by my health insurance or other payer. Estimated patient responsibility is due at the time of service. Any remaining charges are due and payable upon receipt of the bill. I understand the practice may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the practice. **I consent to be contacted by regular mail, or by e-mail regarding any matter related to my account by the practice or any entity to which the practice assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account.**

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5 **COMMUNICATIONS CONSENT.** By providing my cell or other phone number(s), I expressly consent to receive communications from the practice, its agents or business associates at any numbers I provide or that are later acquired, to be used to contact me by live agent, voice mail, text message, using an auto dialer or other computer-assisted technology, pre-recorded message, or by any other form of electronic communication for any purpose, including scheduling, notifications, confirmations, reminders, instructions, accounting, billing, assignment of benefits, and/or collections. I understand that depending on my phone plan, I could be charged for these calls or text messages. I agree to provide new numbers if my numbers change. Providing these numbers is not a condition of receiving healthcare services.

6 **PREAUTHORIZATION REQUIREMENTS.** I understand that it is my sole responsibility to verify all pre-authorizations are in place and to comply with all requirements of any insurance plan upon which I am relying for coverage of the practice's and physicians' charges. I also understand that my insurance may require an office visit referral from my primary care physician to see a specialist. It is my responsibility to contact my primary care physician and acquire the necessary referral prior to my scheduled appointment. If a referral is not obtained prior to my appointment, I may be financially responsible for the charges incurred during the visit.

7 **ASSIGNMENT FOR DIRECT PAYMENT.** I authorize and direct that payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my physicians. I understand that I am financially responsible to the practice or my physicians for charges not covered or paid pursuant to this authorization.

8 **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.** I acknowledge that Centura Health has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on Centura Health's web-site. I understand this acknowledgment in no way affects the care I shall receive.

By initialing one of the boxes below, I acknowledge:

☐ **I have been offered or accepted a copy of the Notice of Privacy Practices**
☐ **I declined a copy of the Notice of Privacy Practices**

Practice Representative Comments: _____

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

_____ _____ _____
SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON NAME (PRINT) DATE TIME

_____
RELATIONSHIP / REASON WHY PATIENT IS UNABLE TO SIGN

_____
ADDRESS OF PATIENT