



Date ___/___/___

Name: _____ Date of Birth ___/___/___ Age _____ Sex M F
 First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

Hm Phone: _____ Wk Phone: _____

Cell Phone: _____ E-mail: _____

SS#: _____ Employer: _____ Occupation: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Emergency contact (1): _____ Phone: _____ Relationship: _____

Emergency contact (2): _____ Phone: _____ Relationship: _____

Spouse's Name: _____ D.O.B.: ___/___/___ SS#: _____ Wk Phone: _____

Referred by: TV ___ INS ___ Internet ___ Dr ___ Other _____

Primary Care Physician: _____ Phone: _____

Pharmacy Name: _____ Pharm#: _____ Pharm Add: _____

Primary Insurance Company: _____ Phone: _____

Name of Policy Holder: _____ Relationship to Patient: _____ D.O.B.: _____

ID# _____ Group# _____

Secondary Insurance Company: _____ Phone: _____

Name of Policy Holder: _____ Relationship to Patient: _____ D.O.B.: _____

ID# _____ Group# _____

Assignment of Benefits:

I hereby instruct and direct my Insurance Company to pay by check made out and mailed to: Understanding Women, P.C.. If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows: for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I authorize the release of any information needed to secure payment for any services. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signed: _____ Date: _____

Understanding Women, P.C.
Financial Policy

Thank you for choosing Understanding Women for your gynecological needs. We welcome you! We are committed to providing the finest care and professionalism for our patients. Please carefully read and sign the following statement of our financial policy prior to treatment. Feel free to speak to our office personnel if you have any questions.

The patient or their guarantor is responsible for payment of services that are rendered. If we are a preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information that you provide. Please present your insurance card at each visit. You will be responsible for all co-pay, coinsurance, and deductibles on the day of service. Should an overpayment occur on the deductible or percentage amounts charged we would apply a credit to your account. A refund is available upon request. If a procedure is scheduled please be aware there will be a Physician, Facility, Anesthesia and Lab fee. We will submit for the Physician and Facility. If a procedure is generally deemed to be “cosmetic” or “non medically necessary”, we do not bill insurance companies directly. You must pay for the procedure in full and we will provide you with the necessary paperwork to submit to your insurance company upon request.

IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS.

You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. For your convenience, we accept VISA, MC, or cash.

All insurance information, including prior authorizations and referral forms, must be provided at the time of service and before you are seen. If information is not provided at the time of your appointment you will be rescheduled or considered self pay, your appointment will not be delayed while you obtain the information.

Delinquent accounts over 90 days will be subject to the following action. A collection-processing fee will be added to your outstanding balance and turned over to our collection agency Transworld Systems for further processing.

FEES: There will be a \$40 fee for the following: Copy of Medical records to a patient or insurance company, FMLA, or disability paperwork.

There will be a \$25 service fee for all returned checks. NSF checks must be redeemed with certified funds (cashiers check, money order, certified check or cash).

If you need to cancel a scheduled appointment, please contact our office at least **72 business hours** before your appointment time. Because of high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. **A FEE WILL BE ASSESSED DEPENDING ON THE LEVEL OF COMPLEXITY FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 72-BUSINESS HOURS ADVANCE NOTICE.**

It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.

Understanding Women will not be sending patient statements, as this procedure will be a pre-arranged which will be authorized by the responsible party.

I have read and I understand the Financial Policy and Notice of Privacy Practices and I agree to abide by its terms, a copy will be provided upon patient’s request.

PRINTED NAME OF PATIENT

SIGNATURE OF PATIENT/RESPONSIBLE PERSON

DATE



Patient Communication Authorization

Date: _____

Patient's Name: _____

Patient's Date of Birth: _____

We must call on occasion to discuss confidential protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

It's okay to call my home phone number Okay to leave a message? yes no

It's okay to call my mobile number Okay to leave a message? yes no

It's okay to call my work phone number. Okay to leave a message? yes no

Call only this number. _____ Okay to leave a message? yes no

Do not speak to family members.

I give permission to the individual(s) listed below to receive protected health information:

This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature _____

Date _____



PATIENT-PHYSICIAN ARBITRATION AGREEMENT

Section 1: I agree to binding arbitration to resolve any claim I may have against Keri Sweeten, M.D., or her staff. If I wish to assert a claim for medical malpractice, including any claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, I agree that such claim will be submitted to binding arbitration by the American Arbitration Association, and not by a lawsuit or resort to court proceedings. I agree that both parties to this contract are giving up their constitutional right to have any such claim decided in a court of law before a jury, and instead are agreeing to binding arbitration. I understand that binding arbitration means that a private arbitrator or arbitrators, and not a judge or jury, will decide my claim and that the arbitrator's decision ordinarily will be final.

Section 2: I agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to the treatment or services provided by Dr. Sweeten or her staff, including my spouse or heirs and any children, whether born or unborn. This Agreement covers all claims for monetary damages including, without limitation, suits for loss of consortium and companionship, wrongful death, emotional distress and punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against Dr. Sweeten and any employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of any parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement.

Section 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Section 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE DR. SWEETEN'S SERVICES, AND THAT IF I DO SIGN THIS AGREEMENT AND LATER CHANGE MY MIND, I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO DR. SWEETEN WITHIN 30 DAYS STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT. I ALSO UNDERSTAND THAT I MAY HAVE MY ATTORNEY OR OTHER ADVISORS DISCUSS THIS AGREEMENT WITH DR. SWEETEN OR HER STAFF, AND THAT I OR ANY SUCH REPRESENTATIVE MAY REQUEST REVISIONS TO THIS AGREEMENT.

Section 5. OPTIONAL: RETROACTIVE EFFECT

If I intend this Agreement to cover services rendered before the date it is signed (for example, prior emergency treatment), I have indicated the earlier effective date below. Otherwise this Agreement covers only services rendered after this Agreement was signed.

Earlier effective date: _____ Patient's Initials: _____

Section 6. I have read and understood this Agreement. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

BY SIGNING THIS CONTRACT I AM AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND TO GIVE UP MY RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 of THIS CONTRACT.

(Patient, Parent, Guardian or Legally Authorized Representative of Patient) Dated: _____, 20__.

If signed by other than patient, indicate relationship: _____

PHYSICIAN'S AGREEMENT TO ARBITRATE

In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by arbitration on the terms set forth in this Agreement.

(Physician or Duly-Authorized Representative) Dated: _____, 20__.

Print name of Physician, Medical Group, Partnership or Association Dated: _____, 20__.



Information about our Arbitration Agreement.

To Our Valued Patients:

We would like to explain our policy regarding our Arbitration Agreement. We are concerned about the rising cost for medical liability insurance and the growing number of physicians who are leaving the practice of medicine because of the threat of malpractice litigation. It is our feeling that our Arbitration Agreement discourages frivolous litigation, and may help prevent increases in medical liability insurance premiums. Binding arbitration can also resolve claims more quickly and at less expense than court proceedings, and can avoid years of appeals. We believe this benefits both the patient and the physician.

The American Arbitration Association is a nationally-recognized organization which has qualified neutral arbitrators available to decide claims in a prompt and fair manner.

We are very grateful for your understanding and cooperation in this matter. Please feel free to discuss any concerns with our physicians or our office manager.

We will understand and respect your decision if you elect not to sign this Agreement. If you decide not to sign the Agreement, then we will happily see you in consultation today and for the next 30 days; after this 30-day period we would request that you seek further care with another physician. We can provide you with the names of other surgeons.

Sincerely,

Keri Sweeten, M.D.



DATE: _____

Patient Name: _____ Marital Status: _____ Age: _____

Occupation: _____ Why have you come to the office today? _____

Drug Allergies: _____

Are you allergic to Nickel? Yes No

Are you allergic to Latex? Yes No

How many pregnancies? _____ How many live births? _____

Review of Systems

- Abdominal pain
- Anemia
- PMS
- Breast masses/discharge
- Heavy bleeding
- Decreased libido/sex drive
- Painful periods
- Fatigue/tired/sluggish
- Hemorrhoids
- Rectal Bleeding
- Urinary control problems
- Menopausal symptoms
- Other _____

Past Medical History

- Hypertension
- Diabetes
- Asthma
- Seizures
- Heart disease
- Stroke
- Cancer
- Liver Disease
- Hepatitis
- Kidney disorder
- Bleeding disorder
- Thyroid disease
- Cholesterol disorder
- Lupus/Autoimmune Dis
- Other _____

Past Surgical History/Year

- Gallbladder _____
- Tonsils _____
- Hysterectomy _____
- Heart Surgery _____
- Appendix _____
- Hemorrhoids _____
- Prostate _____
- Colon _____
- Other _____
- Other _____

Current Medications

<u>Name/Dosage</u>

Social History

Tobacco use: Everyday Some days Former Never

Family History:

- Heart Disease, Stroke, HTN,
- Sudden death younger than 50
- Blood clots in lungs or legs
- Osteoporosis

Immediate Family

- Who: _____
- Who: _____
- Who: _____
- Who: _____

- Prostate Cancer Who: _____
- Breast Cancer Who: _____
- Ovarian Cancer Who: _____
- Colon Cancer Who: _____
- Uterine Cancer Who: _____
- Skin Cancer Who: _____

GYN History: LMP: _____

Date of last:

Pap Smear: _____ Abnormal pap: _____ Treatment: burning freezing laser

Mammogram: _____ normal abnormal Colonoscopy: _____ normal abnormal

Bone Density Scan: _____ normal abnormal Pelvic U/S: _____ normal abnormal

Endometrial Biopsy: _____ normal abnormal

Method of contraception: Vasectomy Tubal Pill/Patch Injectable IUD Barrier Essure

Sexual history: Heterosexual Homosexual Bisexual

Received treatment in past for: Gonorrhea Chlamydia Herpes Syphilis Genital Warts

Would you like testing for sexually transmitted diseases? Yes No

IF YOU HAVE MENSTRUAL BLEEDING PROBLEMS FILL OUT QUESTIONS BELOW.

Are you done with childbearing? Yes No Are/were your periods usually (circle): Regular (every 21-35days) or Irregular

Do you have more than one period in a month? Yes No How long does your period last? _____ Do you have painful periods? Yes No

How long has the bleeding been a problem? _____ Do you use double protection? Yes No Do you change protection hourly or less? Yes No

Are you exceptionally tired or weak during your period? Yes No Does you period impact on personal, social, or work activities? Yes No

Have you used any treatment or over the counter medications for you bleeding (hormones, birth control pills, iron,etc..)?

Yes No If yes, what treatment? _____

Do you have any other concerns? If yes please explain:



PATIENT ASSESSMENT QUESTIONNAIRE

Patient Name _____ Date _____

Instructions

This questionnaire is to help assess your **DAILY** urinary habits and pelvic discomfort. (This includes everyday not only pertaining during your menstrual cycle.)

For each question below, please circle the answer that best describes how you feel. Then, mark your score (0 to 4) for each answer in the column on the right. When you are finished, add up the numbers in this column for your total score.

	0	1	2	3	4	START OF THERAPY MONTH 1 SCORE	MONTH 3 SCORE
1 How many time do you go to the bathroom?	3-6	7-10	11-14	15-19	20+		
2 How many time do you go to the bathroom at night?	0	1	2	3	4+		
3 If you get up at night to go to the bathroom, does It bother you?	Never	Mildly	Moderate	Severe			
4 Are you currently sexually active? YES ___ NO ___							
5 If you are sexually active, do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
6 If you have pain, does it make you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
7 Do you have pain associated with your bladder or in your pelvis (vagina, lower abdomen, urethra, perineum, testes, or scrotum)? If you do not have pain, please skip question 8.	Never	Occasionally	Usually	Always			
8 a. If you have pain, is it usally....	No Pain	Mild	Moderate	Severe			
b. Does your pain bother you?	Never	Occasionally	Usually	Always			
9 Do you have urgency after going to the bathroom? If you do not have urgency, please skip final question.	Never	Occasionally	Usually	Always			
10 a. If you have urgency, is it usually....	No urgency	Mild	Moderate	Severe			
b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
TOTAL SCORE							

Patient Name: _____ Date: _____

11. Do you have recent (Past 12 months) onset bloating?	YES	NO
12. Do you have unexplained weight loss?	YES	NO
13. Do you feel full quickly (early satiety) when you haven't eaten much?	YES	NO
14. Do you have difficulty with bowel movements?	YES	NO
15. Do you feel a bulge from your vaginal area or feel like something is falling out?	YES	NO
16. Do you experience abdominal swelling, pressure, or pain?	YES	NO
17. Do you have new onset lower back pain or leg pain that cannot be attributed to an injury?	YES	NO
18. Do you experience vaginal pain, pressure, bleeding or spotting?	YES	NO