Richard J. Taylor, M.D., Nancy H. Cook, M.D., Kathleen S. Khan, M.D., Dr. Adrienne Zertuche, M.D., Caitlin Szabo, M.D. , Nidhi S. De, M.D, Courtney Franz Adank, MMSc, PA-C

Name:_____ **Date:**_____ **Date of Birth:**_____

Occupation: _____ Age _____

REASON FOR VISIT: (If not routine briefly describe main symptoms) _____

_____

_____

_____

PAST MEDICAL HISTORY:

List ALL operations you have had.

OPERATION	DATE
A.	
B.	
C.	

List ALL illnesses you have had that required hospitalization.

ILLNESS	DATE
A.	
B.	
C.	

Have you ever had?

YES	NO	ILLNESS	DATE
( )	( )	Anemia	_____
( )	( )	Arthritis	_____
( )	( )	Bladder Infection	_____
( )	( )	Chlamydia	_____
( )	( )	Condylomata (genital warts / HPV)	_____
( )	( )	Convulsions	_____
( )	( )	Diabetes	_____
( )	( )	Heart Murmur	_____
( )	( )	Heart Trouble	_____
( )	( )	Herpes - Genital	_____
( )	( )	High Blood Pressure	_____
( )	( )	Jaundice /Liver Disease	_____
( )	( )	Kidney Infection	_____

YES	NO	ILLNESS	DATE
( )	( )	Diverticulitis	_____
( )	( )	Kidney Infection (upper tract)	_____
( )	( )	Kidney Stones	_____
( )	( )	Liver Trouble	_____
( )	( )	Mental Trouble	_____
( )	( )	Migraines	_____
( )	( )	Pelvic Inflammatory Disease	_____
( )	( )	Pneumonia	_____
( )	( )	Rheumatic Fever	_____
( )	( )	Serious Injury	_____
( )	( )	Thrombophlebitis	_____
( )	( )	Thyroid Trouble	_____
( )	( )	Tuberculosis	_____
( )	( )	Ulcers	_____

MEDICATIONS: List all medications that you take REGULARLY or have taken RECENTLY.

1.

2.

3.

ALLERGIES: Please list any allergies to medications, drugs, chemicals or foods_____

_____

HAVE YOU EVER HAD A PROBLEM WITH AN ANESTHETIC? _____

_____

FAMILY HISTORY:

Relationship	Age	Current Health Problems	Age at Death	Cause of Death
Father				
Mother				
Sisters				
Brothers				

Did any blood relative (mother, father, sisters, grandparents, aunts, uncles, first cousins, children) ever have any serious medical problems?

SOCIAL HISTORY:

Do you smoke cigarettes? _____ How many/day? _____ How many years? _____

Have you ever smoked cigarettes? _____ How long ago did you quit? _____

Do you drink alcohol? _____ How many drinks/day? _____ Per week? _____

Do you get any regular exercise? _____

Are you married/single/widowed/divorced? _____

GYNECOLOGIC HISTORY:

MENSTRUAL HISTORY:

First day of last period _____

Age first started period _____

Usual # of days from one period to next _____

Usual # of days of flow _____

Are your periods: Light _____ Moderate _____ Heavy _____

Any excessive bleeding or spotting between cycles? _____

Cramps with periods? _____

Depression, anxiety, emotional upset before periods? _____

Has there been a recent change in you periods? _____

PAP SMEARS:

Last pelvic exam _____ Last pap smear _____

Have you EVER had an abnormal pap Yes _____ No _____

If so, what treatment did you receive? _____

Did your mother take hormones while pregnant with you? _____

VAGINITIS: Have you ever had:

Yeast _____ Trichomonas _____ Non Specific / Hemophilus Vaginitis / Gardnerella _____

Are you having any problems with discharge now? _____

SEXUAL HISTORY:

Any problems with pain? _____ Orgasm _____ Other _____

IF YOU WOULD LIKE TO DISCUSS SEXUAL ISSUES WITH THE DOCTOR, PLEASE DO NOT HESITATE

CONTRACEPTIVE HISTORY:

List PRESENT and PREVIOUS HISTORY of birth control you have used.

	TYPE OF METHOD	DURATION OF USE	COMPLICATIONS
1.	(PRESENT)		
2.			
3.			

OBSTETRIC HISTORY: List ALL pregnancies, dates, and outcomes.

	DATE	DURATION	SEX	WEIGHT	COMPLICATIONS
1.					
2.					
3.					

REVIEW OF SYSTEMS: How have you been feeling RECENTLY?

A. GENERAL

YES	NO	
( )	( )	Recent weight gain or loss exceeding 25 lbs.
( )	( )	Depression
( )	( )	Headaches
( )	( )	Any Problems with eyes, ears or nose

B. CHEST AND HEART

( )	( )	Palpitation
( )	( )	Skipped or irregular heart beat
( )	( )	Chest discomfort on exertion
( )	( )	Chest pain with breathing
( )	( )	Shortness of breath with exertion
( )	( )	Awakening at night short of breath
( )	( )	Short of breath lying down
( )	( )	Coughing up blood

C. BREASTS

( )	( )	Breast lump
( )	( )	Breast tenderness
( )	( )	Nipple discharge
( )	( )	Family history of breast Cancer

Last Mammogram , date if over 40

_____

D. GASTROINTESTINAL

YES	NO	
( )	( )	Any problems with your digestive system
( )	( )	Bright Blood in stools
( )	( )	Clay colored stools
( )	( )	Black Stools

E. GENITO-URINARY

( )	( )	Frequent or painful urination
( )	( )	Difficulty holding urine
( )	( )	Difficulty starting urine
( )	( )	Change of color of urine
( )	( )	Blood or pus in urine

Drs. Taylor, Cook, Khan, Zertuche, Szabo and De

Richard J. Taylor, MD
Nancy H. Cook, MD
Kathleen S. Khan, MD
Adrienne D. Zertuche, MD
Caitlin R. Szabo, MD
Nidhi S. De, MD
Courtney F. Adank, PA-C, M.M.Sc.

PATIENT INFORMATION
PLEASE COMPLETE FULLY

PATIENT'S LEGAL NAME:

Miss Mrs. Ms. _____ Age _____ Birthdate _____
(Last) (First) (Middle Initial)

Nickname or Name you wish to be called _____ S.S.# _____

Res. Address _____ Apt. # _____

City _____ State _____ Zip Code _____

E-Mail_____ (private e-mail)

Home Phone (___) _____ Bus. Phone (___) _____ Cell Phone (___) _____

Marital Status: Single Married Separated Divorced Widowed Religious Preference _____

Please circle the best number to reach you. May we leave a message? YES_____ NO_____

Employed By _____ Occupation _____

SPOUSE'S NAME: _____ Spouse's Social Security # _____

Spouse's Birthdate _____ Contact Phone (___) _____

Employed By _____ Occupation _____

IF MINOR, NAME OF PERSON RESPONSIBLE FOR PAYMENT: _____

Relationship to minor _____ Res. Address _____

Home Phone (___) _____ S.S.N. _____ D.O.B. _____

Employed By _____ Occupation _____

Bus. Phone (___) _____ Cell Phone (___) _____

INSURANCE INFORMATION:

Primary Insurance Company: _____ Primary Insured _____

Relationship _____ Insured's Date of Birth _____

Secondary Insurance Company: _____ Name of Insured _____

Relationship _____ Insured's Date of Birth _____

Patient Referred by _____

DUE TO CONSTANT CHANGES AND VARIETIES OF INSURANCE PLANS, YOU WILL NEED TO PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST EACH TIME YOU VISIT OUR OFFICE. IF YOU DO NOT HAVE YOUR CARD, PLEASE EXPECT TO PAY FOR THAT VISIT. WHEN INSURANCE INFORMATION IS RECEIVED, WE WILL FILE FOR YOU

RELEASE OF INFORMATION: I authorize the release of any medical or other information in order to process a claim being filed on my behalf.

PAYMENT OF INSURANCE BENEFITS: I authorize payment of benefits directly to Drs. Taylor, Suarez, Cook, Carroll, Khan, and Zertuche when an insurance claim is being filed on my behalf. Any amount not paid by the insurance company is due by me.

SIGNED _____ DATE _____

DRS. TAYLOR, COOK, KHAN, ZERTUCHE, SZABO, AND DE
A Division of Atlanta Women's Healthcare Specialist, LLC

Patient Name:_____ Date of Birth:_____ Date:_____

We would like to thank you for taking the time to complete this short questionnaire. Due to recent government initiatives, we are now required to collect certain information. Please complete the following information regarding the patient that is being seen today. If you prefer not to share this information, please feel free to choose the "decline to answer" option in each category.

Please choose one from each section.

Race:

- ☐ American Indian/Alaskan
- ☐ Asian
- ☐ Black/African American
- ☐ Hawaiian/Pacific Islander
- ☐ Multiracial
- ☐ White
- ☐ Unknown/Unsure
- ☐ Decline to answer

Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown/Unsure
- ☐ Decline to answer

Preferred Language:

- ☐ English
- ☐ Other (List preferred language):_____
- ☐ Decline to answer

Atlanta Women's Healthcare Specialists, LLC

275 Collier Road, NW Atlanta, Georgia 30309

FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

(Please print

Atlanta Women's Healthcare Specialists (AWHS) providers are committed to meeting your health care needs! We are pleased that you have chosen us. Listed below are our financial policies. If you have any questions, please discuss them with our financial team.

Patient Responsibility

1. All co-payments are due at the time of visit. Postdated checks are not accepted.
2. Co-insurance and unmet deductibles are due prior to scheduled office visits, ultrasounds, surgeries, and procedures. Once benefits are verified and my financial responsibility calculated, I will be notified of the payment amount and due date.
3. I am responsible for payment of charges for services I receive from AWHS office. As a convenience, this practice will submit claims for reimbursement with your insurance provider; however, all payment responsibility is ultimately yours.
4. In accordance with my insurance member handbook, it is my responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If I do not have insurance or do not present a valid insurance card, I will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
5. It is my responsibility to ensure that AWHS physicians are in your insurance network.
6. If my plan requires a referral, it is my responsibility to obtain this prior to being seen by our provider.
7. It is my responsibility to notify the office of any changes to your mailing address, phone number(s), email, and insurance information.
8. Failure to divulge or misrepresent all active insurance policies to the practice will result in the full charge amount being your responsibility.
9. Cancellations for appointments and procedure must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time.
10. Payment is due for rendered services 7 days from receipt of your billing statement. Unpaid previous balances must be paid in full prior to any additional visit unless arrangements have been made with our financial counselor.
11. I agree to provide the above practice and/or its designated payment agent with my debit/credit card or check for services rendered at the time of service.
12. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan.
13. **I understand that my signature and payment information will be maintained on file digitally for payment plan arrangements with the practice. The applicable payment card or check information will be truncated & "tokenized" by the payment agent in order to help maintain the security of my payment information. Credit Card or check information will be obtained through a card swipe, manual entry, voided check, or orally in person or over the phone.** I authorize AWHS and/or its designated payment agent to apply charges to my payment card and/or ACH account for all amounts owed to the practice for medical visits, procedures or supplies, medical record requests, including (i) amounts agreed as part of a payment plan, (ii) copays, (iii) coinsurance, (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation, or returned check fee.
14. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive monthly statements for any outstanding balance. You are responsible for paying this balance by its due date in order to avoid paying interest on the balance.
15. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address

16. I authorize AWHS and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

Fees

1. The returned check fee is $30.00.
2. There will be an additional charge of 25% of the balance owed for any past due balance that is submitted to an outside agency for collections.
3. Patients who fail to keep and fail to cancel a scheduled appointment may be charged a $50.00 No Show Fee. There is a $200.00 cancellation fee for scheduled surgeries that are cancelled less than 5 business days from the date and time of surgery unless cancellation is due to insurance denial or medical necessity.
4. Medical records requests must be received in writing at least 72 hours prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Georgia. Fees must be received prior to record delivery. Company policy does not allow for medical records to be faxed to patients. Patients can access medical records via the web portal or pick up in person.

When a physician treats you via telephone after hours it is for emergencies only. Therefore, for routine problems that require history, diagnosis and treatment (i.e., calling a prescription or refill into a pharmacy), the provider **may** bill a $50 to $75 service fee.

Administrative Services

There is a fee for patient Administrative Services. Our office collects an **OPTIONAL** Administrative Service Fee of $15.00 annually for Gynecologic visits and $75.00 per pregnancy for Obstetrical visits (payable at the beginning of the Prenatal Care) which covers all forms that need to be completed during your pregnancy. **YOU ARE NOT REQUIRED TO PAY THIS FEE**; however, if you choose not to pay the fee there is a $20.00 charge for **each** required completed form, payable prior to service completion.

This Administrative Service Fee covers specific administrative services such as forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative item not covered by insurance.

_____ (Initial) I accept the Administrative Service Fee. I will pay $15.00 annually. (GYN)

_____ (Initial) I accept the Administrative Service Fee. I will pay $75.00 today. (OB per pregnancy)

_____ (Initial) I decline the Administrative Service Fee, by declining the Administrative Service Fee. I understand that I will be charged $20.00 for each completed form.

My signature authorizes Atlanta Women's Healthcare Specialists, LLC, to file insurance claims on my behalf to Medicare or other insurance plans and for payments of any benefits due under my insurance plan to be made to Atlanta Women's Healthcare Specialists, LLC, when insurance is filed on my behalf.

By my signature below, I acknowledge that I have read and understand this Financial Policy.

Patient Signature _____ Date _____

DRS. TAYLOR, COOK, KHAN, ZERTUCHE, SZABO, AND DE

275 COLLIER ROAD, SUITE 100-B

ATLANTA, GEORGIA 30309

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I _____ HAVE HAD AVAILABE TO ME A COPY OF DRS. TAYLOR, COOK, KHAN, ZERTUCHE, SZABO AND DE'S NOTICE OF PRIVACY PRACTICES.

_____ _____

SIGNATURE OF PATIENT DATE