Wise Health Clinics
Obstetrics and Gynecology
2451 S. FM 51, Suite 200
Decatur, Texas 76234
940-627-2409 940-626-4579 Fax

Last Name	First Name	Middle Initial

Date of Birth	SSN #	Driver's License Number	Marital Status: M S D W

Mailing Address:	City:	State:	Zip:

Parent/Legal Guardian if Patient is a Minor:

Home Number:	Cell Number:	Work Number:
Text/ leave a voice message? Yes ☐ No ☐	Preferred time for calls/messages Morning ☐ Afternoon ☐ Evening ☐	Email Address:

Race: Asian: ☐ White: ☐ Indian: ☐ Hispanic: ☐ African American: ☐ Other: ☐

Language:English: ☐ Spanish: ☐ Other: ☐

Occupation:	Employer's Name:		
Employer's Address:	City:	State:	Zip:

Spouse Name:	Spouse's Employer:

Are you a Veteran of the US Armed Forces? yes ☐ No ☐

Emergency Contact Name:		Relationship:	Phone Number:
Address:	City:	State:	Zip:
Home Number:	Work Number:	Cell Number:	

NEAREST RELATIVE (NOT LIVING WITH YOU)

Name:	Relationship	
Home Number	Work Number:	Cell Number:

Pharmacy Name:	Phone Number:

INSURANCE INFORMATION: (PERSON RESPONSIBLE FOR FEES)

Insurance Company:	Policy #	Group #
Subscriber's Name:	Date of Birth:	SSN#:

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Patient Name:_____ **DOB:**_____

CONSENT FOR TREATMENT FORM

_____
(Initial)

I understand that I have presented myself to WISE HEALTH CLINICS for evaluation and/or treatment for my condition. I authorize and direct WISE HEALTH CLINICS to perform quality care upon me, and understand that all options will be discussed prior to the administration of such treatment. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of any procedures and/or treatments. I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

FACSIMILE AUTHORIZATION FORM

_____
(Initial)

I, undersigned, authorize WISE HEALTH CLINICS to send/receive confidential healthcare information as the term is defined by HIPPA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed. I may revoke this authorization by giving WISE HEALTH CLINICS five (5) days written notice. This revocation may be by facsimile transmission; however a written copy of the revocation must be mailed to WISE HEALTH CLINICS as well.

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

_____
(Initial)

I hereby give authorization of insurance benefits to be made directly to WISE HEALTH CLINICS for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

ACKNOWLEDGEMENT OF PATIENT RIGHTS

_____
(Initial)

I have read the NOTICE OF PATIENT RIGHTS and have had any questions answered by this office. I understand that by signing this form I acknowledge that I have read the Patient Rights Notice. My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing. Any disclosures given in reliance on this prior consent will be permissible.

Patient Name:_____ DOB:_____

ACKNOWLEDGEMENT OF PATIENT RESPONSIBILITIES

_____ **(Initial)** I have read the NOTICE OF PATIENT RESPONSIBILITIES and have had any questions answered by this office. I understand that by signing this form I acknowledge that I have read the Patient Responsibilities Notice posted in all WISE HEALTH CLINICS locations. My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

_____ **(Initial)** I acknowledge that WISE HEALTH CLINICS has provided me with the opportunity to view and read a written copy of their Notice of Privacy Practices.

SHARING OF INFORMATION FOR PURPOSE OF PAYMENT

_____ **(Initial)** I acknowledge that WISE HEALTH CLINICS will share all necessary information with my insurer(s), payer(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies. Sharing of information for purposes of operations: You will share all information necessary for ongoing operations of this office (including, but not limited to) the credentialing for ongoing operations of this office and any relevant processes, the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

COMMUNICATION AUTHORIZATION

_____ **(Initial)** I acknowledge that WISE HEALTH CLINICS may communicate with me via US mail, e-mail, and land line home phone, through the patient portal, on a cell phone and through text messaging.

PCMH AGREEMENT CONSENT FORM

_____ **(Initial)** I have had an opportunity to read and review my own copy of WISE HEALTH CLINICS'S Patient Centered Medical Home Patient-Provider Agreement. Furthermore I consent to be treated under this medical model which aims to benefit my health outcomes.

PRESCRIPTION POLICY CONSENT FORM

_____ **(Initial)** For non-narcotic prescription refills I will give the office at least 24 hour notice. I also understand that if I do not sign the drug policy consent or refuse to submit for a drug test I could be dismissed from the practice. By initialing here I also agree to give WISE HEALTH CLINICS to look up past medicines prescribed to me by this provider and any others.

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1. **Cancellation / No Show Policy for Doctor Appointment**

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

   ******If an appointment is not cancelled at least 24 hours in advance you will be charged a $25.00 fee; this will not be covered by your insurance company. ******

1. **Scheduled Appointments**

   We understand that delays can happen however we must try to keep the other patients and doctors on time.

   ******If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment. ******

2. **Cancellation / No Show Policy for Surgery**

   Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

   ******If surgery is not cancelled at least 10 days in advance you will be charged a $75.00 fee; this will not be covered by your insurance company. ******

3. **Account Balances**

   We will require that patients with self-pay balances do pay their account balances to zero prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over $100.00 must make payment arrangements prior to future appointments being made.

_____ **Date:** _____

Print Name

_____

Patient Signature

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Obstetrics and Gynecology

STD and DRUG SCREENING

_____ **I understand that STD testing (including HIV) and drug screening are a routine part of your GYN or prenatal testing at this office and I consent to such screening.**

_____ **I understand that if my STD screen is positive, I will be notified and treated in a confidential manner by this office.**

_____ **I understand that it is MY responsibility and NOT the responsibility of this office notify my sexual partner(s) of a positive STD screen.**

_____ **I understand that certain STD'S are reported to the Texas State Health Department as required by law.**

_____ **I understand that random drug screening may occur with or without my knowledge throughout my prenatal care at the discretion of my provider.**

_____ **I understand that if my drug screen is positive, I may be reported to Child Protective Services.**

_____ _____

Print Patient Name **Date of Birth**

_____ _____

Patient's or Guardian (If patient is minor) Signature **Today's Date**

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Release of Medical Information

Patient Name: _____

I authorize Array Women's Health to release my health information to the following individuals. I understand that this will include all of my medical records unless otherwise noted below.

_____

(Information you do not wish to be released, if any)

_____	_____
Name	Relation
_____	_____
Name	Relation
_____	_____
Name	Relation
_____	_____
Name	Relation
_____	_____
Patient's Signature	Date
_____	_____
Office Staff Signature	Date

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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records: Initial: _____ Date: _____

Release my protected health information **to** the following person(s)/entity:

WISE HEALTH CLINICS OB/GYN
2451 S. FM 51, SUITE 200
Decatur, TX 76234
Phone # (940) 627-2409 **Fax#** (940) 626-4579

Release my protected health information **from** the following person(s)/entity:

Name: _____Phone#_____
Street: _____
City: _____ State: _____ Zip: _____

Limitations on the information you may release subject to this Release Form are as follows:

_____

The reasons or purpose for this release of information are as follows:

☐ Continuing Care
☐ Changing Physician
☐ Other_____

Patient Name: _____

DOB: _____SS#: _____ Phone: _____

_____ Date: _____
Patients Signature or Legal Guardian

Review of Systems

Please circle "yes" if you have experienced any of these symptoms in the last 7 days.

Constitutional

Y N Chills
Y N Fever
Y N Fatigue
Y N Unexplained weight gain (# of pounds _____)
Y N Unexplained weight loss (# of pounds_____)

Opthalmic

Y N Eye pain
Y N Changes in vision

Ears, Nose, and Throat

Y N Ear pain
Y N Difficulty hearing
Y N Sinus pain
Y N Sinus congestion
Y N Sore throat
Y N Swollen glands

Endocrine

Y N Heat intolerance
Y N Cold intolerance
Y N Hot flashes

Cardiovascular

Y N Chest pain
Y N Shortness of breath with activities
Y N Palpitations

Respiratory

Y N Cough
Y N Wheezing
Y N Shortness of breath

Gastrointestinal

Y N Abdominal pain
Y N Nausea
Y N Vomiting
Y N Diarrhea
Y N Constipation
Y N Bloody stools
Y N Heartburn
Y N Change in bowel habits

Breast/Genitourinary

Y N Breast lump
Y N Breast pain / tenderness
Y N Nipple discharge
Y N Pelvic pain
Y N Irregular periods
Y N Heavy periods
Y N Painful periods
Y N Bleeding between periods
Y N Bleeding after intercourse
Y N Pain with intercourse
Y N Vaginal dryness
Y N Vaginal discharge/itching

Genitourinary

Y N Bloody urine
Y N Urinary frequency
Y N Painful urination
Y N Urinary urgency

Musculoskeletal

Y N Muscle aches
Y N Joint pain
Y N Back pain

Skin

Y N Rash
Y N Skin lesions
Y N Itching

Neurological

Y N Difficulty walking
Y N Weakness
Y N Pain
Y N Numbness or tingling

Psychiatric

Y N Anxiety
Y N Depression
Y N Suicidal thoughts
Y N Mental or physical abuse

Do you practice self-breast exam? Yes_____ No_____
When was your last pap smear? _____
Have you ever had a colonoscopy? Yes_____ No_____
When was your last mammogram? _____
Did you ever have an abnormal pap? _____

Patient Name: _____ DOB: _____ Date:_____

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Brief Medical History

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

Reason for Today's Visit: _____

Please check if you have ever had any of the following:

Yes	No		Yes	No	
		High blood pressure			Kidney stones
		Diabetes			Diverticulosis
		Stomach ulcers/bleeding			Thyroid problems
		Chest pain/heart attack			Asthma/respiratory disease
		Heart murmer			High cholesterol
		Stroke			Anxiety
		Hepatitis			Depression
		Gallstones			Other:

Please list any surgeries you have had in the past: **None**

Year	Name of Surgery	Year	Name of Surgery

Have you ever had a blood transfusion? **Yes** **No**

Have you ever been hospitalized? **Yes** **No**

Year	Reason for hospitalization

Patient's Signature: _____ **Date:** _____

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

Please list all medications you are taking: **None**

Name of Medication	Dosage	How often is medication taken? (once daily, etc)

What medications are you allergic to? _____

Do you drink alcohol? No Yes How many per day? _____
How many per week? _____

Do you smoke tobacco? No Yes How many per day? _____

Do you use any recreational drugs? No Yes
What Type: _____

Would you accept a blood transfusion if medically necessary? No Yes

Date of your last menstrual cycle: _____

Are you pregnant now? No Yes

How many times have you been pregnant? _____

How many vaginal deliveries did you have? _____

How many cesarean sections did you have? _____

How many living children do you have? _____

How many miscarriages or abortions did you have? _____

Have you ever had an abnormal pap smear? No Yes When: _____

Date of last pap smear: _____ Was it normal? Yes No

Do you practice self-breast exam? No Yes

Have you ever had a mammogram? No Yes Date: _____

Have you ever had a colonoscopy? No Yes Date: _____

Patient's Signature: _____ **Date:** _____

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Family Cancer History

Please check all that apply:

	You	Age Diagnosed	Children/Brothers or Sisters	Age Diagnosed	Mother's Side	Age Diagnosed	Father's Side	Age Diagnosed
Breast Cancer								
Ovarian Cancer								
Male Breast Cancer								
Pancreatic Cancer								
Uterine Cancer								
Colon Cancer								
Stomach Cancer								
Bladder Cancer								
Kidney Cancer								
Brain Cancer								
Bowel Cancer								
Thyroid Cancer								
Melanoma								

Are you of Ashkenazi Jewish Descent? Yes _____ No _____

Have you or anyone in your family had genetic testing for hereditary cancer syndrome: Yes _____ No _____

Patient's Signature: _____ **Date of Birth:** _____

Date of Signature_____

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Family History

Please check all that apply:

	High Blood Pressure	Heart Disease/Attack	Diabetes	Stroke	Blood-clotting disorder
Child					
Brother/Sister					
Mother					
Father					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					
Other Relative					

Patient's Signature: _____ **Date of Birth:** _____

Date of Signature: _____