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

PATIENTS NAME: _____
LAST FIRST M

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PRIMARY PHONE: _____ **SECONDARY PHONE:** _____

SOCIAL SECURITY #: _____ **DATE OF BIRTH:** _____/_____/_____

MARITAL STATUS: S, M, D, W **DRIVER'S LICENSE #:** _____

EMPLOYER: _____ **OCCUPATION:** _____

EMERGENCY CONTACT: _____ **CONTACT #** _____

EMAIL ADDRESS: _____

PRIMARY INSURANCE ***PLEASE COMPLETE THIS SECTION AND PRESENT YOUR CARD TO THE FRONT DESK ***

INSURANCE COMPANY: _____ **PHONE #:** _____

POLICY #: _____ **GROUP #:** _____

POLICY HOLDER'S NAME: _____ **DATE OF BIRTH:** _____

POLICY HOLDER'S SS#: _____ **RELATIONSHIP TO PATIENT:** _____

SECONDARY INSURANCE
INSURANCE COMPANY: _____ **PHONE #:** _____

POLICY #: _____ **GROUP #:** _____

POLICY HOLDER'S NAME: _____ **DATE OF BIRTH:** _____

POLICY HOLDER'S SS#: _____ **RELATIONSHIP TO PATIENT:** _____

I acknowledge that I have been read, understand and been offered a copy of the HIPAA policies of Balcones Obstetrics & Gynecology, PA.

I authorize qualified staff to perform upon me, rehabilitation, therapy and/or any other care including treatment necessary to improve my well being. I acknowledge that no guarantees can be made to me as to the outcome of treatment.

I authorize my insurance benefits to be paid directly to Balcones Obstetrics & Gynecology, PA realizing I am responsible to pay non-covered and/or denied services. In the event that my insurance carrier denies payment for any reason, I acknowledge that I am responsible for payment of services provided to me.

I authorize the release of information to my insurance carrier named above concerning my medical condition and for the purpose of claims processing. I also authorize the release of medical information to my referring physician and any physician I am recommended to see for continuation of care. I understand that the release of information will only consist of medical records belonging to Balcones Obstetrics & Gynecology, PA.

PATIENT SIGNATURE: _____ **DATE:** _____

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: _____

Balcones Obstetrics & Gynecology, PA
3705 Medical Parkway, Suite 540, Austin, Texas 78705
Phone (512)452-8888 Fax (512)452-8889

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 <u>every</u> 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

First day of last menstrual period:
Age of first period:
Regular cycles? Yes No
How many days between the start of each period?
Total flow : light medium heavy
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:

OBSTETRICAL

Total # of pregnancies: Total # of live births:
Total # of miscarriages : Total # of abortions:
Any cesarean sections? Yes No How many?
Any pregnancy complications? Yes No
Please explain:

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

Have you ever had surgery? Yes No List date, place, & surgery below:

HOSPITALIZATION

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

REVIEW OF SYSTEMS

Do you *currently* 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?		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

What is the reason for your visit today?_____

_____

_____

Patient/Guardian signature Date

Balcones Obstetrics & Gynecology, PA
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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: _____

BALCONES
OBSTETRICS & GYNECOLOGY, PA

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: _____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Date of Birth: _____ Age: _____
Height: _____ Weight: _____ Age at Frist Period: _____ Age at Delivery of First Child: _____
Are you menopausal: YES or r NO Have you ever used hormone replacement therapy: YES or NO
Has anyone in your family had genetic testing for a hereditary cancer syndrome: (Ex: (BRCA or Lynch)? YES or NO

Please mark below if there is a **personal or family history** of any of the following cancers and **indicate family relationship** along with **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

BREAST AND OVARIAN CANCER (BRCA)

		Type	You (age of diagnosis)	Siblings/Children (age at diagnosis) *Ex: Brother 36yrs*	Mother's Side (Who + age at diagnosis) *Ex: Aunt 44yrs*	Father's Side (Who + age at diagnosis) *Ex: Grandfather 65yrs*
Y	N	Breast cancer				
Y	N	Breast cancer in both breasts OR multiple primary breast cancers				
Y	N	Ovarian cancer				
Y	N	Male breast cancer				
Y	N	Are yo of Jewish descent				

COLON AND UTERINE CANCER (Colaris)

Y	N	Uterine (endometrial) cancer				
Y	N	Colon cancer				
Y	N	Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer				
Y	N	10 or more colon polyps found in a lifetime				

OTHER CANCERS

Y	N	Prostate cancer (BRCA)				
Y	N	Pancreatic cancer (Col/BRCA)				
Y	N	Melanoma (BRCA)				

Patient Signature: _____ Date: _____

For Office Use Only:

BRCA/Lynch Testing Indicated? YES NO
Patient offered hereditary cancer testing? YES NO If YES: ACCEPTED DECLINED
Follow-up appointment scheduled? YES NO Date of Appointment: _____

Physician Signature: _____ Date: _____

BRCA - Personal or Fam. History	**BRCA - Personal or Fam. History**	**Lunch Syndrome (Colon/Endo)**
One person with (out of 2nd degree) * Breast cancer at 45 or younger * Ovarian cancer at any age * Male breast cancer at any age * Breast cancer + Jewish heritage * Bilateral breast at 50 or younger * Triple Neg Br.Ca at 60 or younger	Two persons with (out to 3rd degree) * 2 Breast cancers, w 1 at age 50 or younger * Breast & ovarian (any age) Three persons with (out to 3rd degree) * Breast and/or ovarian and/or pancreatic (any age)/aggressive Prostate	Personally affected with: * Colon or endometrial at age 50 or younger Family hisotory of Colon, endometrial, or + another Lynch cancer (out of 2nd degree) (gastric, ovarian, brian, kidney, small bowel) * 2 or more Lynch cancers, 1 dx at 50 or younger