CENTER FOR PELVIC HEALTH POLICIES AND PROCEDURES

AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT: As the patient, you have the right to be informed about your conditions and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s). I hereby request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions. I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns. In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV, hepatitis B or hepatitis C I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who was exposed. I have read or had read to me and fully understand this consent; I have had the opportunity to ask questions and had these questions addressed. I acknowledge that the practice of medicine is not an exact science. No one has guaranteed nor can anyone guarantee the results of the care to be provided.

CONSENT TO OBTAIN PRESCRIPTION HISTORY: I authorize The Center for Pelvic Health and Its Affiliated Providers to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

PATIENT FINANCIAL POLICY: I will pay for the care and services provided and not paid for by third-party payers, including co-pays and deductibles. It is my responsibility to understand my health insurance benefits and what is and is not covered and to address any coverage concerns with my insurance company prior to receiving treatment. It is my responsibility to provide current and accurate insurance information at each visit. I also understand payment is due at the time services are rendered. This includes, but is not limited to co-pays, co-insurance and unmet annual deductibles. The full patient financial policy is available at the front desk and online at our practice website, www.centerforpelvichealth.org.

DELINQUENT ACCOUNTS: We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing. If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT**:** I grant permission and consent to AdvancedHEALTH and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

MISSED APPOINTMENT FEE: I understand that I will be charged a $25.00 fee for any missed or cancelled appointment for which I did not provide at least a 24 hour notice of cancellation.

NOTICE OF PRIVACY PRACTICES: The practice's "Notice of Privacy Practices" describes ways in which we may use and disclose medical information. The notice also describes my rights and legal obligations with regard to my medical information. My signature below acknowledges that I have been given or offered a copy of the "Notice of Privacy Practices". A current copy of the Notice of Privacy Practices is also available on the practice's website.

Please initial below:

_____ **I have read the information on this form, Center for Pelvic Health Policies and Procedures, or have had it read to me. I have had the opportunity to ask any questions I might have.**

_____ **I have been provided or offered a copy of the Patient Financial Policy. I also understand that I may at any time access the policy online at the practice's website, www.centerforpelvichealth.org or obtain a printed copy at the office during regular business hours.**

_____ **I have been provided or offered a copy of the Notice of Privacy Practices. I also understand that I may at any time access the policy online at the practice's website, www.centerforpelvichealth.org or obtain a printed copy at the office during regular business hours.**

By voluntarily signing my name below, I indicate that I understand and accept each of these provisions.

_____ _____

Patient or Authorized Representative Signature Date

Patient Registration Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____

Home Phone: _____ Ok to Leave Message: Yes No

Cell Phone: _____ Ok to Leave Message: Yes No

Work Phone: _____

Date of Birth: _____ Marital Status: _____

Social Security #: _____

Race: __American Indian __Asian __Native Hawaiian __African American __White __Hispanic __Other

Ethnicity: __Hispanic __Not Hispanic

Primary Language: __English __Spanish __Other_____

Primary Care Doctor: _____

Doctor Who Referred You Here: _____

Primary Insurance: _____

ID #: _____ Group #: _____

Subscriber: _____ Date of Birth: _____

Secondary Insurance: _____

ID #: _____ Group#: _____

Subscriber: _____ Date of Birth: _____

NEW PATIENT FORM

Name: _____

Date of Birth: _____

What problems brought you to the office today? _____

Marital Status: _____ Who do you live with: _____

Occupation: _____ Tobacco: ☐ Yes _____PPD ☐ Never Smoked ☐ Former Smoker

Caffeine: ☐ Coffee ☐ Tea ☐ Soda ☐ More than 2 servings/day ☐ Less than 2 servings/day

Alcohol: ☐ None ☐ Daily ☐ Weekly ☐ Socially Only ☐ Rarely ☐ Drinks Alone

Other Substances / Recreational Drugs: ☐ Yes ☐ No _____

PAST MEDICAL HISTORY (please answer all questions with YES or NO)

Asthma:	☐ Yes ☐ No	Endometriosis:	☐ Yes ☐ No	Thyroid Disease:	☐ Yes ☐ No
High Blood Pressure:	☐ Yes ☐ No	Anemia:	☐ Yes ☐ No	Abnormal Pap Smears:	☐ Yes ☐ No
Stroke/TIA	☐ Yes ☐ No	Back Injury	☐ Yes ☐ No	Migraines	☐ Yes ☐ No
Diabetes:	☐ Yes ☐ No	Kidney Disease/Stones:	☐ Yes ☐ No	Sexually Transmitted Infections:	☐ Yes ☐ No

Additional: _____

REVIEW OF SYSTEMS (please answer all questions with YES or NO if you have experienced these symptoms recently)

Constitutional
Weakness: ☐ Yes ☐ No
Chills ☐ Yes ☐ No
Fever ☐ Yes ☐ No
Weight Change ☐ Yes ☐ No

Gynecologic
Heavy Menses ☐ Yes ☐ No
Irregular Menses ☐ Yes ☐ No
Painful Intercourse ☐ Yes ☐ No
Pelvic Pain ☐ Yes ☐ No
Hot Flashes ☐ Yes ☐ No

Genitourinary
Frequent UTI ☐ Yes ☐ No
Painful Urination ☐ Yes ☐ No
Blood in Urine ☐ Yes ☐ No
Urinary Leakage ☐ Yes ☐ No
Urinary Urgency ☐ Yes ☐ No
Waking>1 to Urinate ☐ Yes ☐ No

Gastrointestinal
Diarrhea ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
Heartburn ☐ Yes ☐ No
Bowel/Gas Leakage ☐ Yes ☐ No

Eyes
Glasses/Contacts ☐ Yes ☐ No
Double Vision ☐ Yes ☐ No
Blurry Vision ☐ Yes ☐ No

Ear, Nose, Throat
Hearing Change ☐ Yes ☐ No
Sore Throat ☐ Yes ☐ No
Sinus Pain ☐ Yes ☐ No

Psychiatric
Depression ☐ Yes ☐ No
Mood Changes ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No

Hematologic
Bleeding ☐ Yes ☐ No
Bruising ☐ Yes ☐ No

Respiratory
Shortness of Breath ☐ Yes ☐ No
Coughing Blood ☐ Yes ☐ No
Wheezing ☐ Yes ☐ No
Nose Bleeds ☐ Yes ☐ No

Cardiac
Chest Pain ☐ Yes ☐ No
Swelling ☐ Yes ☐ No
Irregular Heart Beat ☐ Yes ☐ No

Neurologic
Headaches ☐ Yes ☐ No
Fainting Spells ☐ Yes ☐ No
Memory Loss ☐ Yes ☐ No
Numbness/tingling ☐ Yes ☐ No

Skin
Rash ☐ Yes ☐ No
Hair growth/loss ☐ Yes ☐ No
Pigment Changes ☐ Yes ☐ No

Musculoskeletal
Joint Pain ☐ Yes ☐ No
Muscle Weakness ☐ Yes ☐ No
Unsteady Gait ☐ Yes ☐ No

Breast
Breast Lump ☐ Yes ☐ No
Breast Pain ☐ Yes ☐ No
Nipple Discharge ☐ Yes ☐ No

Endocrine
Heat/Cold Intolerant ☐ Yes ☐ No
Excessive Thirst ☐ Yes ☐ No
Increased Urination ☐ Yes ☐ No

FAMILY HISTORY (please answer all questions with YES or NO)

Father: ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Mother: ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Brother(s): ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Sister(s): ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Son(s): ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Daughter(s): ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Paternal Grandfather: ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Paternal Grandmother: ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Maternal Grandfather: ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis
Maternal Grandfather: ☐ Deceased ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Osteoporosis

ADDITIONAL: _____

Patient Signature: _____ Date: _____

CURRENT MEDICATIONS (include strength & directions for all medications including over the counter)
Indicate by marking here if no medications taken regularly _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

PHARMACY: _____ PHONE: _____
LOCATION: _____

PAIN CLINIC – Are you currently being treated by a pain specialist? ___Yes ___No
If so, please list the doctor/clinic information and phone number below:

_____

ALLERGIES & REACTION (please list current known drug allergies including betadine and latex and the reaction)
If no known drug allergies (including betadine and latex) please indicate by checking here: No Known Allergies _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

PAST SURGERIES (please list all past surgeries including date performed if known) Indicate by marking here if none ____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

100 Covey Drive, Suite 205
Franklin, TN 37067

1. By signing this Authorization, I authorize Center for Pelvic Health to disclose protected health information to the following individual(s) for the purpose of keeping them informed about my condition and treatment, and I understand that these disclosures are in addition to those disclosures described in the Notice of Privacy Practices:

Name: _____ Relationship: _____

Method of Communication: ☐ Any ☐ Written Only ☐ In Person Only

Name: _____ Relationship: _____

Method of Communication: ☐ Any ☐ Written Only ☐ In Person Only

2. May we contact you regarding your protected health information, health status, appointments, and test results?

____ You may contact me by email, my address is _____

____ Do not contact me by email for this purpose.

____ Yes, you may contact me by phone, my daytime phone numbers are:
(_____)_____ (_____)_____

Can we leave a message regarding your protected health information at the numbers you provided above?
_____ Yes _____ No

3. May we send you newsletters and other marketing information by email?

____ Yes, please use the following email address: _____

____ No, I do not want to be sent newsletters or other marketing information.

I understand that I do not have to sign this Authorization in order to receive treatment and revocation of any authorizations will not affect my ability to continue receiving treatment.

I understand that once my health information is disclosed to a third party, that party may disclose my information to other parties and any redisclosures of my health information by a third party may no longer be protected under federal or state privacy laws.

I understand that protected health information may include information relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection.

I understand that this Authorization will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this Authorization to the address above. However, any disclosure that occurred prior to the date of the revocation will not be affected.

I understand that no protected health information (other than as outlined by the Health Insurance Portability and Accountability Act and in the Practice Notice of Privacy Practices, a copy of which I have received) can be released to anyone, including spouses, parents, other family members, significant others or friends without this Authorization.

Patient Signature: _____ Date: _____

Printed Patient Name: _____ DOB: _____

Signature of Patient Representative: _____ Date: _____

Printed Name of Patient Representative: _____ Relationship: _____

100 Covey Drive, Ste 205
Franklin, TN 37067
Phone: 615-284-4664
Fax: 615-284-4668

Authorization for Release of Medical Records

Patient: _____ Date of Birth: _____
Social Security Number: _____ Phone #: _____

1. I authorize _____ (phone_____)
(fax_____) to release my health information to the Center for Pelvic Health.

2. The purpose for the use or disclosure is as follows: Continue Medical Care

3. The type and amount of information to be used or disclosed is as follows: health information covering treatment from: _____ to _____
Date of Service Date of Service

___Copy of Complete Record
___Abstract to include:
(H&P, Progress Notes, Procedure Reports, Consult
Discharge Summary, Diagnostic Testing, Dictations)
___History and Physical
___Consultation
___Discharge Summary
___Operative Procedure Report
___Pathology Report
___Laboratory Report
___X-Ray Report

4. I understand that my health information may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for drug and alcohol abuse.

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Practice. I understand that my revocation will not apply to the extent that CPH has taken in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. CPH may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that if I authorize CPH to disclose my health information, the health information may be subject to re-disclosure by the recipient and may no longer be protected by certain federal privacy regulations.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient

_____ _____
Witness Date