Advance Gynecology & Wellness Dr. David Marden, D.O.
Phone: 423.844.5640 Fax: 423.844.5645

Date:_____
Name:_____ DOB:_____ Age:_____
Primary Care Physician:_____ Consult/Referred by:_____
Reason for Visit:_____
_____
Medications: (name, dose, frequency) _____
_____
_____
Drug Allergies: _____
Latex Allergies: _____

Past Medical History: (circle all that apply)

Hypertension	Diabetes		Stroke		Hepatitis Seizures
Frequent UTI	Lung problems		Incontinence	Asthma	Bowel problem
Heart disease	Liver disease		Eye problems	Ulcers	Osteoporosis
Skin problems	Arthritis	Kidney disease	GI reflux		
Hearing problem	Psychiatric disorder	Cancer: _____			

Other: _____

On a scale from 1-10 (1=unhealthy, 10=healthy) How Healthy do you feel? _____

Past Surgical History: (list all past surgeries and date) _____
_____
_____

Family History: (circle yes or no, if yes please explain)
Breast Cancer yes/no _____ Blood Disorders yes/no _____
GYN cancer yes/no _____ Heart Disease yes/no _____
Diabetesyes/no _____

Social History: (circle yes or no, if yes please explain)
Do you smoke yes/no _____ Do you drink yes/no _____
Do you use drugs yes/no _____ Do you exercise yes/no _____
Your Occupation _____ Marital status S M W D P
Spouse first name _____

GYN History
Last Menstrual Period: _____ Period problems: _____
Pregnancies: how many_____ Deliveries _____ Largest baby_____
Have you ever had an abnormal pap yes/ no _____
History of Sexually Transmitted Diseases yes/no _____
Do you have incontinence problems (leaking urine) yes/no _____

Last Pap smear: _____ Results: _____
Last Mammogram: _____ Results:_____
Last Colonoscopy: _____ Results: _____
Last Bone Density Scan: _____ Results: _____
Last Thyroid Screening: _____ Results:_____
Last Cholesterol Screening: _____ Results: _____

Sexual History
Are you sexually active? yes/no Pain with Intercourse? yes/no Problems with orgasms? Yes/no

Abuse History
Is anyone hitting or hurting you yes/no

Chart #_____ Dat

Patient Information

Salutation: ☐Mr. ☐Mrs. ☐Ms. ☐Miss Social Security Number: ___-___-___

Last Name:_____ Suffix: ☐Jr. ☐Sr. ☐Other _____ First Name:_____

Middle Name: _____ Other Name (Nickname, Maiden):_____

Address:_____ Apt#:_____ City:_____

State:_____ Zip:_____ Home Phone:(____)_____ Work Phone:(____)_____

Date of Birth: ____/____/____ Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Notify In Case of Emergency:_____ Phone:(____)_____

Relationship to Patient:_____ Referred by:_____

Responsible Party Information

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Employer ☐Other_____ If self, please go to Employment Information.

Salutation: ☐Mr. ☐Mrs. ☐Ms. ☐Miss Social Security Number: ___-___-___

Last Name:_____ Suffix: ☐Jr. ☐Sr. ☐Other _____ First Name:_____

Middle Name: _____ Other Name (Nickname, Maiden Name):_____

Address:_____ Apt#:_____ City:_____

State:_____ Zip:_____ Home Phone:(____)_____ Work Phone:(____)_____

Date of Birth: ____/____/____ Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Employment Information

☐Patient or ☐Responsible Party

Employer Name:_____

Occupation:_____ Address:_____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Is the patient a student? ☐Yes ☐No If yes, School Name:_____

Insurance Information

Insurance #1:_____ Address:_____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Patient Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other_____ Subscriber Sex ____Male ____Female

Subscriber Name:_____ Subscriber Date of Birth: _____ Subscriber Employer:_____

Effective Date: ____/____/____ Policy #:_____ Group #:_____

Insurance #2:_____ Address:_____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Patient Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other_____ Subscriber Sex ____Male ____Female

Subscriber Name:_____ Subscriber Date of Birth: _____ Subscriber Employer:_____

Effective Date: ____/____/____ Policy #:_____ Group #:_____

If you are covered under more than two insurance policies, please see reverse.

Accident Information

Is this related to an accident?: ☐Yes ☐No If yes, please see reverse.

Additional Insurance Information

Insurance #3:_____ Address:_____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Patient Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other_____ Subscriber Sex ____Male ____Female

Subscriber Name:_____ Subscriber Date of Birth_____ Subscriber Employer:_____

Effective Date: ____/____/____ Policy #:_____ Group #:_____

Insurance #4:_____ Address:_____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Patient Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other_____ Subscriber Sex ____Male ____Female

Subscriber Name:_____ Subscriber Date of Birth: _____ Subscriber Employer:_____

Effective Date: ____/____/____ Policy #:_____ Group #:_____

Additional Accident Information

Date of Accident:____/____/____ Type: ☐ Employment ☐Auto ☐Other_____

Insurance:_____ Address:_____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Adjuster Name:_____ Claim Number:_____

Accident Description:_____

_____

Accident Address:_____

EMBRACE ADVANCED GYNECOLOGY AND WELLNESS
1 Medical Park Blvd., Ste. 305E
Bristol, TN 37620 (423) 844-5640
OFFICE POLICIES

Thank you for choosing us to provide healthcare for you. Our staff is committed to providing you with the best medical care possible and to assisting you with the administrative process. The following is an overview of our office policies. PLEASE READ AND SIGN.

The following applies to every visit:

- Bring your insurance card.
- Be prepared to pay your co-pay and deductible. We accept cash, check, MasterCard and Visa and Discover.
- For medical care not covered by your insurance, payment in full is due at the time of your visit.

INSURANCE:
Our office participates in a variety of insurance plans, which we will file with your insurance company. We cannot bill your insurance company without the proper information. Please make sure all of your insurance information is up to date, including your address and phone numbers.

REFERRALS:
As a specialty office we see new patients with a referral from their primary care physician. Many insurance plans also require your primary care physician to make the referral to the specialist. To avoid delays, please call our office prior to your appointment to confirm we have the referral or bring any required referral for treatment at the time of your visit. If you do not have a referral your visit may be rescheduled or you may be financially responsible.

COPAYMENTS and DEDUCTIBLES:
All co-payments and deductibles for office visits are due at the time of check-in. Co-payments and deductibles for surgery will need to be paid at the time of your pre-operative appointment. If your insurance plan changes from the time you see the physician for the pre-operative visit and/or surgery, please notify our office so necessary changes can be made prior to your surgery. You will be financially responsible if this is not done.

SELF PAY:
Patients without health insurance are required to pay at the time of service unless other arrangements are made prior to your visit. If you are unable to pay in full for necessary medical care at the time of service, our office will assist you in setting up a payment plan.

BILLING:
Statements will be mailed monthly and the payment is due within 30 days. If you have not paid your bill, or have not arranged for a payment plan, we may ask fro the assistance of an outside collection agency. If your account is turned over to a collection agency, you will be dismissed from our practice. We will try to work with you to avoid this.

NO-SHOW / CANCELLATIONS:
To cancel or reschedule, please call 48 hours prior to your appointment. You may receive a $20.00 charge for failure to keep an office visit appointment. On missed procedures in our office, you may be charged $50.00. This fee will be your responsibility, not your insurance's. Failure to call us in a timely manner results in other patients who need to see the physician being denied access to an appointment. Please notify our staff if you have any questions.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THESE OFFICE POLICIES:

_____Signature of Patient and/or Responsible Party

_____Signature of Witness

_____Date

Advanced Gynecology
& Wellness

Patient (printed) Name:_____
Date-of-Birth:_____

1. **General Consent for Treatment and Tests:** I consent to treatment by Advanced Gynecology and Wellness Physician, nurses, associates and staff for my illness and/or health evaluations, including but not limited to blood tests, laboratory procedures, ultrasounds, pathological testing, medications and procedures. I acknowledge and agree that NO GUARANTEES have been made to me as to the results or outcome of my medical care. I understand that State Law requires physicians to report certain communicable diseases to the Health Department.

2. **Release from Liability for Leaving Against Medical Advice or Declining Medical Services:** I agree that if I leave this physician's office against the advice of a physician, associate or staff member, or if I decline services, then Advanced Gynecology and Wellness, its personnel and physician(s) are released from responsibility or liability for any injuries or damages which may result from my leaving against medical advice or declining medical services.

3. **Authorization to Release Medical Information:** I authorize Advanced Gynecology and Wellness, its physician(s) and staff involved in my medical care to disclose and release my medical information (which may include alcohol and drug abuse, psychiatric, sickle cell anemia, AIDS and HIV test results) to any person or organization which is or may be liable or responsible for payment of my bill, including Medicare Intermediaries and fiscal agents. I also consent to the release of my medical information to other physicians, laboratories or medical offices for the sole purpose of my medical care.

4. **Phone Authorization:** I authorize Advanced Gynecology and Wellness to contact me by phone. I understand that if I cannot be reached, messages may be left for me.

5. **Independently Practicing Doctors:** I understand and agree that most radiologists, pathologists anesthesiologists and some allied health professionals are engaged in the practice of their professions on behalf of themselves or other corporations and do not practice as employees of Advanced Gynecology and Wellness. I hereby authorize payment directly to these physicians the insurance benefits otherwise payable to me but not to exceed the total charges due to the physicians. I also authorize the release of any medically necessary information to process these insurance claims.

6. **Assignment of Insurance Benefits/Promise to Pay:** For and in consideration of services rendered and to be rendered by Advanced Gynecology and Wellness, I hereby guarantee payment for all charges incurred for the account of the above named patient. I understand and direct any person, firm or corporation, including but not limited to, insurance companies or attorneys representing the patient or any other party, for such services, to assign proceeds of any payment for payment for services rendered to said patient directly to Advanced Gynecology and Wellness. I understand that by Advanced Gynecology and Wellness accepting assignment of said benefits, the provider does not relinquish its right to collect any balance not paid by any third party. I further agree that if such indebtedness is placed in the hands of a collector or attorney for collection, I will pay reasonable collection fees and attorney fees, interest, court costs and other collection expenses.

7. **Acknowledgement of Receipt of Notice of Privacy Practices:** I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 423-844-5640 or by requesting one at the office._____(Initials)

I have read and understand this document and I agree to its terms.

_____ _____ _____
Patient signature or authorized party relationship today's date

If unable to obtain patient or authorized party's signature or initials, please indicate reason: _____

EMBRACE ADVANCED GYNECOLOGY AND WELLNESS

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I, _____have received a copy of the Privacy Practice for Embrace Advanced Gynecology and Wellness.

_____ _____

Patient Signature Date

EMBRACE ADVANCED GYNECOLOGY AND WELLNESS

I authorize EMBRACE Advanced Gynecology and Wellness to communicate my healthcare, appointment and/or billing information to the following people:

NAME: _____

DOB: _____

PHONE: _____

NAME: _____

DOB: _____

PHONE: _____

NAME: _____

DOB: _____

PHONE: _____

_____ _____

Signature Date