Center for Women in Hixson PLLC

2051 B Hamill Road • Suite 211
Hixson, Tennessee 37343
Ph. 423/702-9240
Fax 423/702-9245
www.obgofhixson.com

FINANCIAL POLICY

As your physicians, we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our payment policy. We ask that all services be paid at the time of service. We accept Visa/ Master Card/Discover/checks and cash. If you have insurance, please present your insurance card for verification. If your insurance changes, please notify us immediately. Please be prepared to provide your insurance card for review on each visit for verification. Without proof of insurance we may require that non-emergent appointments be rescheduled until you can provide necessary information.

Although we are providers with most of the local market insurance carriers we recommend that your inquire prior to your first visit to verify if we are providers with your network. For those networks that we are contracted with we ask that the co-pay and deductibles (if applicable) be paid in full at the time of your visit. We accept assignment for services covered and will bill the insurance. Any balance outstanding following payment from the insurance will be billed to you.

Medicare/Managed Care: We are participating Medicare providers, and will file Medicare for you. Any services routinely not covered by Medicare we will request that the services be paid at the time of service. We request payment for the 20% of the allowable Medicare charges and any deductible (if applicable) that has not been met at the time of your visit if you do not have secondary coverage for this. If you are a member of a Managed care program that we are not contracted with, and choose to see us as your physician, please be prepared to pay for services at the time of your visit. Or, if your physician has referred you to us, please verify **BEFORE** your appointment that we have received authorization for payment.

Preventative Services (well-woman visit): Most insurance plans cover annual preventative visits at 100%. However, if a problem is addressed, insurance and Medicare guidelines provide for billing a problem visit in addition to the preventative service. The problem visit may require a co-pay or coinsurance. These amounts can be paid at the time of service or billed to you after your insurance has paid.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is customary for our area. If you are a member of a MCO that we aren't contracted with you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

FINANCIAL AGREEMENT: We will be glad to discuss your proposed treatment and the cost of those services. If you have questions if your insurance will cover a medical service, we will be glad to try to find out if the insurance will cover for those services. HOWEVER, please be aware that your insurance is a **contract between you, your employer (if applicable) and the insurance company.** We are not a party to your contract. Unfortunately, not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (e.g., yearly physicals). We must emphasize that as your physician(s) our relationship and concern is with you and your health, not with your insurance company. ALL CHARGES FOR SERVICES ARE YOUR RESPONSIBILITY AT THE TIME OF THE SERVICE. Co-payments are due at the time of service. On any balance on your account after 90 days, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. **There will be a 2% interest charge added to account balances over 61 days which accrues monthly.** If placed with an outside collection agency there will be a fee of 33.3% added to the balance for agency fees. All legal fees will be charged to the patient.

Minor Patients
The adult accompanying a minor, parents (or guardians of the minor) are responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless accompanied by an adult.

If you have any questions regarding the above, or any uncertainty regarding insurance coverage or request for payment, please do not hesitate to ask. We are here to help you.

I HAVE UNDERSTOOD AND AGREED TO THE FINANCIAL POLICY FOR CENTER FOR WOMEN IN HIXSON, PLLC. I AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY CLAIMS AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN FOR SERVICES HERE ON DESCRIBED.

Signature:_____ Date:_____

Witness:_____ Date:_____

Center for Women in Hixson

(Obstetrics & Gynecology or Hixson, PLLC)

2051A Hamill Road, Suite 211

Hixson, Tennessee 37343

Dear Patient:

An annual well women visit consists of a complete physical examination and collection of laboratory specimens. It will also contain a discussion of your questions and current medications with your medical provider.

If there are new problems to diagnosis, changes in medications, or prescribing alternate therapies, Medicare coding guidelines and our contracts with commercial payers require us to bill for a problem visit in addition to the well women visit.

The Affordable Care Act provides that preventative care, such as a well women visit, are to be provided without a copayment or deductible. However, the problem visit may require a copayment or apply to your deductible, depending on the benefits available with your insurance plan.

Please sign that you have read and understand this notice.

_____

Center for Women in Hixson

Patient Information Sheet

DATE:_____ CHECK PROVIDER NAME: ❑ SHUCK ❑ DILLARD

LAST NAME:_____ FIRST:_____ MIDDLE:_____

PREFERRED NAME:_____ MAIDEN NAME:_____

PREFIX: ❑ MRS. ❑ MS. ❑ MISS DATE OF BIRTH_____ AGE_____

SOCIAL SECURITY #:_____ MARITAL STATUS:_____

ADDRESS:_____ CITY:_____

ZIP CODE:_____ STATE:_____ COUNTY:_____

HOME PHONE:_____ WORK:_____ CELL:_____

PATIENT EMPLOYER:_____ OR STUDENT STATUS:_____

OCCUPATION:_____ REFERRING PHYSICIAN:_____

SPOUSE INFORMATION

NAME:_____ DATE OF BIRTH:_____

EMPLOYER:_____ WK PHONE:_____

EMPLOYER ADDRESS:_____ CITY:_____ STATE:_____

INSURANCE INFORMATION

INSURANCE CARRIER:_____ POLICY #:_____

INSURED'S NAME:_____ RELATION:_____

INSURED'S ADDRESS:_____

INSURED'S DOB:_____ INSURED'S SS#:_____

EMPLOYER NAME:_____ ADDRESS:_____

SECONDARY INSURANCE

INSURANCE CARRIER:_____ POLICY #:_____

INSURED'S NAME:_____ RELATION:_____

INSURED'S ADDRESS:_____

INSURED'S DOB:_____ INSURED'S SS#:_____

EMPLOYER NAME:_____ ADDRESS:_____

AUTHORIZED SIGNATURE IS ON FILE. BY SIGNING I ATTEST THAT ALL INFORMATION PROVIDED IS TRUE AND COMPLETE. MY SIGNATURE AUTHORIZES THE OFFICE E TO SUPPLY MEDICAL RECORDS TO MY INSURANCE CARRIER FOR PAYMENT. I UNDERSTAND AN AGREE THAT IF I FAIL TO MEET THE FINANCIAL AGREEMENT OF THIS OFFICE I WILL BE LIABLE FOR ALL COLLECTION COSTS AND ATTORNEY FEES OF 33.3% ADDED TO MY BALANCE. A 2& INTEREST FEE WILL BE ADDED TO MY MONTHLY BALANCE AFTER THE 61ST DAY OF AN UNCOLLECTED BALANCE.

PATIENT SIGNATURE:_____ DATE:_____

Please complete this form and:

- ☐ Bring it to your appointment
- ☐ Mail it in the enclosed envelope
- ☐ Fax it to : (4230 702-9245 at least one day before your appointment

Center for Women in Hixson

Susan M. Shuck, M.D., F.A.C.O.G.
Sonya L. Dillard, FNP-C

Today's Date:_____/_____/_____

Name_____ Preferred Name_____

Address_____

Birthdate_____/_____/_____ Social Security Number_____

Home Phone(____)_____ Work Phone(____)_____ Cell Phone(____)_____

Primary Physician_____ Partner's Name_____

Reason for Visit: ☐ Routine Annual Exam ☐ Problem

Describe Problem_____

CHECK IF YOU HAVE HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST & LIST DATE

☐ Anemia	_____	☐ Fracture	_____	☐ Mood Disorders	_____
☐ Anxiety	_____	☐ Glaucoma	_____	☐ Pneumonia	_____
☐ Arthritis/Joint Pain	_____	☐ Gonorrhea / GC	_____	☐ Rheumatic Fever	_____
☐ Asthma	_____	☐ Heart Murmur	_____	☐ Sexually	
☐ Blood Transfusions	_____	☐ Heart Trouble	_____	Transmitted Diseases	_____
☐ Bowel Trouble	_____	☐ Hepatitis / Jaundice	_____	☐ Stroke	_____
☐ Breast Cancer	_____	☐ Herpes / HSV	_____	☐ Syphilis	_____
☐ Cancer	_____	☐ High Blood Pressure	_____	☐ Tuberculosis - TB	_____
☐ Chicken Pox	_____	☐ High Cholesterol	_____	☐ Thyroid Disease	_____
☐ Chlamydia	_____	☐ HIV / AIDS	_____	☐ Ulcers	_____
☐ Chronic Lung Disease	_____	☐ HPV / Human Papilloma Virus	_____	☐ Chronic Lung Disease	_____
☐ Depression	_____	☐ Kidney Infection	_____	☐ Other:	_____
☐ Diabetes	_____	☐ Urinary Tract Infect.	_____		_____
☐ Eating Disorder	_____	☐ Kidney Stones	_____		_____

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD

Surgery / Hospitalization / Reason	Date

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?

- ☐ Bone Density.....Date_____
- ☐ Colonoscopy / Sigmoidoscopy.....Date_____
- ☐ Mammogram.....Date_____
- ☐ Last Normal PAP Smear.....Date_____
- ☐ Last Abnormal PAP Smear.....Date_____

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

Drug Name	Dosage	Physician

List Any Allergies to Medications/Substances (latex gloves, etc.) _____

YOUR GYN HISTORY

Were you using any birth control when you got pregnant? ☐ Yes ☐ No

☐ Condoms
☐ Depo Provera
☐ Diaphragm
☐ IUD: Kind_____
Date Inserted _____
☐ Birth Control Pill
Name of Pill_____
☐ Contraceptive Foam/Jelly
☐ Nuvaring
☐ Birth Control Patch
☐ None
☐ Natural Family Plan / Rhythm
☐ Tubal Ligation
☐ Vasectomy
☐ Withdrawal
☐ Other_____

What age did you have your first period?_____

How many days are there from the start of your period tot he start of your next period?_____days

How long does your period last? _____days Flow: ☐ Light ☐ Medium ☐ Heavy

What number of tampons or pads are used in a day?_____

Do you pass clots? ☐ Yes ☐ No

Date of last period:_____ Are you sure of this date? ☐ Yes ☐ No

Was it a normal period? ☐ Yes ☐ No

Have you had a home urine pregnancy test? ☐ Yes ☐ No When:_____

Have you had an office urine pregnancy test? ☐ Yes ☐ No When:_____

Have you had an office blood pregnancy test? ☐ Yes ☐ No When:_____

Have you had recent abnormal bleeding? ☐ Yes ☐ No When:_____

IF YOU HAVE STOPPED HAVING PERIODS, PLEASE ANSWER THE QUESTIONS BELOW:

Age of Menopause_____ Do you take prescription hormones now? ☐ Yes ☐ No

Did you take hormones in the past? ☐ Yes ☐ No Do you take herbal hormones? ☐ Yes ☐ No

YOUR OB HISTORY

	Number		*Number*
Total Number of Pregnancies		Full Term Births	
Premature Delivery (less than 37 weeks)		Abortions / Terminations	
Miscarriages		Living Children	

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.

No.	Birth Date	Wks. Gest.	Labor (hrs.)	Baby's Weight/Sex	Del. Type Vag/Csection	Epid Y/N	Preterm Labor?	Wt. Gain	Comments/ Complications	Hospital
1				☐M ☐F						
2				☐M ☐F						
3				☐M ☐F						
4				☐M ☐F						

CHECK ANY THAT APPL[illegible] AND LIST IF YOUR BLOOD [illegible]LATIVES HAVE HAD:

Major Illness	Yes	What Blood Relative?	Mother's	Father's
Anemia				
Arthritis / Joint Pain				
Asthma				
Bowel Troubles / Ulcers				
Breast Cancer				
Cancer				
Chronic Lung Disease				
Depression / Anxiety / Mood Disorders				
Diabetes				
Glaucoma				
Heart Trouble / Murmur				
Hepatitis / Jaundice				
High Blood Pressure				
High Cholesterol				
Kidney Infections / Stones				
Stroke				
Thyroid Disease				
Tuberculosis - TB				
Other				

SOCIAL HISTORY

Do you exercise? ☐ None ☐ Less than 3 times per week ☐ More than 3 times per week

Do you have sex with: ☐ Men ☐ Women ☐ Both

First Intercourse at age:_____ New sexual partner ☐ Yes ☐ No

Lifetime sexual partners ☐ Less than 5 ☐ More than 5

Do you have any sexual problems you want to discuss today? ☐ Yes ☐ No

Describe:_____

Do you want to be screened for HIV / AIDS? ☐ Yes ☐ No (This screening is NOT covered by insurance.)

Do you want to be screened for other STD's? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No Date_____

Smoking: ☐ Yes ☐ No ☐ Previously Packs per day_____ # of years_____ Stopped_____ Years Ago

Alcohol: ☐ Yes ☐ No ☐ Previously Drinks per day_____ Drinks per week_____

Caffeine: ☐ Yes ☐ No Drinks per day_____ Drinks per week_____

Drug User: ☐ Yes ☐ No ☐ Previously Kind/Type_____ Frequency_____

History of Abuse ☐ Yes ☐ No ☐ Physical ☐ Emotional ☐ Sexual

Are you in a relationship with someone who physically threatens or hurts you? ☐ Yes ☐ No

List all "Natural" or "Herbal" remedies, over the counter drugs, vitamins, or minerals you are taking:_____

_____

_____

_____

Highest Grade Completed in School: ☐ GED ☐ High School ☐ Attended Some College

☐ Associate Degree (2 years) ☐ Bachelor's Degree (4 years) ☐ Post-Graduate

☐ Some Graduate Work ☐ Did not attend school ☐ Did not complete high school

Other:_____

Occupation:_____

Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ Other_____

Marital Status: ☐ Single ☐ [illegible]ged ☐ Married ☐ Divorced ☐ Widowed

REVIEW OF SYSTEMS

Please check if any of the following applies to you TODAY:

CONSTITUTIONAL		Notes
Weight Loss	☐	
Weight Gain	☐	
Fever	☐	
Fatigue	☐	
Night Sweats	☐	
Hot Flashes	☐	
EYES		
Double Vision	☐	
Vision Changes	☐	
HENT		
Headaches	☐	
Dizziness	☐	
Sore Throat	☐	
Sinus Pain	☐	
Nose Bleeding	☐	
Thyroid Mass	☐	
Neck Pain	☐	
BREASTS		
Lumps	☐	
Tenderness	☐	
Swelling	☐	
Discharge	☐	
Pain in Breast	☐	
Abn. Changes in Breast	☐	
CARDIOVASCULAR		
Chest Pain	☐	
Irregular Heart Beats	☐	
Rapid Heart Rate	☐	
Fainting	☐	
Swelling of Legs	☐	
Varicose Veins	☐	
RESPIRATORY		
Wheezing	☐	
Cough	☐	
Shortness of Breath	☐	
Spitting Up Blood	☐	
GASTROINTESTINAL		
Nausea	☐	
Vomiting	☐	
Diarrhea	☐	
Constipation	☐	
Abdominal Pain	☐	
Bloody/Black Stool	☐	
Hemorrhoids	☐	
Jaundice	☐	
GENITOURINARY		
Urgency of Urination	☐	
Frequency of Urination	☐	
Pain with Urination	☐	
Nighttime Urination	☐	
Losing Urine	☐	

GENITOURINARY: Continued		Notes
Decreased Sex Drive	☐	
Painful Intercourse	☐	
Possible Pregnancy	☐	
Genital Sores	☐	
SKIN		
Rashes	☐	
Itching	☐	
Skin Dryness	☐	
Skin Lesions	☐	
Changes to Lesions or Moles	☐	
Acne	☐	
NEUROLOGICAL		
Muscular Weakness	☐	
Numbness or Tingling	☐	
Difficulty Concentrating	☐	
Memory Difficulties	☐	
Speech Difficulties	☐	
Seizures	☐	
Loss of Balance	☐	
MUSCULOSKELETAL		
Joint Pain or Swelling	☐	
Muscle Pain	☐	
Back Pain	☐	
ENDOCRINE		
Loss of Hair	☐	
Difficulty Tolerating Cold	☐	
Difficulty Tolerating Heat	☐	
PSYCHIATRIC		
Anxiety	☐	
Depression	☐	
Impulsive Behavior	☐	
Suicidal Thoughts	☐	
Excessive Anger	☐	
Mood Swings	☐	
Emotional Abuse	☐	
Physical Abuse	☐	
Sexual Abuse	☐	
HEMATOLOGIC/LYMPHATIC		
Bruises Frequently or Easily	☐	
Cuts do not stop Bleeding	☐	
Enlarged Lymph Nodes	☐	
ALLERGIC/IMMUNOLOGIC		
Frequent Illness	☐	
Seasonal Allergies	☐	
OTHER		

1. _____

2. _____

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Operations

I,_____, understand that as part of my health care, Center for Women in Hixson, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care options.

I understand that Center for Women in Hixson, is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sing this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Center for Women in Hixson reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Center for Women in Hixson change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health: _____

_____

_____

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

In regard to contacting me with my protected health information:

1. ☐YES ☐NO Do we have your permission to call your home to discuss appointments, scheduling of tests and/or procedures and results of tests/procedures?

2. ☐YES ☐NO Do we have your permission to call your workplace to discuss appointments, scheduling of tests and/or procedures and results of tests/procedures?

3. ☐YES ☐NO May we leave a message at your home to persons other than yourself, or on an answering machine to call our office? WORK? ☐YES ☐NO

4. If you marked yes to any of the above, who can we release information to regarding appointments, test results and/or financial matters? _____

_____

I fully understand and accept / decline the terms of consent.

Patient or Authorized Signature_____Date Signed _____Witness Signature_____

FOR OFFICE USE ONLY