GRACE OBGYN, PA

PATIENT INFORMATION

In order to comply with new national standards, meeting meaningful use,
we must have answers to the following questions.

ACCOUNT # _____ DATE_____

PATIENT'S LEGAL NAME _____RACE _____ETHNICITY_____

SOCIAL SECURITY# _____ DATE OF BIRTH _____ AGE _____

MAILING ADDRESS _____

HOME PHONE _____ CELL_____ MARITAL STATUS _____

EMPLOYER_____ WORK PHONE _____

OCCUPATION_____ EMAIL _____

POLICYHOLDER IF NOT YOU _____ DATE OF BIRTH _____

SSN# OF POLICYHOLDER _____EMPLOYER OF POLICYHOLDER _____

(We must have this information in order to file your visit today.)

IN CASE OF EMERGENCY, NOTIFY _____ PHONE_____

NAME OF PRIMARY CARE PHYSICIAN _____(We must have this information.)

HOW DID YOU HEAR ABOUT OUR PRACTICE?_____

Lifetime Insurance Authorization: I hearby authorize the undersigned physician to release any information acquired in the course of my examination or treatment to the social security administration, or its intermediaries, or carriers involved in processing and collection of a claim. I understand that I am financially responsible for the charges not covered by this authorization.

_____ _____

Signature Date

IF PATIENT IS A MINOR, PLEASE COMPLETE:

I, _____, give permission to _____to examine my daughter _____.

_____

Patient or Guardian: _____ Date: _____

Witness _____ Date: _____

CURRENT MEDICATION LIST

Patient Name: _____ Date: _____

Date of Birth: _____

Please TYPE or PRINT each medication you are taking, dosage (amount you take), frequency and prescribing MD. Also include any over-the-counter medications, vitamins and herbal supplements that you take frequently as well as medication allergies in the spaces provided.

	MEDICATION NAME	DOSAGE	FREQUENCY	PRESCRIBING MD
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

OVER-THE-COUNTER MEDICATIONS

1. _____ 3. _____
2. _____ 4. _____

VITAMINS / HERBAL SUPPLEMENTS

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

ALLERGIES TO MEDICATIONS

MEDICATION NAME	REACTION

Grace OBGYN

2 Yorkshire Street | Asheville, NC 28803
(p) 828.252.1050 | (f) 828.253.0457

Patient Release of Medical and/or Financial Information Authorization

Patient Name: _____ Account Number: _____

Date of Birth: _____

I, _____ , give consent to Grace OBGYN to provide medical record information and/or financial information to the person(s) named below:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____
5. _____ Relationship: _____

Phone Calls and Voice Mail Preferences

May we leave messages on your voice mail regarding appointment reminders, return call messages, etc?

Home Phone: Yes No With Family Members: Yes No

Cell Phone: Yes No

Please list any other specific instructions regarding phone calls and messages:

_____

_____

Patient Signature: _____ Date: _____

PLEASE COMPLETE ALL HISTORY INFORMATION AS IT PERTAINS TO YOU, THE PATIENT.

NAME: _____ Date of Birth: _____

PAST MEDICAL HISTORY			
Major Illness	**If Yes, Date**	**Major Illness**	**If Yes, Date**
Anemia		Hepatitis / Yellow Jaundice	
Arthritis		High Blood Pressure	
Asthma		High Cholesterol	
Back Problems		HIV / AIDS	
Blood Clots in Lungs or Legs		Irritable Bowel Syndrome	
Blood Transfusions		Kidney Disease / Problems	
Broken Bones		Kidney Infections / Stones	
Cancer		Liver Disease	
Chickenpox		Migraines: [ ] w/aura [ ] w/o aura	
Colitis		Pneumonia / Lung Disease	
Collagen Vascular Disease (Lupus)		Reflux / Hiatal Hernia / Ulcers	
Depression or Anxiety (circle)		Rheumatic Fever	
Diabetes		Seizures / Convulsions / Epilepsy	
Eating Disorders		Stroke	
Gallbladder Disease		Thyroid Disease	
Glaucoma		Tuberculosis	
Heart Disease		Other:	

GYNECOLOGICAL HISTORY					
Problem	**Yes**	**No**	**Problem**	**Yes**	**No**
Abnormal Bleeding			Infertility		
Abnormal Hair Growth			Lichen Sclerosis		
Abnormal Pap Smear / Dysplasia			Osteoporosis		
Bartholin's Cyst / Abscess			Sexual Problems		
Breast Problems			Sexually Active / # of partners in last yr: _____		
DES Exposure			Sexually Transmitted Disease		
Endometriosis			Uterine Abnormality		
Fibroid Uterus			Urinary Leakage		

GYNECOLOGICAL SURGERIES			
Surgery	**Yes**	**No**	**Date / Comments**
Abdominal Surgery			
C/Section			
Dilation & Curettage (D&C)			
Hysterectomy [ ] Vaginal [ ] Abd. [ ] Lap.			
Hysteroscopy			
Laparoscopy			
Urinary Incontinence Surgery / Sling			
Vaginal Surgery			

OTHER OPERATIONS / HOSPITALIZATIONS			
Date	**Diagnosis**	**Procedure**	**Findings**

PLEASE COMPLETE ALL HISTORY INFORMATION AS IT PERTAINS TO YOU, THE PATIENT.

NAME: _____ Date of Birth: _____

FAMILY HISTORY									
					Grandmother		Grandfather		
Illness	**Mother**	**Father**	**Sibling**	**Child**	**Maternal**	**Paternal**	**Maternal**	**Paternal**	**Other**
Alcohol									
Alzheimer's Disease									
Birth Defect									
Blood Clots in Lungs or Legs									
Breast Cancer									
Colon Cancer									
Depression									
Diabetes									
Endometriosis									
Fibroid									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Mental Illness									
Osteoporosis									
Ovarian Cancer									
Stroke									
Thyroid Disease									
Other:									

SOCIAL HISTORY	
Preferred Name:	Primary Physician:
Occupation:	Number of People in Household:
Marital Status (Circle one) Single Married Widowed Divorced Separated Living w/Partner	Name of Significant Other:
Education (Last Grade Completed):	How many days per week do you exercise?
Seat Belt Use (Circle one) Always Frequently Occasionally Never	Occupational Risk (Circle all that apply) None Bio-hazard Chemical Physical Labor
How many caffeinated beverages do you consume per day?	How many times per week do you drink alcohol?
Do you smoke? If yes, how many per day? Yes No	Do you use any of the following? (Circle all that apply) Cocaine Hallucinogens Marijuana Narcotics
Have you ever been or are you currently being physically, verbally or sexually abused?	Other Social History that you feel is important:

ANNUAL CARE	Yes	No	WHEN WAS YOUR LAST ...	Year
Do you examine your breasts?			Bone Density?	
Do you get 1200 – 1500 mg of calcium per day?			Colonoscopy?	
Have you seen your Primary Care MD in the last year?			Mammogram?	
Do you currently use contraception?				
If yes, what type of contraception do you use?				

PLEASE COMPLETE ALL HISTORY INFORMATION AS IT PERTAINS TO YOU, THE PATIENT.

NAME: _____ Date of Birth: _____

OBSTETRICAL HISTORY					
	Full Term	**Preterm (< 20 wks)**	**Miscarriage**	**Abortion**	**Ectopic**
Number of times you have been pregnant:					
Number of children living:					
Number of adopted / step-children in the home:					

Pregnancy #	**1**	**2**	**3**	**4**	**5**	**6**
Pregnancy Outcome T = Full Term P = Premature M = Miscarriage						
Delivery Date						
Weeks at Delivery						
Number of Hours in Labor						
Epidural / Anesthesia						
Delivery Type V = Vaginal C = C/Section VE = Vacuum Ex.						
Did you have preterm labor?						
Delivery Location						
Who delivered your baby?						
Baby's Weight						
Baby's Sex						
Baby's Name						

COMPLICATIONS (Check all that apply) **Pregnancy #**	**1**	**2**	**3**	**4**	**5**	**6**
4th Degree Tear						
Gestational Diabetes / Insulin						
Infection / Separation of C/Section Incision						
Macrosomia (> 9 lbs)						
Multiple Gestation						
Post Dates (> 41 wks)						
Postpartum Hemorrhage						
Preeclampsia						
Preterm Delivery						

David L. Cobb, Jr., MD
Logan L. Lechner, MD
Danica E. McAden, MD
Jennifer L. Paltzer, DO

Grace OBGYN, PA
Appointment Cancellation Policy

In an effort to continue to provide efficient and excellent care for our patients, we have implemented a cancellation policy. Our physicians reserve time for you to have direct patient care and to evaluate and treat your women's health needs. The inability to keep this reserved appointment time without a 24-hour notice, makes it difficult to be used for another patient needing medical care.
Most insurance companies will cover your annual preventative exam once a year (every 366 days).

As of June 2023, Grace OBGYN, PA is now requesting a 24-hour notice be given if you are unable to keep your appointment. In the case of inclement weather or a personal emergency, we ask that you call our office as soon as possible to discuss rescheduling.

If you cannot keep your appointment, failure to cancel or reschedule within the 24-hour time frame, will result in a $50.00 per occurrence charge. This charge is not covered by insurance and will be directly billed to the patient

Thank you for your understanding and trusting us with your women's healthcare needs.

I acknowledge and understand the Appointment Cancellation Policy. I understand that it is my/the patient's responsibility to provide a 24-hour cancellation if I cannot make my scheduled appointment. I also understand that I will be responsible for a $50.00 cancellation fee.

Patient name: _____ Date: _____

Patient signature: _____ MRN: _____

Annual Preventative Exam

Important information about your visit

We want to keep you up to date on information regarding insurance coverage and billing. Your annual exam is very important, and it gives you and your provider a chance to discuss preventative care, assess any risk factors for disease, and discuss what tests may be needed for health screening. The goal of the preventative exam is to stay healthy.

If you have commercial insurance:

Most insurance companies will cover your annual preventative exam once a year (every 366 days).

- What an annual preventative visit includes:
  A full physical exam and getting you up to date on recommended health screening.

- Examples of what an annual preventive visit doesn't include:
  Evaluation and treatment of new health problems. This may be subject to your deductible.
  Pelvic ultrasound. This must be billed separately and will be subject to your deductible.

Additional items like those noted above may be able to be addressed at your annual if time allows but also may require a return visit.

If Medicare is your primary insurance for office visits:

- Medicare has changed the way annual preventive visits are covered and billed. As a result, patients with Traditional Medicare are now responsible for **$129 each year** for the annual visit. Patients with Medicare Advantage (replacement) plans and other insurance plans will be billed according to their plan benefits and may have similar charges.

Your annual visit is divided into two separately billed components:

- **Part 1: Physical Examination**
  This includes the physical exam only. Medicare covers this service once every two years, so we bill it only every other year.
- **Part 2: Preventive Health Review and Medical Management**
  This includes health screenings, medication review and prescriptions, and discussion and management of any existing health conditions or concerns. Medicare requires this portion of the visit to be billed separately, and it is subject to your annual deductible and any applicable copays or coinsurance.

We will address as many concerns as possible during your annual visit; however, depending on the complexity of your medical needs and the time available, a follow-up appointment may be necessary.

If you are Self Pay:

Payment for all services rendered is expected at the time of service. Please ask to speak with a billing representative if you have any questions regarding self-pay.

Patient Acknowledgment (All Patients)

I acknowledge that I have reviewed and understood the information above regarding annual preventive exams, insurance coverage, billing, and potential patient financial responsibility. I understand that services provided during my visit may be billed separately depending on my insurance coverage, the reason for my visit, and the services rendered.

This acknowledgment is required for all patients, regardless of insurance status (commercial insurance, Medicare, or self-pay).

Patient Name: _____ Account # _____

Patient Signature: _____ Date: _____