1692 Chatham Parkway
Savannah, GA 31405
www.themidwifegroup.com

GYNECOLOGY PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH_____ MARITAL STATUS_____ SOCIAL SECURITY NUMBER _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
PHONE: HOME _____ CELL _____ WORK _____
EMAIL ADDRESS (for patient portal access): _____
EMPLOYER _____
RACE:

○ White	○ Asian	○ Other
○ Black/African American	○ Hispanic or Latino (no race info available)	○ Decline to Report
○ American Indian or Alaskan Native	○ Native Hawaiian or Pacific Islander	

ETHNICITY:

○ No, not Spanish/Hispanic/Latino	○ Decline to Answer	○ Unknown
○ Yes/Cuban ○ Yes/Puerto Rican	○ Yes, Mexican, American, Chicano	○ Yes, Other Hispanic ○ (Specify)_____

PREFERRED LANGUAGE:

○ English	○ Spanish	○ Japanese	○ Chinese	○ Italian	○ Hindi
○ Portuguese	○ Russian	○ French	○ Guatemalan	○ Tagalog	○ Arabic
○ Bosnian	○ Vietnamese	○ Laotian	○ German	○ Gujarati	

INSURANCE INFORMATION

please be sure to provide information for the PRIMARY POLICY HOLDER when completing this section
NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH_____ GENDER _____ SOCIAL SECURITY NUMBER _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
PHONE NUMBER_____PATIENT'S RELATIONSHIP TO POLICY HOLDER _____
INSURANCE COMPANY_____
GROUP NUMBER _____ POLICY NUMBER _____
CLAIMS MAILING ADDRESS: _____
(usually found on back of card) _____
_____

SECONDARY INSURANCE INFORMATION (if applicable)

please be sure to provide information for the PRIMARY POLICY HOLDER when completing this section
NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH_____ GENDER _____ SOCIAL SECURITY NUMBER _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
PHONE NUMBER_____PATIENT'S RELATIONSHIP TO POLICY HOLDER _____
INSURANCE COMPANY_____
GROUP NUMBER _____ POLICY NUMBER _____
CLAIMS MAILING ADDRESS: _____
(usually found on back of card) _____
_____

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PATIENT NAME (please print)_____ DATE OF BIRTH _____

SPOUSE/SIGNIFICANT OTHER

NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH_____ MARITAL STAUS_____ SOCIAL SECURITY NUMBER _____
PHONE: HOME _____ CELL _____ WORK _____
EMPLOYER _____ OCCUPATION _____

PARENT/GUARDIAN (if applicable)

NAME: LAST _____ FIRST _____ MIDDLE _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
PHONE_____ RELATIONSHIP TO PATIENT _____

ALTERNATIVE CONTACT (other than spouse/significant other – if applicable)

NAME: LAST _____ FIRST _____ MIDDLE _____
ADDRESS_____ CITY _____ STATE _____ ZIP _____
PHONE_____ RELATIONSHIP TO PATIENT _____

PREFERRED PHARMACY: _____ LOCATION _____

PREFERRED LAB

We send all lab work to LabCorp. Your insurance provider may require the use of a different lab. Please select:

○ LabCorp	○ Other (specify):_____

LIVING WILL

Do you have a living will?

○ Yes	○ No	○ I'd like information about establishing a living will

DISCLOSURE OF CONFIDENTIAL INFORMATION (select one)

○ I choose to have voicemail left with minimally necessary information. In the event that I am not available, you may leave a message	○ I choose to opt-out of voicemail messages.

You also have my permission to disclose information about my care to the following individual(s):

NAME:_____ RELATIONSHIP_____

NAME: _____ RELATIONSHIP _____

PARTICIPATION IN EDUCATION

I hereby give my permission for the participation of students in my care. Students will always be supervised by a Certified Nurse Midwife, Nurse Practitioner, Medical Doctor, Radiologic Technologist, or Registered Diagnostic Medical Sonographer. I may refuse student involvement at any time.

PATIENT SIGNATURE _____**DATE**_____

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PRIVACY NOTICE

This privacy notice describes how your medical information may be disclosed and used by this practice. This notice also discusses your rights to access your medical information.
The HIPAA Privacy Rule allows your health information to be disclosed to carry out treatment, payment, and other healthcare operations. We are required to abide by the information outlined in this privacy notice. We reserve the right to update this policy as changes occur in the HIPAA Privacy Rule. HIPAA grants you the right to access and control your health information.

USES AND DISCLOSURES

Treatment: Your health information will be disclosed to provide, coordinate, and manage your healthcare. All providers in our practice may have access to your medical records. Additionally, our medical consultants and ultrasonographer review some records to assist us with your care. Your health information may be disclosed to any other physician or healthcare provider that may become involved in your care.
Healthcare Operations: Your health information will be used to support the business activities of the practice. Examples include, but are not limited to: quality assessment, employee reviews, nursing and midwifery student training, licensing, and other business activities. Health information may be shared in our group prenatal sessions.
Payment: Your health information will be used to obtain payment for services provided by this practice. Disclosures may be given to health plans, insurance providers, and collection agencies.
Business Associates: Your health information may be shared with third party business associates. Examples include billing and legal services. We have established written contracts that contain the terms that will protect your health information with all third-party business associates. All business associates must comply with HIPAA guidelines.
Disclosures Requires by Law and Workers Compensation: We are permitted to disclose your health information to comply with workers compensation laws and legal proceedings. If required, you will be notified of disclosure. The protected health information of members of the armed forces may be disclosed to authorized federal officials, under certain circumstances.
Abuse or Neglect: We may disclose your protected health information to the appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence.
Emergencies: If you are incapacitated, we may use our best judgement to disclose information that is only directly relevant to your care.
Research and Health Oversight: We are permitted to disclose your information to researchers with an institutional review board has reviewed a research proposal and established protocols to ensure your health information will be kept confidential. We are permitted to disclose your health information to a health oversight agency for activities authorized by law. Examples include: audits, investigations, and inspections.
Written Authorization: Unless not required by law, your written authorization will be required for all disclosures of your protected health information. You can revoke authorization at any time via written request. It is important to note that we are unable to undo any disclosures previously made with your authorization.
Voicemail: Employees may only leave detailed voicemail messages if the greeting appropriately identifies the patient or another person who is authorized to receive information regarding the patient. If there is not appropriate identification, only the minimum necessary information will be left. This includes the caller's name, practice name, and a contact number. Patients have the right to opt out of voicemail messages.

PATIENT RIGHTS

You have the right to inspect and copy your protected health information. You may obtain your medical record that contains medical and billing information. As permitted by federal or state law, we may charge you a reasonable copy fee to provide a copy of your records. You may request an amendment of your protected health information. We reserve the right to deny your request. If we deny your request for amendment, you have the right to file a statement of disagreement. We may provide you with a copy of any rebuttal. Federal law prohibits you from inspecting or copying psychotherapy notes and information compiled in reasonable anticipation of, or use of, civil or criminal proceedings, or administrative actions or proceedings.

PRIVACY COMPLAINTS/ CLIENT GRIEVANCES

Should you believe that your privacy rights have been violated, and wish to file a complaint, you may contact us by calling our office at (912)629-6262 and asking to speak with our privacy officer. The director or her designee will personally respond within 10 business days to any complaint registered by a client about any aspect of Family Health and Birth Center. You may also contact our accrediting organization, The Commission for the Accreditation of Birth Centers at 240 Independence Drive, Hamburg, PA 19526, phone number 1-877-241-0262. Unresolved complaints may be directed to the Georgia Department of Community Health, Health Facilities Regulation Division, Attention: Complaints, 2 Peachtree Street NW, Atlanta, GA 30303-3142, phone: 1-800-878-6442.

I have read the Privacy Notice and understand these policies.

PATIENT SIGNATURE _____**DATE**_____

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GYN HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record. Please complete ***ENTIRE*** form.

Name *(Last, First, M.I.):*				**DOB:**		
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Significant other name:						
Who do you live with?						

PERSONAL MEDICAL, SURGICAL HISTORY AND SOCIAL HISTORIES:
Please complete this portion of your health history in the ***patient portal PRIOR*** to your appointment. This is a very important part of your care and we want to make the most of your visit with the midwife by having the most updated and complete information. ***If the patient portal is not completed, we may be required to reschedule, or have you return for an additional visit to complete the appointment***.

What medications or supplements are you currently taking? _____
_____

Do you have any allergies to medications? ☐ Yes ☐ No If yes, list allergies:_____
_____

FAMILY HEALTH HISTORY:
Your family history is very important for certain health screening as well as anticipating your health care needs. Please ensure you complete this section in the patient portal PRIOR to your appointment.

OB/GYN HEALTH HISTORY

Pregnancy History: Total # pregnancy: ____ # Premature births _____ #miscarriages/ abortions: _____# term births?_____

Please answer all the questions below and write in any explanations or comments in the space provided

First day of last Menstrual Period:			
Last pap test:	Have you ever had an abnormal Pap test?		
Age period began?	Length of periods?	#days between periods?	
Do you have recent any changes in your periods?			
Are you sexually Active?	☐ Yes	☐ No	☐ One partner ☐ more than one partner ☐ Heterosexual ☐ Homosexual ☐ Bisexual
Do you use birth control?	☐ Yes	☐ No	What type?
Any history of Sexually Transmitted infection	☐ Yes	☐ No	☐ Gonorrhea ☐ Chlamydia ☐Trichomonas ☐ HPV ☐ Syphilis ☐ HIV
Do you or your partner have a history of herpes?	☐ Yes	☐ No	
Any abnormal vaginal bleeding or vaginal discharge?	☐ Yes	☐ No	
Any history of pelvic or vaginal infections?	☐ Yes	☐ No	
Any problems with intercourse?	☐ Yes	☐ No	

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OUR FINANCIAL POLICY / RELEASE AND ASSIGNMENT

Full payment is due at the time of service. We accept cash, checks, and credit cards. Our practice is committed to providing the best treatment for our clients, and our charges are reasonable and customary for our area.

I am responsible for payment regardless of the insurance company's arbitrary determination of reasonable and customary rates or decisions regarding non-covered services. I agree to pay collection fees associated with any outstanding balance on my account.

I hereby authorize The Midwife Group and Birth Center/Family Health and Birth Center, Inc. to release any of my medical records deemed necessary to process my insurance claim. I authorize payment of medical benefits to The Midwife Group/Family Health and Birth Center Inc., or its providers for services rendered to me. I fully understand that I am responsible for all charges incurred because of services rendered to me and any balance remaining after my insurance pays. I, the undersigned, a patient at this facility, hereby authorize the providers (and whomever they may designate as their assistants) to administer treatment as necessary. I hereby certify that I have read and fully understand this authorization for medical treatment. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

PATIENT SIGNATURE _____**DATE**_____

OR SIGNED FOR PATIENT BY _____**RELATIONSHIP** _____

Late Arrival

If a patient is more than **10 minutes late** for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day **if one is available.**
We will try to accommodate late-comers in the best manner possible but cannot compromise on the quality and timely care provided to our other patients.

- If a patient presents to the office **15 minutes late** for a scheduled appointment with our providers, the patient will be asked to reschedule their appointment.
- If you are a **New Patient** and you arrive at the scheduled appointment time and not early to complete your forms as instructed and it takes more than 10-15 minutes to complete the forms and the registration process, you may also be asked to reschedule.

Last Minute Cancelations and Missed Appointments

We require **24-hour notice** on all cancelations. As a courtesy to our patients, we attempt to confirm all appointments. We recognize that situations arise that are out of your control; however, it is imperative that you contact our office immediately to notify us of your cancelation in a timely manner.
Appointments canceled with less than a 24-hour notice or NO SHOW to your appointment will be subject to a $40.00 fee. ***We ask for your consideration and cooperation in scheduling your next appointment. Please understand that we are partners in your health care, and we are committed to offering you appropriate care when you need it.***

_____ _____

Signature **Date:**

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NAME	**DOB:**

Do you have or ever had any GYN problems such as: ☐ uterine abnormality · endometriosis ☐ infertility ☐ PCOS

Any menopause symptoms?	☐ Yes	☐ No	
Any breast lumps or abnormal nipple discharge?	☐ Yes	☐ No	
Do you have any history of physical or sexual abuse?	☐ Yes	☐ No	

SOCIAL HISTORY

Do you smoke or vape? · yes · no
If so. How many packs per day? _____ How many years? _____

Do you drink? · yes · no
If yes, what type of alcohol? · beer · wine · liquor How often? · Daily · weekly · monthly

Have you used drugs other than those required for medical reasons? · yes · no
☐ cannabis (marijuana, hashish) ☐ solvents (e.g., paint thinners) ☐ tranquilizers (e.g., Valium) ☐ barbiturates ☐ cocaine, ☐ hallucinogens (e.g., LSD) ☐ or narcotics (e.g., heroin).

What is your highest level of education? · GED · High School · Some college · College degree · advanced degree

Are you employed? · Yes · No Occupation: _____

Exercise	Do you exercise? Yes ☐ No ☐ What type of exercise do you enjoy? How often?				
Diet	Are you on any special diet or have dietary restrictions? If so what?			☐ Yes	☐ No
	Do you eat three meals a day? If no, how many?			☐ Yes	☐ No
	Do you have a working stove?			☐ Yes	☐ No
	Do you have running hot and cold water?			☐ Yes	☐ No
	Do you receive WIC?			☐ Yes	☐ No
	#meals you eat in an average day.	How much water a day?	How much caffeine a day?		

Reviewed By:_____ **Date:**_____

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ DATE: _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+
		TOTAL:		

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Hurt, Insulted, Threatened with Harm and Screaming (HITS)

Domestic Violence Screening Tool

Name:_____ Date:_____

How often does your partner?	Never	Rarely	Sometimes	Fairly Often	Frequently
1. Physically hurt you?					
2. Insult or talk down to you					
3. Threaten you with harm?					
4. Scream or curse at you					
	1	2	3	4	5
Total Score:					

Reviewed by:_____

Each item is score from 1-5. Range between 4-20. A score greater than 10 signifies that you are at risk of domestic violence abuse and should seek counseling or help from a domestic violence resource center.

Sherin, K. et.al. *HITS: A Short Domestic Violence Screening Tool for Use in a Family Practice Setting,* Family Medicine 1998;30(7):508-12.)

National Hotlines can connect clients to local resources and provide support.

For Free help 24 hours a day, call:

National Domestic Violence Hotline
1-800-799-SAFE (1-800-799-7233) TTY: 1-800-787-3224

Teen Dating Abuse Hotline
1-866-331-9474

Rape, Abuse, Incest, National Networks (RAINN)
1-800-656-HOPE (1-800-656-4673)

Georgia 24 Hour Statewide Domestic Violence Hotline
1-800-33HAVEN (1-800-334-2836) https://gcadv.org/get-help/

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DEFINITION OF A WELL-CARE VISIT

The focus of a well-care visit is preventive care**. <u>If tests or services beyond the scope of a well-care visit are provided, then additional charges may be incurred for those services</u>**. The choice to address both well-care and medical issues may be offered during the same visit for convenience, if the provider's schedule will allow. This is up to your provider so that they may stay on schedule and keep other scheduled patients from waiting. Although our office will assist you with your insurance processing, it is the patient's responsibility to understand their insurance benefits.

What is a Well-Care Visit?	
YES	NO
A review of your current health and medical history	Treatment or consultation for a specific medical condition
Counseling about ways to improve your health	Any service not considered part of a well-care visit
A physical exam tailored to your preventive care needs	
Referral or performance of screening tests, if needed (billed separately by providers who perform the service)	

Your scheduled appointment day is for an Annual Exam which is a well-care visit. Each insurance company has different contracts regarding group and individual coverage for well-care (preventive care) benefits. We do not know your contract so we cannot tell you if your insurance company is going to cover the charge for a well exam. Insurance plans typically do not pay for this service twice in less than one year regardless of where you have it done. If there is any question about when your last well-woman exam was, please contact the office where you last had one to ensure you have been scheduled appropriately with us. If your last well-woman exam was at our office, we can find the date of your last exam for you. If tests or services beyond the scope of a well-care visit are provided, then you may be required to pay a co-pay and may incur additional charges.

PATIENT SIGNATURE: _____ **DATE:** _____