

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL: _____ HOME: _____ WORK: _____ EMAIL: _____

SOCIAL SECURITY #: _____ PHARMACY: _____ PHARMACY ADDRESS: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT #1: _____ PHONE #: _____ RELATIONSHIP: _____

EMERGENCY CONTACT #2: _____ PHONE #: _____ RELATIONSHIP: _____

INSURANCE POLICYHOLDER NAME: _____

(If same as patient may leave the following blank)

DOB: _____ SSN #: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PRIMARY INSURANCE CARRIER: _____

PLAN TYPE: HMO EPO PPO POS

BILLING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____

POLICY #: _____ GROUP #: _____

COPAY/COINSURANCE AMOUNT: _____

SECONDARY INSURANCE? Y N (IF YES, PLEASE PROVIDE A COPY OF ABOVE INFORMATION TO RECEPTIONIST)

Please complete entire form. If something does not apply, please mark N/A. Thank you!

PATIENT NAME: _____ DOB: _____

*NEW MEDICATION ALLERGIES (PLEASE LIST REACTION): _____

*NEW MEDICATIONS/DOSAGES (INCLUDING OVER THE COUNTER MEDICATION): _____

NEW MEDICAL HISTORY: _____

NEW SURGERIES: _____

ANY PROBLEMS W/MENSTRUAL CYCLE: Y N 1ST DAY OF LAST MENSTRUAL CYCLE: _____ DAYS BETWEEN 1ST DAY OF 1 CYCLE & 1ST DAY OF NEXT CYCLE: _____

ARE YOUR CYCLES REGULAR? Y N HOW MANY PADS/TAMPONS USED ON HEAVIEST DAY? _____ HOW MANY DAYS OF FLOW? _____

ARE YOU CURRENTLY SEXUALLY ACTIVE? Y N NEVER WITH: MALE FEMALE BOTH HISTORY OF SEXUAL ABUSE: Y N

BIRTH CONTROL: PILL IUD TUBAL RING PATCH DEPO INJECTION NEXPLANON VASECTOMY CONDOMS OTHER

DO YOU PERFORM SELF-BREAST EXAMS? MONTHLY OCCASIONALLY NEVER PRIMARY CARE PHYSICIAN: _____

DATE OF LAST COLONOSCOPY: _____ NORMAL? Y N DATE OF LAST BONE DENSITY SCAN: _____ NORMAL? Y N

IMMUNIZATION DATES: TETANUS/TDAP: _____ HPV/GARDASIL: _____ FLU: _____ COVID: _____ SHINGLES: _____ HEPATITIS B: _____

SOCIAL HISTORY:

OCCUPATION: _____ MARITAL STATUS: SINGLE SIGNIFICANT OTHER MARRIED DIVORCED WIDOWED SEPARATED

TOBACCO USE: Y N CIGARETTES/DAY: _____ HOW LONG? _____ VAPING: Y N HOW LONG? _____

ILLICIT DRUG USE: Y N ALCOHOL USE: Y N DRINKS/WEEK: _____ CAFFEINE USE: Y N SERVINGS/DAY: _____

EXERCISE REGULARLY? Y N TYPE: _____ DAYS/WEEK: _____

DO YOU FEEL SAFE IN YOUR CURRENT RELATIONSHIP? Y N

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Bloating
<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Bloody stools	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Pain with urination	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Frequency
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Painful intercourse	<input type="checkbox"/> Painful periods
<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Vaginal itching	<input type="checkbox"/> Vaginal dryness
<input type="checkbox"/> Back pain	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Breast mass
<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Nipple discharge	<input type="checkbox"/> Acne
<input type="checkbox"/> Rash	<input type="checkbox"/> Warts	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Headaches	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Easy bleeding
<input type="checkbox"/> Enlarged lymph node	<input type="checkbox"/> History of blood transfusion	<input type="checkbox"/> Hair loss
<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Excessive hair growth	<input type="checkbox"/> Seasonal allergies	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression	<input type="checkbox"/> PMS	<input type="checkbox"/> Insomnia

PATIENT NAME: _____

DOB: _____

Appointment Policy

We value our patients and the time we spend with each of you, and we would like to set aside appointments that work well for your schedule. If there is a conflict with your scheduled appointment time, we ask that you call the office at least 24 hours in advance to cancel or reschedule your appointment. **Appointments cancelled without a 24 hour advanced notice will be charged \$25. If you miss more than 3 appointments, you may be dismissed from the practice.**

HIPAA (Health Insurance Portability and Accountability Act)

You have been given a secure a copy of our Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of your protected health information and your rights under HIPAA. You understand that we reserve the right to change the terms of this notice from time to time and that you may contact us at any time to obtain the most current copy of this notice.

Clarification of Medical Visits

In our office, we want to put the patient first by providing outstanding medical care. In order for us to do this, we want to make sure our patients understand our policy for billing your medical visits. If you are scheduled to come in for your annual well woman exam, the doctors will only discuss details or perform services regarding that visit. If there are other medical issues that you would like to discuss that are not considered part of an annual well woman exam, we ask that you schedule another appointment for those issues. If you have an emergent problem, we will address that problem and you will need to reschedule your annual well woman exam. If the problem visit and annual well woman exam are done on the same day, you will be billed for each service separately. Depending on your insurance benefits, you will be responsible for any out of pocket expenses associated with both services, as problems addressed are usually subject to a copay and/or deductible. If you have any questions or concerns regarding these policies, please ask our staff.

Policy on Insurance Coverage

We are enrolled in numerous insurance programs. While we are pleased to be able to provide this service to you, it is difficult for us to keep track of all the individual requirements of each plan. Each plan has different stipulations and restrictions. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated. Your medical insurance is a benefit that your employer provides for you or you purchase for yourself. During the course of treatment, charges will be accumulated and routinely filed with your insurance company. Charges not covered by your insurance, such as copays, deductibles, and co-insurance will be your responsibility and are due at the time of service. Understanding your benefits can be confusing, and we will do our best to assist you in this area, but keep in mind we have limited access to your medical benefits. Your employer or you have chosen this plan and benefits, not your physician. **If you do not inform us of any special requirements in your contract, and we subsequently order services, such as labs, pathology, or hospitalization that are not covered, we or the selected medical facility will bill YOU directly for those charges.**

Your insurance company will never guarantee your benefits to you or to this office. Therefore, we can only estimate your portion. Regardless of what we calculate as your medical plan benefit, ultimately **YOU are responsible for the TOTAL cost of your medical treatment.** If you are unable to pay the estimated portion for your appointment today, we will be happy to reschedule it to a later date.

If your insurance company requires a "referral" from your primary care physician, **you will be responsible for contacting your primary care physician for the referral (this is NOT the responsibility of our office).** Treatment rendered by this office without the required referral will serve as your consent for treatment not covered by insurance and will be payable by you. If your insurance requires a referral and one was not obtained by you prior to your appointment, you may pay a cash fee for your visit or reschedule your appointment.

Please check the appropriate boxes:

- I certify that I have **no insurance** and will be solely responsible for payment in full.
(Payment is expected at the time of service)
- I certify that the insurance reported to this office is a complete and current listing. I understand the office will not submit a claim for any insurance not reported at the time of service.
- I **DO NOT** have any other insurance coverage other than that which has been provided upon submission of this authorization.

***** You are responsible for providing the correct information regarding which insurance is PRIMARY and SECONDARY. *****

I have read and understood the office policy stated above and agree to accept responsibility as described.

Signature of Patient/Guardian

Printed Name of Guardian if under 18

Date

PATIENT NAME: _____ DOB: _____

Authorization to Discuss Medical Information

Drs. Ward, Ku and Gulick are committed to quality patient care. We are advocates of maintaining patient confidentiality. Our policy is to speak only to patients and/or guardians in regards to their medical information. We will not leave any confidential medical information on a voicemail system without permission. By filling out this form and signing below, you are giving the physicians permission to communicate more detailed information on your voicemail and/or to individuals that you designate below. Examples include but are not limited to your lab and test results, information about your condition, prescription refills or changes, appointment scheduling, and/or insurance details.

Our office will keep this consent form in your chart. **THIS FORM WILL BE EFFECTIVE UNTIL OTHERWISE NOTIFIED BY YOU WITH A WRITTEN REQUEST.**

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

I _____ (initial) authorize the physicians and staff to leave a detailed voice message regarding my medical care at the following phone number(s).

Patient Phone #1 _____

Instructions: _____

Patient Phone #2 _____

Instructions: _____

I _____ (initial) authorize the physician and staff to speak with the following individual(s) about my medical care.

Name: _____ Relationship: _____ Date: _____

Instructions: _____

Name: _____ Relationship: _____ Date: _____

Instructions: _____

PATIENT NAME: _____

DOB: _____

Consent to Treat Patient

I, _____ (name of patient) have an appointment for an examination and treatment, and I give permission to be examined and treated by the following physicians. By signing this form, you are giving consent to be examined and treated by the physicians below. This consent is valid for one year from the date signed below.

Alisa K. Ward, M.D. Christine V. Ku., M.D. Jennifer R. Gulick, M.D.

PLEASE INITIAL EACH OF THE FOLLOWING SECTIONS TO ACKNOWLEDGE YOU HAVE READ THE INFORMATION AND SIGN BELOW:

_____ **Assignment of Benefits:**

By signing this form, you authorize payment of medical benefits, including private insurance benefits, directly to Alisa K. Ward, M.D., P.A., Christine V. Ku, M.D., P.L.L.C., and Jennifer Gulick, M.D., P.L.L.C. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete your insurance claim. The duration of this consent is definite and continues until revoked in writing.

_____ **Acknowledgement of Receipt of Notice of Health Information Practices**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. Alisa K. Ward, M.D., P.A., Christine V. Ku, M.D., P.L.L.C., and Jennifer Gulick, M.D., P.L.L.C. are furnishing you with the attached notice, which provides information about how our office may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of this office's notice of Health Information Practices.

_____ **Acknowledgement of Receipt of Notice of Office Policies and Procedures**

Alisa K. Ward, M.D., P.A., Christine V. Ku, P.L.L.C., and Jennifer Gulick, M.D., P.L.L.C. are furnishing you with the attached notice, which provides information regarding our office protocols and policies which we have developed in order to optimize our ability to deliver you care. By signing this form, you acknowledge that you have received a copy of our office policies.

_____ **Acknowledgement of Physician Ownership**

To further our commitment to the quality of care for our patients, both Dr. Ward and Dr. Gulick have chosen to participate in ownership at Baylor Medical Center at Frisco. Their ownership enhances their ability to direct the manner in which your care is delivered at this facility. This information is being provided to you to help you make an informed decision regarding your health care. You have the right to choose your healthcare provider and the option of obtaining care at a different facility. If you choose care at a facility outside of Baylor Medical Center Frisco, your physician will be unable to treat you. By signing this form, you acknowledge that you have read and understand this disclosure.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____ DATE: _____

Consent to Treat a Minor

_____ (name of minor) has an appointment for examination and treatment. I, _____ (parent/legal guardian) give permission for _____ (name of minor) to be examined & treated by the following physicians. By signing this form, you are giving consent for the above named minor to be examined and treated by the physicians below. This consent is valid for one year from the date signed below.

Signature of parent/legal guardian: _____ Date: _____

Alisa K. Ward, M.D. Christine V. Ku., M.D. Jennifer R. Gulick, M.D.