☐Alisa K. Ward, M.D., P.A. ☐ Christine V. Ku., M.D., P.L.L.C. ☐ Jennifer R. Gulick , M.D., P.L.L.C.
3880 Parkwood Blvd. Suite 403 • Frisco, Texas 75034 • Phone 214-618-2802 • Fax 214-618-3208

PATIENT NAME:_____ **DOB:**_____

NAME: _____
LAST FIRST DATE OF BIRTH

ADDRESS: _____
STREET CITY STATE ZIP

PHONE (PLACE CHECK WHERE WE MAY LEAVE A MESSAGE, YOU CAN PICK MORE THAN ONE)

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

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐LEGALLY SEPARATED

SOCIAL SECURITY NUMBER: _____-___-_____ PHARMACY: _____ PHARMACY PHONE:_____

RACE (PLEASE CIRCLE ONE): CAUCASIAN AFRICAN AMERICAN NATIVE AMERICAN CHINESE ASIAN FILIPINO HISPANIC S. AMERICAN JAPANESE PACIFIC ISLANDER RUSSIAN MULTIRACIAL OTHER: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

EMPLOYER: _____

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

_____
EMERGENCY CONTACT #1 PHONE # RELATIONSHIP

_____
EMERGENCY CONTACT #2 PHONE # RELATIONSHIP

INSURANCE POLICYHOLDER NAME: _____
(If same as patient may leave 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 NUMBER: _____ GROUP # : _____

COPAY/COINSURANCE AMOUNT: _____

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

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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 24 hours in advance to cancel or reschedule your appointment. ***Appointments cancelled without a 24 hours advance notice will be charged $25. If you miss more than 3 scheduled appointments, you may be dismissed from the practice.***

HIPAA (Health Insurance Portability and Accountability Act)

I have been given a secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you 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 is not considered part of an annual well woman exam, we ask that you schedule another appointment.

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 is done on the same day, you will be billed for each service separately. Depending on your insurance benefits, you may be held responsible for any out of pocket expenses associated with both services.

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 extremely difficult for us to keep track of all the individual requirements of each plan. Each one 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,

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PATIENT NAME:_____ **DOB:**_____

pathology or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill YOU directly for those charges.

Your insurance company will never guarantee your benefits to you or to this office. That is why 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 the patient's responsibility NOT the responsibility of this 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 we are contracted with your insurance company, your appointment will be rescheduled until a referral can be obtained.

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 Date

_____
Printed Name of Guardian if under 18

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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 physician.

☐ **Alisa K. Ward, M.D., P.A.** ☐ **Christine V. Ku., M.D., P.L.L.C.** ☐ **Jennifer R. Gulick, M.D., P.L.L.C.**

PLEASE INITIAL EACH OF THE FOLLOWING SECTIONS TO ACKNOWLDEGE 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 your 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.

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 physician.

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PATIENT NAME:_____ **DOB:**_____

PHYSICIAN OWNERSHIP DISCLOSURE FORM

During the course of your physician/patient relationship with Dr. Jennifer Gulick or Dr. Alisa Ward, they may refer you to Baylor Medical Center in Frisco. The address of the hospital is 5601 Warren Parkway, Frisco TX 75034.

In connection with any referral the hospital, you are hereby advised that Dr. Jennifer Gulick and Dr. Alisa Ward have an investment interest in the Hospital.

This information is being provided to you to help you make an informed decision about your health care. You have the right to choose your healthcare provider. You have the option of obtaining healthcare ordered by your physician at a different facility other than Baylor Medical Center in Frisco. You will not be treated differently by your physician or Baylor Medical Center in Frisco if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

By signing below, you acknowledge that should you be referred to the Hospital, your signature below evidences your informed decision to decline the option to have your health care provided at another health care facility.

Date_____

Patient Signature_____

Patient Printed Name_____

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PATIENT NAME:_____ **DOB:**_____

FAMILY HISTORY QUESTIONNAIRE

GENESCREEN
GENETIC COUNSELING

PATIENT INFORMATION

Patient Name:_____ DOB: _____/ _____/ _____

Are you adopted? No_____ Yes_____

What is your ethnic background? (ex: African, Ashkenazi Jewish, Italian) _____

FAMILY HISTORY

Please make below if there is a personal or family history of any of the following cancers. If yes, then indicate family relationship in the appropriate column.

Cancer Type	Self	Siblings	Family Member Mothers Side	Family Member Father's Side
Bone Cancer				
Breast Cancer – Male				
Breast Cancer Before Age 60				
Colorectal Cancer Before Age 50				
Melanoma + Another Cancer Discussed in this Form				
Melanomas in an individual – Two or More				
Ovarian Cancer				
Pancreatic Cancer				
Soft Tissue Cancers (fat, muscle, nerves, fibrous, tissues, blood vessels, or deep skin tissues)				
Stomach, Kidney/Urinary Tract, Brain or Small Bowel Cancer				
Uterine Cancer Before Age 50				
Other Cancer: Please List Any That Have Not Been Mentioned.				

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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 confidentially. Our physician policy is to speak only to patients and/or guardians personally in regards to their confidential medical information. Also, we will not leave any confidential medical information on a voice mail system without permission to do so. By filling out this form and signing below, you are giving the physicians at our office permission to communicate more detailed information to other individuals and/or your voicemail. 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 THE PATIENT WITH A WRITTEN REQUEST**.

Patient Name:_____Date of Birth:_____

Patient Signature:_____Date:_____

I_____(initial) authorize the physicians Drs. Ward, Ku, Gulick and staff to leave a detailed voice message regarding my medical care at the following phone number(s). You may write specific instructions below.

Patient Phone #1_____

Instructions:_____

Patient Phone #2_____

Instructions:_____

I_____(initial) authorize the physician and staff in our office to speak with the following individual(s) about my medical care. You may write instructions below.

Name:_____Relationship:_____Date:_____

Instructions:_____

Name:_____Relationship:_____Date:_____

Instructions:_____

***** I AUTHORIZE RELEASE OF INFORMATION TO INSURANCE COMPANIES AND PAYORS. *****

_____

Signature

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Name _____ DOB _____ Marital Status _____ Date _____

Reason for Visit

_____
_____

Allergies to Medications

If yes, please name medicine and describe type of reaction

_____
_____

Medications and Supplements

Please give name and dosage

_____
_____
_____

Pregnancy History

Total Pregnancies___ Full Term___ Pre-term___ Miscarriage___ Abortion___ Ectopic___

Date	Length of Pregnancy	Type of Delivery	Sex	Weight	Living	Complications
_____	_____	_____	____	_____	_____	_____
_____	_____	_____	____	_____	_____	_____
_____	_____	_____	____	_____	_____	_____
_____	_____	_____	____	_____	_____	_____

Menstrual History

At what age did you start having menstrual periods? _____
Number of days between first day of one and first day of next period? _____
Length of period? _____ Regular or Irregular _____
Would you call your periods ( ) light ( ) medium ( ) heavy ( ) clots
When was the first day of your last menstrual period? _____ Do you have cramps?_____
Was it a normal period? _____ If not, when was the last normal one? _____
Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods/cramps? __ Y __ N

Contraception

Are you sexually active? ___yes ___no ___never With: ___males ___females ___both

What is your current form of birth control?

Abstinence Birth Control Pill Hysterectomy IUD Menopause Tubal Ligation Vasectomy
NuvaRing Patch DepoProvera Rhythm Condoms Nexplanon Nothing

How long have you been using your current form of birth control? (please check one)

__ 2 yrs or less __ 3-5 yrs __ 6-10 yrs __ over 10 yrs

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When are you planning to have another child? (please check one)
__ within 1-2 yrs __ within 5-10 yrs __ my family is complete
If menopausal, at what age did your periods stop? _____
Date of last pap smear? _____ Normal/Abnormal? Have you had an abnormal pap smear? _____
If yes, please give dates, type (ASCUS, HPV, CIN I, etc.) and treatments (Colposcopy, Cryo, Cone Biopsy, LEEP)
_____
Date of last mammogram? _____ Normal/Abnormal? Have you had an abnormal mammogram? _____
If yes, please give dates and explain: _____
Date of last Bone densitometry? _____ Normal / Osteopenia / Osteoporosis

Past Medical History

Please check if you currently have or have had a history of any of the following:

YES	NO		YES	NO	
( )	( )	Reflux/Heartburn	( )	( )	Fibromyalgia
( )	( )	Spastic Colon/Irritable Bowel	( )	( )	Arthritis-Rheumatoid/Osteo
( )	( )	Hepatitis	( )	( )	Diabetes
( )	( )	Ulcers	( )	( )	Thyroid Problems
( )	( )	Hypertension	( )	( )	Osteoporosis
( )	( )	Heart Disease	( )	( )	Nervous Disorder/Depression
( )	( )	Angina	( )	( )	Rheumatic Fever
( )	( )	Heart Murmur	( )	( )	Migraines
( )	( )	Hypercholesterolemia	( )	( )	Dementia
( )	( )	Blood Clotting Problems/DVT	( )	( )	Stroke/TIA
( )	( )	Asthma	( )	( )	Epilepsy
( )	( )	Sleep apnea	( )	( )	Anemia
( )	( )	Tuberculosis	( )	( )	Sickle Cell Disease/Trait
( )	( )	Pneumonia	( )	( )	Allergies
( )	( )	Emphysema	( )	( )	Eczema
( )	( )	Kidney/Bladder Infections	( )	( )	Psoriasis
( )	( )	Kidney Stones	( )	( )	Cancer_____
( )	( )	Hospitalizations - If yes, please explain:			

_____

Is blood transfusion acceptable in an emergency? _____

Past Surgical History

Dates: Procedure:

_____
_____
_____
_____
_____
_____

Immunizations (please list dates)

Tetanus: _____ HPV: _____ Flu: _____

Who is your Primary Care Physician? _____

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Family History

YES	NO		YES	NO	
( )	( )	Breast Cancer	( )	( )	Diabetes
( )	( )	Ovarian Cancer	( )	( )	Thyroid Disorder
( )	( )	Uterine Cancer	( )	( )	Osteoporosis
( )	( )	Colon Cancer	( )	( )	Epilepsy/Seizures
( )	( )	Heart Disease	( )	( )	Stroke
( )	( )	Hypercholesterolemia	( )	( )	Depression/Bipolar/Schizophrenia
( )	( )	Hypertension	( )	( )	Birth Defects
( )	( )	DVT/Pulmonary Embolus	( )	( )	Other

If yes, please explain:
_____

Social History

Employer/Occupation _____ Marital Status_____

Exercise Type/Frequency_____ Education Level_____

Smoking ___cigs/day Vaping___ Alcohol __drinks/wk Caffeine ___servings/day Illicit Drugs_____

Have you ever had a sexually transmitted disease? _____

Type/dates_____

Do you feel safe in your current relationship?_____

Review of Symptoms: (Circle current symptoms)

GENERAL - Fatigue Fever Weight gain Weight loss
CARDIOVASCULAR – Palpitations Chest pain
PULMONARY - Cough Shortness of breath
GASTROINTESTINAL - Bloating Constipation Diarrhea Hemorrhoids Bloody stools Nausea
URINARY - Pain with urination Blood in urine Frequency UTI's Incontinence
GENITAL - Irregular periods Painful intercourse History of sexual abuse Vaginal discharge Vaginal itching
MUSCULOSKELETAL - Back pain Joint pain
BREAST – Perform self breast exams-Regularly/Irregularly/Never Masses Tenderness Nipple discharge
SKIN - Rash Warts
NEUROLOGIC - Dizziness Headaches
BLOOD/LYMPHATIC - Easy bruising Bleeding easily History of blood transfusion Enlarged lymph nodes
ENDOCRINE – Hair loss Temperature intolerance Excessive hair growth
ALLERGIES – Seasonal allergies
PSYCHIATRIC - Anxiety Depression PMS Insomnia