fearfully and wonderfully made OB/GYN, PLLC

FOR OFFICE USE ONLY

Weight:_____Blood Pressure:_____Height:_____ Pulse: _____

Name_____ Today's Date_____

Primary Care Doctor_____ Date of birth _____

Date of last menstrual period_____ Current Age_____

Can we leave test results or appointment information on your voicemail? _____

By what name do you prefer to be called? _____

In the event of a life threatening emergency, would you consent to a blood transfusion if necessary to save your life? _____

Reason for today's office visit: _____

***Obstetrical History**:*

Total Number of pregnancies:_____ Number of living children: _____

Number of miscarriages or ectopics:_____ Number of abortions: _____

| ***Date of Delivery*** | ***Due date*** | ***Hours of Labor*** | ***Birth Weight*** | ***Gender*** | ***Vaginal or csection*** | ***Complications*** | ***Hospital*** |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

***Gynecological History**:*

Age of first period_____ Are your periods regular or irregular? _____

My periods occur every_____days; my periods usually last for_____days.

Number of pads or tampons used in 24 hour period?_____passage of clots? _____

Do you experience painful cramping? _____

Age at first intercourse?_____ Number of lifetime sexual partners: _____

What type of sexual activity are you currently participating in (ie vaginal, oral, anal, with men, women, etc)? _____

Do you have a history of abnormal pap smears?_____If yes, when? _____

Have you ever been diagnosed with a sexually transmitted infection such as:

*gonorrhea, chlamydia, trichomonas, herpes, syphilis, hepatitis, hiv?* _____

If yes, please circle any that apply and indicate the year diagnosed.

***Medical History***

Please list any medical conditions that you have been diagnosed with and the year you were diagnosed or any previous hospitalizations:

_____

_____

_____

***Medications*** (including over the counter medication and herbal supplements)

_____

_____

***What form of contraception are you using?*** _____

***Allergies*** (including the reaction)

_____

***Surgical History***

Please list any surgeries that you have previously undergone and the year of operation

_____

_____

_____

_____

***Social History:***

What is your current marital status?_____

Have you ever or do you ever use tobacco? _____ If yes, how much?_____What kind?___ _

Have you ever or do you ever use alcohol?_____If yes, how much?_____What kind?___ _

Have you ever or do you ever use illicit drugs or controlled prescription medications including but not limited to methadone, oxycodone, hydrocodone, cocaine, marijuana, methamphetamines, or heroine?_____

What is the name of your spouse or significant other? _____

What is your occupation?_____

Have you ever been a victim of domestic abuse? _____Or victim of rape? _____

Do you feel safe at home?_____If no, please explain: _____

Do you have any adopted children?_____If yes, names and ages please?_____

_____

***Family History:***

Please list any **medical problems** in the following relatives being careful to include female cancers such as breast, ovarian, and uterine cancers. If you know the age at diagnosis, please include.

Are you adopted? _____

Mother _____ Father _____

Brother _____ Sister _____

Aunt _____ Uncle _____

Grandmother _____ Grandfather _____

Other family member not already mentioned _____

Did your mother take DES while pregnant with you? _____

***Preventative Health Screening:***

Date of last pap smear for cervical cancer screening: _____ result _____

Date of last mammogram for breast cancer screening: _____ result _____

Date of last colonoscopy for colon cancer screening: _____ result _____

Date of last DEXA scan for osteoporosis screening: _____ result _____

Date of last flu vaccination: _____

Date of last tetanus/pertussis/diptheria vaccination: _____

Date of Gardasil or other HPV vaccination: _____

**Date of COVID-19 vaccination(s): _____**

**Please circle which COVID vaccination manufacture you received: Pfizer, Moderna, Johnson & Johnson**

***Review of Systems*** – Please check all symptoms that you experience:

***General***

- ⌋ Chills
- ⌋ Decline in health
- ⌋ Fatigue
- ⌋ Fever
- ⌋ Weakness
- ⌋ Weight gain
- ⌋ Weight loss

***Skin***

- ⌋ Dryness
- ⌋ Easy bruise
- ⌋ Skin color change
- ⌋ Hair dye
- ⌋ Hair texture change
- ⌋ Hives
- ⌋ Lumps
- ⌋ Itching
- ⌋ Eczema
- ⌋ Mole increased size
- ⌋ Nail appearance change
- ⌋ Nail texture change
- ⌋ Rash

***Respiratory***

- ⎦ Asthma
- ⎦ Cough
- ⎦ Wheezing
- ⎦ Bronchitis
- ⎦ Coughing blood
- ⎦ Pain
- ⎦ Pleurisy
- ⎦ Positive TB test
- ⎦ Recent chest x-ray
- ⎦ Short of breath
- ⎦ Sputum
- ⎦ Tuberculosis

***Cardiovascular***

- ⎦ Chest pain
- ⎦ Palpitations
- ⎦ Varicose veins
- ⎦ Cool extremity(s)
- ⎦ Discolored extremity(s)
- ⎦ Hair loss on legs
- ⎦ Heart murmur
- ⎦ Heart tests (not EKG)
- ⎦ High blood pressure
- ⎦ History of heart attack
- ⎦ Leg pain (walking)
- ⎦ Recent electrocardiogram
- ⎦ Rheumatic fever
- ⎦ Short of breath (exertion)
- ⎦ Short of breath (lying flat)
- ⎦ Short of breath (sleeping)
- ⎦ Swelling of legs
- ⎦ Thrombophlebitis
- ⎦ Ulcers on legs

***Gastrointestinal***

- ⎦ Abdominal pain
- ⎦ Constipation
- ⎦ Diarrhea
- ⎦ Heartburn
- ⎦ Jaundice
- ⎦ Liver disease
- ⎦ Rectal bleeding
- ⎦ Abdominal x-ray tests
- ⎦ Antacid use
- ⎦ Black tarry stools
- ⎦ Change in frequency of BM
- ⎦ Change in stool caliber
- ⎦ Change in stool color
- ⎦ Change in stool consistency
- ⎦ Decreased appetite
- ⎦ Excessive hunger
- ⎦ Excessive thirst
- ⎦ Gallbladder disease
- ⎦ Hemorrhoids
- ⎦ Hepatitis
- ⎦ Infections
- ⎦ Laxative use
- ⎦ Nausea
- ⎦ Rectal pain
- ⎦ Swallowing problem
- ⎦ Vomiting
- ⎦ Vomiting blood

***Musculoskeletal***

- ⎦ Arthritis
- ⎦ Joint pain
- ⎦ Gout
- ⎦ Back problems
- ⎦ Deformities
- ⎦ Joint stiffness
- ⎦ Muscle cramps
- ⎦ Muscle stiffness
- ⎦ Paralysis
- ⎦ Restricted motion\
- ⎦ Weakness

***Psychiatric***

- ⎦ Depression
- ⎦ Behavioral change
- ⎦ Disorientation
- ⎦ Disturbing thoughts
- ⎦ Excessive stress
- ⎦ Hallucinations
- ⎦ Memory loss
- ⎦ Mood changes
- ⎦ Nervousness
- ⎦ Psychiatric disorders

***Neurological***

- ⎦ Loss of consciousness
- ⎦ Blackouts
- ⎦ Burning
- ⎦ Dizziness
- ⎦ Fainting
- ⎦ Head injury
- ⎦ Headaches
- ⎦ Memory loss
- ⎦ Numbness
- ⎦ Paralysis
- ⎦ Speech disorders
- ⎦ Strokes
- ⎦ Tingling
- ⎦ Tremors
- ⎦ Unsteady gait

***Endocrine***

- ⎦ Weakness
- ⎦ Weight gain
- ⎦ Weight loss
- ⎦ Cold intolerance
- ⎦ Excessive urination
- ⎦ Fatigue
- ⎦ Goiter
- ⎦ Heat intolerance
- ⎦ Increased thirst
- ⎦ Neck pain
- ⎦ Sweats
- ⎦ Thyroid trouble

***Hematologic/Lymph***

- ⎦ Anemia
- ⎦ Bleeding easily
- ⎦ Blood clots
- ⎦ Easy bruising
- ⎦ Lumps
- ⎦ Radiation exposure
- ⎦ Swollen glands
- ⎦ Transfusion reaction

***Allergic/Immunologic***

- ⎦ Coughing
- ⎦ Coughing with exercise
- ⎦ Hives

- ☐ Itchy eyes
- ☐ Itchy nose
- ☐ Recurrent infections
- ☐ Runny nose
- ☐ Sneezing
- ☐ Stuffy nose
- ☐ Watery eyes
- ☐ Wheezing

- ☐ Wheezing with exercise

***Urinary***

- ☐ Awakening to urinate
- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Burning
- ☐ Difficulty starting stream
- ☐ Excessive urination
- ☐ Flank pain
- ☐ Frequency
- ☐ Incontinence
- ☐ Infections
- ☐ Pain on urination
- ☐ Retention
- ☐ Stones
- ☐ Urgency
- ☐ Urine discoloration
- ☐ Urine odor

***Female Genitalia***

- ☐ Birth control
- ☐ Bleeding between periods
- ☐ Change in period duration
- ☐ Change in period flow
- ☐ Change in interval of periods
- ☐ DES exposure
- ☐ Difficult pregnancy
- ☐ Discharge
- ☐ Fertility problems
- ☐ Hernias
- ☐ Itching
- ☐ Lesions
- ☐ Menopause
- ☐ Menstrual pain
- ☐ Pain on intercourse
- ☐ Postmenopausal bleeding

- ☐ Recent pap smear
- ☐ Recent pregnancy
- ☐ Sexual problems
- ☐ Venereal disease

***Breasts***

- ☐ Discharge
- ☐ Lumps
- ☐ Pain
- ☐ Self-examination
- ☐ Tenderness

Other symptoms:

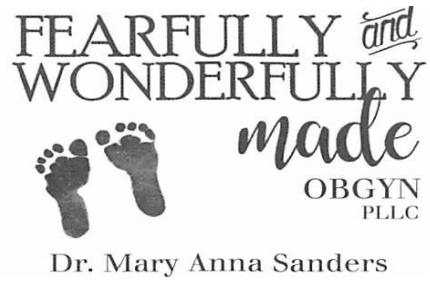
_____

_____

_____

Is there anything else that you wish for us to know about you? _____

What is your preferred pharmacy? _____




**Patient Name**:_____ **Preferred Name**:_____

**Address**:_____

**City**:_____ **State**:_____ **Zip**:_____

**Preferred Phone #**:_____ **Home/Work**:_____

**Email:**_____

**Maiden Name**:_____ **DOB**:_____ **Sex**:_____ **SSN**:_____

**Race**:_____ **Marital Status**:_____ **Partner's Name**:_____

**Driver's License #**:_____ **Primary Language**:_____ **Religion**:_____

**Do we have permission to leave a voicemail message regarding appointment date and time?** _____

**Employer Name**:_____ **Occupation**:_____

**Address**:_____**Phone/Ext**:_____

**Preferred Pharmacy Name**:_____ **Phone**:_____

**Address/City/State**:_____

**Health Insurance Company**_____

**Member ID Number #**:_____ **Group #**:_____

**Policy Holder**:_____

**Policy Holder DOB**:_____ **Policy Holder Social Security #**:_____

**Secondary Insurance Company**:_____

**Secondary Member ID Number #**:_____ **Group #**:_____

**Secondary Policy Holder**:_____

**Policy Holder DOB**:_____ **Policy Holder Social Security #**:_____

_____ _____

**Signature** **Date**

# Notice of Privacy Practice

**I acknowledge receipt of Fearfully and Wonderfully Made GYN Notice of Privacy Practice. I authorize Fearfully and Wonderfully Made GYN to use and disclose my health information for the purpose of treating me, obtaining payment for services rendered to me, and conducting routine healthcare operations.**

_____ _____

**Patient Signature** **Date**

# HIPPA APPROVED CONTACTS

**I hereby authorize Fearfully and Wonderfully Made GYN to communicate confidential health information and financial information to the following individuals:**

**Name:_____ Relationship_____**

**DOB:_____ Gender:_____ Phone:_____**

**Name:_____ Relationship_____**

**DOB:_____ Gender:_____ Phone:_____**

**Name:_____ Relationship_____**

**DOB:_____ Gender:_____ Phone:_____**

Fearfully and Wonderfully **Made GYN, PLLC PO**
**Box 2217**
**Chattanooga, TN 37409**

## LEGAL IRREVOCABLE ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND SUMMARY PLAN DOCUMENTS

Patient Name: _____ Patient SS#:_____Date:_____

In considering the amount of expenses to be incurred, I _____ , the undersigned, have insurance and/or employee health care benefits coverage with_____ (insurance co. information), and hereby irrevocably assign and convey directly to Fearfully and Wonderfully Made OBGYN, PLLC (hereafter "provider") all right, title and interest in all medical benefits payable and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider /practice. Said irrevocable assignment and transfer shall be for the purpose of granting the provider and practice an independent right of recovery against such responsible parties, but shall not be construed to be an obligation of the provider and practice to pursue any such right to recovery. I hereby authorize all responsible parties to pay directly to the provider and practice all benefits and amount due for services rendered by the physician.

I understand that if the provider and practice is not paid in full by proceeds for any benefits, then this assignment does not release my obligation and liability to the provider and practice for payment and all services and items provided to me or by my insurance company or employee health benefit plan, then I agree to pay provider and practice for all charges in excess of the benefits paid. All payments will be made to provider and practice at PO Box 2217 Chattanooga, TN 37409

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider and practice any and all summary plan documents, insurance policy and/or settlement information upon written request from such provider and practice in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chosen action, or the right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named provider and practice and to the extent permissible under law to claim such benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such provider and practice in any attempts by such provider and practice to pursue such claim, chosen action or right against any insurers and/or employee health care plan, including, if necessary, bring suit with such provider and practice against any insurers and/or employee health care plan in my name but at such provider and practice's expense.

This lifetime assignment of benefits will remain in effect until revokes by me in writing. A photocopy of this assignment of benefits is to be considered as valid as the original.

The terms and consequences of these irrevocable assignments and financial responsibilities have been fully explained to me to my understanding and I have signed this document freely and without inducement other than the rendition of services by the physician.

| _____ | _____ | _____ |
|---|---|---|
| **NAME of Insured / Responsible Party** | **Signature of Insured / Responsible Party** | **Date** |

| _____ | _____ | _____ |
|---|---|---|
| **NAME of Patient or Guardian** | **Signature of Patient or Guardian** | **Signature of WITNESS** |

## Fearfully and Wonderfully Made OBGYN, PLLC
## Mary Anna Sanders, DO

## Consent for Care and Treatment

**TO THE PATIENT:** You have the right as a patient to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and benefits involved.

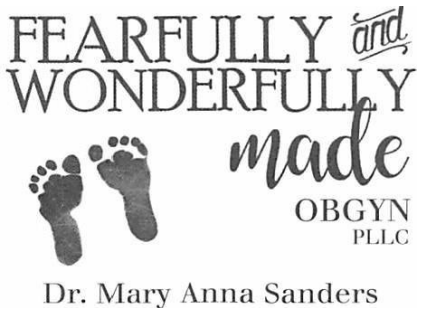
This consent provides us with your permission to perform reasonable and medically necessary examinations, testing, & treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, and (2) you consent to treatment at this office or any other facility required for your care. This consent will remain fully effective until it is revoked by you in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of a test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid- level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialists), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at Fearfully and Wonderfully Made OBGYN, PLLC. I understand that if additional testing, invasive or interventional procedures are recommended. I will be asked to read and sign an additional consent forms prior to the test(s) or procedures(s).

**I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.**

| | |
|---|---|
| **Signature of Patient or Patient Guardian** | **Date** |
| **Printed Name of Patient or Guardian** | **Relationship to Patient** |
| **Witness** | **Date** |




**Financial Policy**

The information in this financial policy is meant to educate the patients of the requirements regarding payment for services rendered. If you have any questions please feel free to speak to the office manager.

**Insurance and demographic information:** Please notify the staff if you have a change in name, address, phone number, or insurance information. You will need to update your paperwork and give us a copy of the updated information giving our office permission to bill your new insurance company. If this is not done and your insurance company does not pay for the services rendered by FAWM you will be responsible for the balance due in full.

**What payment is required?** You will be required to pay any copays, deductibles, or co-insurance at each office visit. All copays are due at the time of service.

**What forms of payment do we accept?** We accept cash, check, check card, money order, cashier's check, Visa, Master Card, Discover card, & American Express. Due to COVID-19, we encouraging taking payments via the telephone to ensure safe social distance. Patients are responsible for charges to their account after insurance has been processed and by signing below you are also consenting to us running your card via telephone authorization and providing us the card numbers, expiration date and the CVV code. If you are uncomfortable paying via telephone, you may send a check in the mail. If you have an HSA or HRA account that is an agreement between you and your employer and FAWM is not a party to that agreement. We will not wait for the account to be funded before payment due is collected.

**Broken appointment charge and policy:** There may be a fee of $50 charged if you do not keep a scheduled appointment. We ask that if the need arises that you must reschedule or cancel an appointment please do so at least 24 hours ahead of time. Insurance does not pay for this charge and it is the responsibility of the patient or responsible party.

**Medicare:** We do accept Medicare assignment for Medicare, however you are responsible for any copay, coinsurance, and/or deductible not covered by a Medicare supplement.

**Our policy on insurance assignment:** We will verify that you have active coverage before each appointment. We will file a claim to your insurance payer, as a courtesy to you. However, please understand that this is a courtesy to our patients and if the insurance does not pay the claim the patient becomes responsible for any unpaid balance due for services rendered. Furthermore, standard procedure for the practice is to collect a urine sample to test for pregnancy on patients who do not report a hysterectomy or menopause. Most insurance companies consider this a lab test and it may be applied to your deductible for which you will be responsible. If we are not in network with your insurance, you will be responsible for payment in full or an estimated amount that is not covered.

**Fees due if your account is turned to collections:** You will be responsible for any fees and/or attorney fees in the event that your account is turned over for collections. This amount could be up to 50% of the amount due in addition to your balance. If your account is turned over to collections you will be required to pay the amount due before making another appointment to receive services from FAWM.

**Labs:** Our office may require you to have lab work in order to provide quality care to you. Please note that you will receive an additional bill from the lab that processes your lab.

**Charge for insufficient funds check:** There is a fee for returned checks of $35.00 which is due before the patient is seen again. This fee must be paid by cash, money order, or cashier's check

**Payment Arrangements:** We will work with our patients in order to resolve account balances. If you are unable to pay your balance in full please speak with the office manager to set up a payment arrangement.

**I have read and understand the financial policy for FAWM, PLLC. I agree to comply with the policy. I understand if I have any questions I should ask to speak to Sheena.**

_____ _____

Signature of Patient or Guarantor Date

_____

Print Name

_____

Patient's name if different from Guarantor