

Balcones Ob/Gyn Patient Information

Nancy Binford, MD

The intent of this handout is to provide you with concise information regarding the conditions, expectations, and procedures of our office and staff. The policies and procedures listed below have been instituted due to the many continuing changes in healthcare, our growing practice, and our desire to respond to these changes in a way that will continue to provide you with the utmost care.

APPOINTMENTS:

We will make every effort to schedule your appointment in an appropriate time frame. Yearly well-woman exams will be scheduled within one to three months of calling. Scheduling these routine exams in that time frame is important in order to allow patients with urgent medical needs to be seen in a shorter time frame.

If you are due for your well-woman exam and have an urgent problem, we will make two appointments for you—an earlier appointment for the problem, and a later appointment for the well-woman exam.

For women who are due for their annual mammogram before a well-woman appointment, we will not mail you an order in advance of that appointment. It is important to examine the breasts each year in advance of the mammogram so that we may order the proper type of testing. If you believe that there is a breast problem requiring immediate attention, we will make two appointments for you—an earlier appointment for the breast problem, and a later appointment for the well-woman exam.

LAB TESTING AND RESULTS:

For all testing done with a blood sample, you may have the labs drawn in our office. Most labs have multiple lab locations for your convenience and operate on a walk-in basis if you choose to have them drawn elsewhere. Please let us know in advance of getting your blood drawn which lab your insurance company considers in-network: Quest, Clinical Pathology, LabCorp, or Seton. Please also confirm that the lab order given to you by our office is for the correct lab company covered by your insurance company.

For any lab testing done during an exam (such as cultures, Pap smears, and biopsies), we will send the sample to the lab company typically covered by your insurance. Again, please let us know at your visit if your insurance does not cover one of the three lab companies above before we send in the sample.

Pap smear results will be reported to you by mail within two weeks of testing if normal. All abnormal results will be called to you in the same time frame. Mammogram results will be reported to you by mail by the radiology facility whether normal or abnormal. We will be sent a report, and we will call you within two weeks if the report shows abnormal findings.

All lab tests done for problem visits will be called to you within two weeks. All screening lab results will be mailed to you within two weeks. All lab tests done in pregnancy will be reported to you at the following visit if normal and called to you if abnormal.

NURSE CALL-BACKS:

If you have a medical question that cannot wait until your appointment, you may leave a message for our nurse. Your call will be prioritized relative to all calls received by the nurse. Problems of an urgent nature will be attended to first. Calls of a less urgent nature may be returned later the same day or the following day. You may choose the phone option for an emergency when calling **if and only if** you have one of the following types of true emergencies:

- Bleeding in pregnancy
- Severe pain when pregnant
- Leaking possible amniotic fluid in pregnancy
- Having painful contractions every 5 to 10 minutes in pregnancy
- Decreased fetal movement after 28 weeks of pregnancy
- Hemorrhaging when not pregnant (soaking a pad every hour for 4 hours)
- Severe pain when not pregnant to the degree that you are confined to bed

MAIL-ORDER PRESCRIPTIONS AND MEDICATION REFILL REQUESTS:

Mail-order pharmacy use by our patients has greatly increased. It is our policy that our nursing staff cannot fax or call in medication orders to mail-order pharmacies. Our intention is that their time may be dedicated to responding to your phone calls about your medical concerns rather than spent on the inordinate amount of paperwork and lengthy phone calls required by the mail-order pharmacies. We will provide you with a written prescription for your medications and we ask that you mail or fax this in yourself.

If you need a refill of your medication, please do not call the office. We ask that you call your pharmacy and request a refill. The pharmacy will then fax this request to our office. These faxes are checked daily, prioritized by importance and the time received, then faxed back to the pharmacy within 48 hours.

OFFICE VISIT PUNCTUALITY:

We value all of our patients and we appreciate that your time is valuable. Our goal is that we are as punctual as possible and see you for your appointment in a timely manner. However, circumstances arise on a daily basis, which compromise our ability to be punctual. It is our hope that you will be as understanding as possible with the demands on our staff, especially due to obstetrical emergencies as well as deliveries which require the physicians to attend to patients at the hospital throughout the day. We will do our best to communicate to those waiting in our waiting room when delays occur. In addition to the needs of patients at the hospital, patients with urgent problems that must be taken care of the same day are asked to come to the office on a daily basis. Again, our intention is to provide all of our patients with the utmost in medical care. We hope that you will be understanding of these dynamics as they are an inherent part of any ob/gyn practice which affect our punctuality.

First time reviewed: Signature: _____ Date: _____

FINANCIAL POLICY

- **Co-payments, deductibles and/or coinsurance are due at the time of service.** We accept Cash, Personal Check, Care Credit, MasterCard, and Visa. If you are not prepared to pay the required amount, we are required to reschedule the appointment. The estimated financial responsibility for scheduled services will be due **prior** to these services being provided. Any remaining balance after your health plan pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to the appointment, the account will be notated as private pay and payment will be due in full. *Account balances over 90 days with no payment activity will be reported to the credit bureau(s).* Initials _____
- **Your insurance policy is a contract between you and your insurer. Do not assume your policy covers everything or pays at 100%. It is your responsibility to know what your policy covers and what it does not. We cannot quote your benefits.** Any item deemed "non-covered" by your insurance carrier will be your financial responsibility. This includes lab designation and payment. Any disputes about payment must be resolved between you and your insurer. You are responsible for ensuring a properly dated referral and/or authorization if required by your insurer for services being provided. You are also responsible for payment if your claim denies for lack of referral/authorization. Failure to provide accurate insurance information within 3 days from the date of service will result in the balance becoming your financial responsibility. Initial _____
- As a courtesy to you, we will file primary participating insurance for you with proper assignment. Any additional insurance policies will be yours to file with receipt from our office. Please bring your primary insurance card with you to every visit. I understand that all remaining balances are my responsibility to satisfy prior to additional services being rendered. Initial _____
- This office is not party to legal disputes. The financial responsibility rests with the patient or parent/guardian for patients under 18 years of age. Initial _____
- A \$35.00 fee will be assessed for all returned checks. Initial _____
- We confirm appointments 48 hours in advance. Please notify our office within 24 hours before scheduled appointment to avoid a \$25.00 cancellation fee. Initial _____
- Payments & credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service. Refunds over \$50 will be provided within 30 days from the date all outstanding claims are satisfied. Credit balances less than \$50 will be available and processed upon request of the patient. Initial _____

ASSIGNMENT OF BENEFITS

I request payment of the medical benefits, otherwise payable to me, directly to *Balcones Obstetrics & Gynecology, PA* for services provided by them.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

Responsible Party Printed Name (Must be 18 or over)

Date

Responsible Party Signature (Must be 18 or over)

Date

BALCONES OB/GYN

Nancy Binford, MD

Name _____ Date _____ Date of Birth _____ Age _____

MENSTRUAL

OBSTETRICAL

First day of last menstrual period:	Total # of pregnancies:	Total # of live births:
Age of first period:	Total # of miscarriages :	Total # of abortions:
Regular cycles? Yes No	Any cesarean sections? Yes No	How many?
How many days between the start of each period?	Any pregnancy complications? Yes No	
Total flow : light medium heavy	Please explain:	
How many days do you bleed with each period?		
Do you pass any blood clots? Yes No		
Pain/cramps? Normal Severe		
Bleeding between periods? Yes No		
Recent changes? Yes No		
Please describe:		

GYNECOLOGY

Please indicate if you have a history of any of the following:			
Abnormal Pap smears	Yes	No	When? If treatment/surgery was required, what kind?
Pelvic Inflammatory Disease	Yes	No	When?
Sexually Transmitted Disease	Yes	No	Which one? When?
Fibrocystic Breast Condition	Yes	No	
What is your method of contraception?	If hormonal birth control, which one?		
When was your last Pap smear?			
When was your last mammogram?	Last bone density test?	Last colonoscopy?	

SURGERY

HOSPITALIZATION

Have you ever had surgery? Yes No	Have you ever been in the hospital for an illness? Yes No
List date, place, & surgery below:	List date, place, & illness below:

REVIEW OF SYSTEMS

Do you <i>currently</i> have any of these symptoms?	
Weight loss/gain #lbs. # months	Heartburn/bloating Yes No
Fever Yes No	Bleed easily Yes No
Night sweats/hot flashes Yes No	Bleeding from source other than vaginal Yes No
Rash Yes No	Joint pain Yes No
Headaches Yes No	Leg pain Yes No
Visual changes Yes No	Fatigue Yes No
Shortness of breath Yes No	Urinary incontinence Yes No
Cough Yes No	Pain with urination Yes No
Chest pain Yes No	Mood swings Yes No
Abdominal pain Yes No	Insomnia Yes No
Back pain Yes No	Vaginal dryness Yes No
Nausea/vomiting Yes No	Vaginal itching/irritation Yes No
Diarrhea/constipation Yes No	Vaginal discharge Yes No

SOCIAL HISTORY

Do you smoke? If so, how many packs per day?	Are you single, married, divorced, widowed?
Do you drink alcohol? If so, how many drinks per week?	Are you a victim of domestic violence?
Do you use drugs? If so, what kind?	Occupation : Employer:

PERSONAL MEDICAL HISTORY

Do you have a history of any of the following?			Please name your family doctor:		
Describe			Describe		
Measles, chicken pox	Yes	No	Blood clot in legs	Yes	No
Anemia	Yes	No	Blood clot in lungs	Yes	No
Bladder/kidney disease	Yes	No	Breast lump	Yes	No
Bone/joint disease	Yes	No	Diabetes	Yes	No
Bowel disease	Yes	No	Heart disease	Yes	No
Lung disease/asthma	Yes	No	What type?		
Neurologic disease	Yes	No	High blood pressure	Yes	No
Rheumatic fever	Yes	No	Migraine headaches	Yes	No
Stomach ulcer/acid reflux	Yes	No	Varicose veins	Yes	No
Tuberculosis	Yes	No	Stroke	Yes	No
Pneumonia	Yes	No	Cancer	Yes	No
Liver disease/hepatitis	Yes	No	What type? When?		
Thyroid disease	Yes	No	Other diseases not listed above:		
Depression/anxiety/other	Yes	No			

FAMILY MEDICAL HISTORY

Has a close relative had a history of any of the following?	Yes	No	Which relative(s)? (i.e. father, maternal grandmother, etc.)	(for office use only) Fam. Hx. reviewed:
Breast cancer	Yes	No		
Ovarian cancer	Yes	No		
Colon cancer	Yes	No		
Other cancer Type?	Yes	No		
Diabetes	Yes	No		
High blood pressure	Yes	No		
Heart disease	Yes	No		
Stroke	Yes	No		
Thyroid disease	Yes	No		
Osteoporosis	Yes	No		

MEDICATIONS

Please list any medications you take currently including all prescribed medications as well as any over-the-counter medications for weight loss, any pain relievers (like Tylenol, ibuprofen, & aspirin), antacids, laxatives, supplements, herbal remedies, etc.

ALLERGIES

Are you allergic to any medications?	Yes	No
If so, please list:		

IMMUNIZATIONS

Have you had the HPV vaccine (Gardasil)?	Yes	No	If so, when?	Did you get all 3 shots within 6 months?	Yes	No
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What is the reason for your visit today? _____

Patient/Guardian signature

Date

*Balcones Obstetrics & Gynecology, PA
3705 Medical Parkway, Ste 540
Austin, Texas 78705*

GENERAL INFORMATION

Patient Name (please print): _____

Patient Email: _____

Preferred pharmacy: _____ Pharmacy location: _____

RELEASE OF INFORMATION

By signing in the spaces below I understand these authorizations will remain in effect until a written change request is received by Balcones Obstetrics & Gynecology, PA. I understand I am responsible for updating the office promptly of any changes in the phone numbers and/or home address on file.

I authorize the staff of Balcones Obstetrics & Gynecology, PA to leave detailed health information, which may be confidential, at the following phone number(s): _____

Patient Signature: _____ Date: _____

I authorize the staff of Balcones Obstetrics & Gynecology, PA to send lab results to my current home address on file.

Patient Signature: _____ Date: _____



PATIENT AGREEMENT: Choosing Visit Type(s)

This form is to **clarify the type of office visit(s)** that you will have today. A Wellness Visit or Well Woman Visit (Preventive Services) includes coordinating health screening, performing a complete physical exam (including a breast and pelvic exam), obtaining a pap smear (if indicated), and refilling any existing prescriptions such as birth control pills or hormone replacement. A Problem Visit addresses any symptoms, problems, or concerns that you may have (such as pelvic pain, abnormal periods, or menopause symptoms), or anything abnormal in your history or discovered on exam.

Please understand that by government rules, a Problem Visit is a separate service to your Wellness Visit, may fall under different benefits, and may leave you **owing a copay** even if there would not be a co-pay for a Wellness Visit only. And, you will be financially responsible for any additional services provided.

Please understand we are contractually obligated to code your visit and bill your insurance company based on the actual services we provide during your visit. Be aware that we cannot modify these codes later in an effort to get your insurance to pay for non-covered services.

Please indicate the type of visit you wish to have today:

_____ **Wellness Visit only**

_____ **Problem Visit only**

List Problems: _____

Patient Name: _____

Date: _____

Patient Name: _____

Date of Birth: _____

Date this form was completed: _____

INSTRUCTIONS: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father'/paternal side. Next to each statement please list the relationship to you and the age of diagnosis. You and the following family members should be considered when completing this form:

Mother, Father, Brother, Sister, Children, Paternal Aunt/Uncle, Maternal Aunt/Uncle, First Cousin, Niece/Nephew, Maternal Grandmother/Grandfather, Paternal Grandmother/Grandfather

Each statement should be answered individually so you may list the same cancer diagnosis more than once. This is a screening toll for the common features of hereditary breast and ovarian cancer syndrome and Lynch syndrome. Share this information with your healthcare professional to determine your hereditary cancer risk.

COLON and UTERINE CANCER			SELF	FAMILY MEMBER			AGE AT DIAGNOSIS	
Y	N	Uterine(endometrial) cancer before age 50						
Y	N	Colorectal cancer before age 50						
Y	N	Ovarian, stomach, kidney/urinary tract, brain, or small bowel cancer						
Y	N	Two or more Lynch syndrome cancers						
BREAST and OVARIAN CANCER			SELF	FAMILY MEMBER			AGE AT DIAGNOSIS	
Y	N	Breast cancer at age 50 or younger						
Y	N	Ovarian cancer						
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family						
Y	N	Male breast cancer						
Y	N	Triple negative breast cancer (ER-, PR-, HER2-, pathology)						
Y	N	Pancreatic cancer with breast cancer or ovarian cancer in the same person or on the same side of the family						
Y	N	Ashkenazi Jewish ancestry with breast, ovarian, or pancreatic cancer in the same person or on the same side of the family						

Have you or any member of your family ever been tested for hereditary risk of cancer?
