Genoveva Nicoleta Prisacaru, MD, FACOG
Obstetrics & Gynecology
phone 512.442.2300
Fax 512.442.2303

PATIENT INFORMATION

Name _____
Last First Middle Maiden

Address_____
Street City State Zip

SS # _____-_____-_____ DOB_____ Age_____ Race: _____

Home Phone_____Work #_____ Marital Status: M S W D SEP

Occupation_____
Employer Position

Address_____

In case of emergency, notify:_____

Phone number_____ or _____

Next of kin not living at your address_____

Address_____ Phone #_____

Spouse Name_____DOB_____

Spouse Employer_____Phone#_____

Insurance Information (PATIENT TO COMPLETE)

	Primary	Secondary
Insurance Company	_____:	_____
Policy/member #	_____:	_____
Group Number	_____:	_____
Policy Holder	_____:	_____
Employer of policy holder	_____:	_____

Were you referred by anyone? YES NO If so, Who?_____

Primary Doctor's name _____

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Acknowledgement of Receipt
Of Practice Notice and Record of Disclosure

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

I understand that as a part of my healthcare, Seven Hills Women's Health originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, as well as plans my future care or treatment. I understand that as a part of Seven Hills Women's Health's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize a representative or my physician to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Seven Hills Women's Health in writing.

Patient/Parent Signature _____ Date: _____

Print Name: _____ Birth date of patient: _____

Healthcare entities must keep records of PHI disclosures. Information provided below, if completely properly, will constitute an adequate record.

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close personal friend(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If we need to reach you regarding test results between 8-5, M-F, how many we reach you? Please check all that apply:

- ❑ Home phone _____
  - ❑ Leave a message with detailed information
  - ❑ Leave a message with call back number only
- ❑ Cell phone _____
  - ❑ Leave a message with detailed information
  - ❑ Leave a message with call back number only
- ❑ Work phone _____
  - ❑ Leave a message with detailed information
  - ❑ Leave a message with call back number only
- ❑ Written communication
  - ❑ Mail to my home address

Should we need to reach you for an emergency, which number is best? (Please circle)

Home Cell Work Other _____

Do we have your permission to send you test results via secured encrypted email? Please circle Yes No

Email address: _____

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices.

I certify that I have read and been offered a copy of the Patient Information Privacy Policy.

Signature of Patient / Legal Guardian _____ Date: _____

(To be completed if patient refuses to sign acknowledgement)

Date: _____ *Name of person providing notice:* _____

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MEDICAL RELEASE

Patient Identification

Printed Name:_____ Date of Birth: _____

Address: _____ Social Security #:_____

_____, TX, _____zip Hm phone: _____ Cell phone:_____

Covering the Period of Health Care from (date) _____to (date) _____

Please check type of information to be released:

▫ Entire medical record	▫ Pathology report	▫ Discharge summary
▫ History and physical exam	▫ Consultation reports	▫ Progress notes
▫ Laboratory test results/reports	▫ X-ray reports	▫ X-ray films/images
▫ Operative report	▫ Emergency room record	▫ Itemized bill
▫ Other (specify)		

Purpose of Request

▫ Treatment or consultation	▫ At the request of the patient	▫ Billing or claims payment
▫ Other (specify)		

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing and /or other sensitive information, I agree to its release.
Check one: ® Yes ® No _____Initials

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.
Check one: ® Yes ® No _____Initials

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Seven Hills Women's Center, PLLC, 4007 James Casey Street, Suite A-100, Austin, Texas 78745. Unless revoked, this authorization will expire on the following date or event_____. If no expiration date is set forth, this authorization will expire 180 days from date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize Seven Hills Women's Center, PLLC, to use and disclose the protected health information specified above.

Person Authorized to Release Information

Printed Name:_____ Phone: _____

Address: _____

Signature: _____ Date:_____

Authority to Sign if not patient: _____

Identity of Requestor Verified via: ***® Photo ID*** ***® Matching Signature*** ***® Other, specify*** _____

FINANCIAL POLICY

FINANCIAL POLICY ACKNOWLEDGEMENT

Seven Hills Women's Health has preferred provider contracts with most major insurance companies. Please contact your insurance company to determine if our practice has a contract with your insurance company. Any financial portion that remains will be the patient's responsibility.

DUE AT TIME OF SERVICE/ PRIOR TO SURGERY

According to the patient's insurance, all coinsurances, copays, or deductibles are due at the time of service. We accept cash, personal check, Visa, MasterCard, American Express, and Discover cards as methods of payment. If the patient cannot provide the copay amount on the date of service, the patient will be asked to reschedule. The office will gather as much of the patients benefit information as we can, and calculate any financial responsibility for services **PRIOR** to services being provided. Any further charges your insurance decides are patient responsibility will be paid upon receipt of a statement. If the estimate paid by the patient is greater than what the insurance decides is proper, the amount will be properly refunded to the patient. If insurance coverage cannot be verified before the appointment, cost of the services provided should be paid in full by the patient.

PATIENT INSURANCE PLAN

The insurance policy contract is between the patient and insurance. Please do not assume that your health insurance will cover 100% of services provided. It is the patient's responsibility to be aware of what their policy covers. Any service deemed as "non-covered" by the insurance company becomes the patient's financial responsibility. Patient is responsible for charges if the insurance provided is not valid on the date of service. It is the patient's responsibility to inform the office of any changes with your insurance. If the patient makes any changes to their insurance policy and does not inform the office, the patient will be responsible for all charges.

POLICY FOR OBSTETRIC CARE

Unlike other types of services, prenatal care is billed ***globally*** and will be billed at the end of your pregnancy, **after delivery**. Prenatal care includes your routine office visits and delivery charges. During your pregnancy, physicians may order additional studies, such as ultrasounds or non-stress tests. These services will be billed to your insurance at the time of the service, and are not included in the global prenatal care fee. Additionally, if you are seen for any problem or condition unrelated to your pregnancy, we are required to bill for the office visit. You may be responsible for co-pays and/or additional fees for these services, which will be determined by your contract with your insurance. Please be aware of the cost of delivery. Some insurance companies apply part of the delivery charges as a co-insurance and/or deductible. This balance is considered part of the total reimbursement to the doctor, and will be your responsibility. After your initial obstetric visit, our office will verify your benefits and make you aware of your total responsibility. ***We require payment in full by the end of the 20 week of pregnancy.***

PRIMARY, SECONDARY, TERTIARY

It is patient responsibility to inform the office of ALL existing insurances. Failure to provide all policies covering the patient will result in patient financial responsibility. If the patient does not have insurance card available at appointment, the patient must reschedule for a day when they can provide their insurance card with driver's license.

SELF-PAY If you will be self-paying for your services, payment is due in full at the time of service. If you are unable to pay for necessary medical services, you may be eligible for a

payment plan through Care Credit. It is your responsibility to inform the office of your financial situation and create a payment plan with our billing department.

PRESCRIPTION REFILLS
If you would like a refill on a previously prescribed non-narcotic, non-regimen based medication ***without a follow-up visit***, a $25.00 fee will apply to refill the requested medication. The fee will be waived if a follow-up visit is performed.

COLLECTION SERVICES
All balances reaching 90 days past due may be sent to a collection agency. In the event that external collection services become necessary to obtain payment on delinquent accounts, you will become responsible for all such collection agency fees.

RETURNED CHECKS
A $35.00 fee will be issued for all returned checks.

NO SHOW/ MISSED APPOINTMENTS
A $40.00 fee will be assessed for failure to inform the office of an appointment cancellation. To cancel an appointment, contact the office no less than 24 hours prior to scheduled appointment. Failure to arrive within 15 minutes of a scheduled appointment will result in a missed appointment.

SURGERY CANCELLATION
A $100.00 fee will be assessed for cancelling a scheduled surgery.

MEDICAL RECORDS/ FORM FEES
We will provide copies for your records within 15 days of receipt of a signed records release and the $25.00 charge for copies. There is also a fee of $25.00 for completion of such forms as FMLA, insurance, disability, etc. These forms will be completed within 7-10 business days. Fees must be paid prior to completion of any form.

TERMINATION FROM OUR PRACTICE
Our office values its patient relationships and wants to protect our patients' rights. We terminate patient relationships only with cause and after careful consideration. Reasons for termination may include: repeatedly not showing up for scheduled appointments; not complying with recommended medical care; failure to render payment or failure to request a budget payment plan in a timely manner.

I have read, understand and agree to abide by the terms stipulated in the practice policies above. I understand that the charges incurred at or through Seven Hills Women's Health are my responsibility and that my insurance coverage is a contract between the insurance company and myself. I authorize medical care and I accept the financial responsibility incurred. I am responsible for all fees and will ensure the charges are paid in reasonable time. I authorize the release of any medical or other information necessary to process any claims. I have read and fully understand the office policies of Seven Hills Women's Health and agree to the terms. I also understand that the terms of these financial policies may be amended by the practice at any time without prior notification.

_____ _____

Signature (must be over 18) Date

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
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** and **AGE at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

BREAST AND OVARIAN CANCER (BRCA)

			You (age at diagnosis)	Siblings / Children (age at diagnosis) *Ex: Brother 36 yrs*	Mother's Side (Who + age at diagnosis) *Ex: Aunt 44 yrs*	Father's Side (Who + age at diagnosis) *Ex: Grandma 65 yrs*
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 you 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's 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: _____

MD Signature: _____ Date: _____

BRCA – Personal or Fam. History	**BRCA – Personal or Fam. History**	**Lynch Syndrome (Colon/Endo)**
One person with (out to 2nd degree) • Breast Cancer at 45 or younger • Ovarian Cancer at any age • Male breast cancer 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 ≤ 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 ≤ 50 or younger Family History of Colon, Endometrial, + another Lynch Cancer (out to 2nd degree) (gastric, ovarian, brain, kidney, small bowel) • 1 or more Lynch cancers, 1 dx ≤ 50

Patient Addressograph

DATE _____

NAME _____
LAST FIRST MIDDLE

ID # _____ HOSPITAL OF DELIVERY _____

NEWBORN'S PHYSICIAN _____ REFERRED BY _____

PRIMARY PROVIDER/GROUP _____

FINAL EDD _____ ADDRESS _____

BIRTH DATE MONTH DAY YEAR AGE RACE MARITAL STATUS S M W D SEP	ADDRESS
OCCUPATION EDUCATION (LAST GRADE COMPLETED)	ZIP PHONE (H) (O)
LANGUAGE ETHNICITY	INSURANCE CARRIER/MEDICAID #
HUSBAND/DOMESTIC PARTNER PHONE	POLICY #
FATHER OF BABY PHONE	EMERGENCY CONTACT PHONE

TOTAL PREG	FULL TERM	PREMATURE	AB, INDUCED	AB, SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

MENSTRUAL HISTORY

LMP ☐ DEFINITE ☐ APPROXIMATE (MONTH KNOWN) MENSES MONTHLY ☐ YES ☐ NO FREQUENCY: Q _____ DAYS MENARCHE _____ (AGE ONSET)
☐ UNKNOWN ☐ NORMAL AMOUNT/DURATION PRIOR MENSES _____ DATE ON BCP AT CONCEPT ☐ YES ☐ NO hCG + ____/____/____
☐ FINAL _____

PAST PREGNANCIES (LAST SIX)

DATE MONTH/ YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES.	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/ COMPLICATIONS

MEDICAL HISTORY

	O Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1. DIABETES		
2. HYPERTENSION		
3. HEART DISEASE		
4. AUTOIMMUNE DISORDER		
5. KIDNEY DISEASE/UTI		
6. NEUROLOGIC/EPILEPSY		
7. PSYCHIATRIC		
8. DEPRESSION/POSTPARTUM DEPRESSION		
9. HEPATITIS/LIVER DISEASE		
10. VARICOSITIES/PHLEBITIS		
11. THYROID DYSFUNCTION		
12. TRAUMA/VIOLENCE		
13. HISTORY OF BLOOD TRANSFUS.		

	AMT/DAY PREPREG	AMT/DAY PREG	# YEARS USE
14. TOBACCO			
15. ALCOHOL			
16. ILLICIT/RECREATIONAL DRUGS			

	O Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
17. D (Rh) SENSITIZED		
18. PULMONARY (TB, ASTHMA)		
19. SEASONAL ALLERGIES		
20. DRUG/LATEX ALLERGIES/ REACTIONS		
21. BREAST		
22. GYN SURGERY		
23. OPERATIONS/ HOSPITALIZATIONS (YEAR & REASON)		
24. ANESTHETIC COMPLICATIONS		
25. HISTORY OF ABNORMAL PAP		
26. UTERINE ANOMALY/DES		
27. INFERTILITY		
28. ART TREATMENT		
29. RELEVANT FAMILY HISTORY		
30. OTHER		

COMMENTS _____

ACOG ANTEPARTUM RECORD (FORM A)

Patient Addressograph

SYMPTOMS SINCE LMP

GENETIC SCREENING/TERATOLOGY COUNSELING

INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO
1. PATIENT'S AGE 35 YEARS OR OLDER AS OF ESTIMATED DATE OF DELIVERY		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV LESS THAN 80		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)		
4. CONGENITAL HEART DEFECT		
5. DOWN SYNDROME		
6. TAY–SACHS (ASHKENAZI JEWISH, CAJUN, FRENCH CANADIAN)		
7. CANAVAN DISEASE (ASHKENAZI JEWISH)		
8. FAMILIAL DYSAUTONOMIA (ASHKENAZI JEWISH)		
9. SICKLE CELL DISEASE OR TRAIT (AFRICAN)		
10. HEMOPHILIA OR OTHER BLOOD DISORDERS		
11. MUSCULAR DYSTROPHY		
12. CYSTIC FIBROSIS		

	YES	NO
13. HUNTINGTON'S CHOREA		
14. MENTAL RETARDATION/AUTISM		
IF YES, WAS PERSON TESTED FOR FRAGILE X?		
15. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
16. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)		
17. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
18. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH		
19. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
IF YES, AGENT(S) AND STRENGTH/DOSAGE		
20. ANY OTHER		

COMMENTS/COUNSELING _____

_____

INFECTION HISTORY	YES	NO
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB		
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES		
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD		

4. HEPATITIS B, C YES ☐ NO ☐
5. HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, HIV, SYPHILIS (CIRCLE ALL THAT APPLY)
6. OTHER (SEE COMMENTS)

COMMENTS _____

_____ INTERVIEWER'S SIGNATURE _____

Goldberg Depression and Anxiety scales

Depression. Think about how you have been feeling recently:

	Yes	No
Have you been lacking in energy?		
Have you lost interest in things?		
Have you lost confidence in yourself?		
Have you felt hopeless?		
Have you had difficulty concentrating?		
Have you lost weight (due to poor appetite)?		
Have you been waking early?		
Have you felt slowed up?		
Have you tended to feel worse in the morning?		

Anxiety. Think about how you have been feeling recently:

	Yes	No
Have you felt keyed up or on edge?		
Have you been worrying a lot?		
Have you been irritable?		
Have you had difficulty relaxing?		
Have you been sleeping poorly?		
Have you had headaches or neckaches?		
Have you had any of the following: trembling, tingling, dizzy spells, sweating, diarrhoea, or needing to pass water more often than usual?		
Have you been worrying about your health?		
Have you had difficulty falling asleep?		

Key reference

Goldberg, D., Bridges, K., Duncan-Jones, P., & Grayson, D. (1988). Detecting anxiety and depression in general medical settings. *British Medical Journal, 297*, 897–899.