Auburn Urogynecology
and Women's Health

Welcome to our practice. This letter is to confirm your appointment. Please arrive 15 minutes prior to your appointment. Please bring the enclosed forms **completed** to your visit as well as a copy of your insurance card and photo ID. All co-payments and deductibles are due at the time of each visit. If you have any questions or concerns prior to your visit, please do not hesitate to call our office.

You will receive an email with instructions on how to register for the patient portal. The portal will provide you access to your medical visits and billing records, enable you to request appoints, and send secure messages to the doctor once you become an established patient. Your test results and patient care summaries will be delivered to you via the portal as well. Please take a moment to register.

Also, please take a moment to visit our website at www.auburnurogyn.com.

In light of the recent COVID-19 pandemic, we have enhanced our infection control protocol as outlined below in order to protect our patients and staff:

1. Please wear a mask at all times as they are required for entry.

2. Our waiting room will no longer offer magazines or the community water dispenser.

3. We will continue to follow best practices for cleaning of instruments, equipment, and the office.

4. Please do not bring anyone to the appointment with you unless it is medically necessary and no children are allowed.

5. If you are sick, please call to reschedule your appointment or see if your visit is eligible for telemedicine.

As a courtesy to the staff and other patients, we ask that you give us a 24-hour notice if you must cancel or reschedule your appointment.

Office Policies and Patient Information

Appointments: Patients are seen by appointment only. Please bring your insurance card and ID to every visit. If you cannot keep your schedule appointment, please call the office 24 hours in advance or log on to your patient portal and send us a secure message to cancel your appointment. There is a $25 fee for no-show appointments.

Communication: Our office offers an online patient portal. The portal provides you secure access to your medical records and also allows you to send secure messages to office staff and your providers. We ask that you utilize the patient portal first when contacting the office. If you call the office and we are unable to answer the phone, you may leave a message and your

question will be answered through your patient portal. Additionally, your visit summaries and lab results will also be sent to your portal. If any lab results require follow up, someone from the office will call you to discuss.

Prescriptions and Refills: Prescriptions are sent electronically to your pharmacy on file. If you would like your prescription sent somewhere else, please notify the medical staff at the time of your visit. If you require a refill, please call your pharmacy at least 3 days before you need your refill. The pharmacist will contact our office for the refill approval.

Labs: All laboratory specimens will be sent to our regular laboratory providers unless you, the patient, advise us the name of the particular laboratory contracted by your insurance company. If you had lab work or pathology testing done in the office, the laboratory will bill you (or your insurance company) separately for these services. We are not aware the amount of cost share you may have for laboratory services so please make sure you contact your insurance if you have concerns.

Forms: Our staff is able to assist you in the completion of medical information on forms such as FMLA/Disability requests. There will be a $15 fee per form for this service. We ask that you complete all demographic information before bringing the form to us.

After Hours Calls: In case of a life-threatening emergency, please call 911. If you have an urgent need to speak to a provider outside of business hours, please call 530-886-6660 and you will be connected to answering service. The provider on call may triage your message and ask that you call back during business hours. Be advised that you may be charged a telemedicine visit for calls after hours that are not covered during the post-operative surgical period.

Sincerely,

James S. Dunn, Jr. MD, Tori Hobel, PA, Rebecca Imseis, NP &
The Staff at Auburn Urogynecology and Women's Health

Patient Registration and Authorization Form

Last Name:_____ First Name:_____

Preferred Name:_____ Legal Sex:_____

DOB:_____ SSN:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Phone: (Cell)_____ (Home)_____

Communication preference: □ Cell □ Home □ Portal

Email: _____

Language: _____ Race:_____ Marital Status: _____

Insurance Information:

Primary Insurance: _____ □ PPO □HMO

If HMO, Medical Group:_____

Policy Holder Name: _____ DOB:_____

Relationship to Policy Holder: □ Self □ Spouse □Child □Other

ID#:_____ Group:_____

Secondary Insurance: _____ □ PPO □HMO

If HMO, Medical Group:_____

Policy Holder Name: _____ DOB:_____

Relationship to Policy Holder: □ Self □ Spouse □Child □Other

ID#:_____ Group:_____

Responsible Party: □ Self □ Other (complete below):

Name:_____

DOB:_____ SSN:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Emergency Contact:

Name:_____ Relationship to Patient:_____

Phone: (H)_____ (M)_____

8/2021 (Office Use) Athena ID:_____

These authorizations and waivers cover all services rendered to the below named patient for today's services and all future dates of service. You may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any events that occurred before you notified us in writing of your decision to revoke.

Please initial each below:

_____ **Assignment of Benefits**: I hereby assign to Dr. James Dunn, Jr. Inc. any insurance or any other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I also understand that the above doctor has the right to refuse or accept assignment of such benefits (except where prohibited by contract). I also understand that in the event that services rendered are not covered under my "insurance", I will accept financial responsibility for all services provided to me.

_____ **Consent to Treat and Medication/Immunization History Authorization:** I (or my legal guardian or parent) authorized James S. Dunn, Jr. MD, Inc. to provide medical care reasonable by today's standards. I understand the James S. Dunn, Jr. MD, Inc. uses electronic prescribing. My prescriptions may be sent and my medication information may be obtained through electronic prescribing function from pharmacy benefit managers. Additionally, my immunization registry will be synced in my medical record.

_____**Insurance Responsibility**: Due to the increasing complexity of all health care programs it has become necessary for our office to place the responsibility of knowing the requirements of your particular insurance policy on you. This includes knowing which facilities can be used for x-rays, laboratory, hospitalization, out-patient surgery or referral to another physician. You must have your co-pay at the time of service or your appointment will be rescheduled. You must show your insurance card at each visit. As there are many insurance plans, all with their individual requirements, it is the patient's responsibility to understand the requirements and limitations of the plan. Note: All laboratory specimens will be sent to our regular laboratory providers unless you, the patient, advise us the name of the particular laboratory contracted by your insurance company. I have read and understand the above information.

Printed Name of Patient:_____ Date:_____

Signature of Patient/Legal Guardian:_____

8/2021 (Office Use) Athena ID:_____

Auburn Urogynecology and Women's Health

Financial Policy

We are committed to providing you with quality and affordable healthcare. To ensure we run an efficient practice and to better serve you, the following is our financial policy.

Insurance: We participate in many insurance plans, including Medicare. If we are not contracted with your insurance, or you have no insurance, you are responsible for payment in full at the time of service. It is your responsibility to confirm participating provider status directly with your insurance company. Due to strict insurance billing time limits, patients who do not bring their insurance cards to their appointment will be considered self-pay patients. Knowing your insurance benefits is your responsibility.

Co-payments and Deductibles: All copayments must be paid at the time of service. All deductibles must be paid when the amount is known. This arrangement is part of your contract with the insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us be compliant with insurance procedures by paying your copayment at each visit.

Secondary Insurance: Having more than one insurer does not guarantee your services will be covered 100%. We will bill your secondary carrier as a courtesy.

Non-covered services: Please be aware the some and perhaps all of the services you receive may be non-covered or not considered reasonably necessary by Medicare or other insurance. You are responsible for these charges.

Coverage: If your insurance changes, please notify us before your next visit so we can make appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim, you will be billed the balance.

Claims submission: As a courtesy to you, we will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If a claim remains unpaid due to the request for information, you will be responsible for the balance.

Pre-surgical payments: A deposit is required to schedule elective surgery and will need to be paid by 2 weeks prior to the scheduled date. We reserve the right to cancel or reschedule should the deposit not be paid in a timely manner. The deposit required will be determined by deductible owed, percentage responsible, or by cash fee for service.

Patient account statements: An account balance becomes the patient's responsibility for three basic reasons:

1. Your insurance has paid for services and the balance remaining is member liability
2. Your insurance has been billed and denied or pended due to missing info from member
3. No insurance information given or invalid information for you exists in our files

As a convenience, we accept most major credit cards and debit cards. You can also make credit/debit card payments online using the patient portal. Any unpaid balance exceeding 90 days may be referred to a third-party collection agency and a collection fee of $15 will be assessed to your account. This action may also breach the physician/patient relationship and you may be discharged from the practice.

Missed appointments: We may charge $25 for missed appointments and $50 for missed procedures not canceled within 24 hours. These charges are not billed to insurance.

Returned checks: Please be advised that there is a $25 fee for all returned or bounced checks.

Disability forms/paperwork: There is a $15 fee for the completion of each paperwork presented. This fee is not billed to the insurance and must be paid in advance.

Records Requests: There is a $15-25 nominal fee for copying of records for personal use. Please allow 10 business days for completion of request.

We must emphasize that as a physician our relationship is with you, not your insurance company. We file insurance claims as a courtesy to our patients, but all charges are your responsibility. Not all the services we provide are covered by your insurance provider. This is NOT decided by us, but rather by your insurance company. It is important that you read and understand your insurance policy and its requirements for coverage.

Print Name:_____

Signature:_____Date:_____

Should you have any questions regarding the content of this form please see a member of our front office staff for clarification prior to signing.

Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned acknowledged that a copy of the currently effective notice of privacy practices for James S. Dunn, Jr. MD, Inc. was made available. (A copy of this signed, dated document shall be effective as the original.)

Print name: _____

Signature: _____Date: _____

Communication Authorization: I consent to receive call/text/email automated reminders.

_____Initial here if we may leave a message with detailed info on your preferred method of contact.

Please list other parties with whom we can discuss your health and financial information. (leave blank if it is no one)

Name: _____ Phone: _____ Relationship:_____

Name: _____ Phone: _____ Relationship:_____

(To be completed by office)

James S. Dunn, Jr. MD, Inc. was unable to obtain acknowledgement because (circle one): Emergency Patient Confused/Disoriented Patient Refused

Other: _____

New Patient Intake Questionnaire

Name:_____ DOB:_____ Height:_____ Weight:_____

PCP:_____ Referring Doctor:_____

Preferred:

Pharmacy:_____

Lab:_____ Imaging:_____

What brings you to the office today:

ALLERGIES (list reaction): □ No Known Drug Allergies

Are you allergic to: □ Latex □ Iodine

List your prescribed medications and over the counter medications, herbs, and supplements:

Drug Name	Dose	Frequency	Drug Name	Dose	Frequency

Immunization History

Covid: Y/N Date: Date:	Influenza: Y/N Date:
Shingles: Y/N Date:	HPV: Y/N Dates:

Gynecologic History

Age when period started: _____
If menopausal, age at menopause: _____
Date of LMP:_____
Duration of flow:_____ (days) Clots: Yes/No
Hx of sexually transmitted disease: Yes/No List:_____
Current birth control method: _____
Are you on hormone replacement therapy?: Yes/No List:_____
Date of last pap _____ Circle: Normal/Abnormal
Date of last mammogram: _____ Circle: Normal/Abnormal
Date of last colonoscopy: _____ Result:_____
Date of last bone density study:_____ Result:_____

Obstetrical History

Total # pregnancies: _____ Full term deliveries: _____ Premature deliveries: _____
Abortion, induced: _____. Miscarriages: _____ Ectopic: _____
Multiple births:_____ Living children: _____
Pregnancy complications:

Family Health History
(relatives: grandparents, parents, siblings, children)

Illness	Yes (X)	Which Relative(s)	Illness	Yes (X)	Which Relatives
Stroke			Cancer: Other		
Diabetes			Cancer of breast		
Heart Disease			Cancer of cervix		
Thyroid Disorder			Cancer of colon		
Kidney Disease			Cancer of ovary		
Cancer of uterus			Osteoporosis		

Any other significant family health history:

Social History

	Yes	No	Notes:
Are you able to care for yourself?			
Are you blind or have difficulty seeing?			
Are you deaf of have serious difficulty hearing?			
Do you have difficulty concentrating, remembering, or making decisions?			
Do you have difficulty walking or climbing stairs?			
Do you have difficulty dressing or bathing?			
Do you have difficulty doing errands alone?			
What is highest level of school completed?			
Are you currently employed?			Occupation:
Do you or have you ever smoked tobacco?			
Do you or have you ever used any other forms of tobacco or nicotine?			If yes, have you e-cigarettes or vape? Yes/No Current user? Yes/No Have you ever used smokeless tobacco? Yes/No Current user? Yes/No

Last name:_____

What was the date of your most recent tobacco screening?	
What is your level of alcohol consumption?	Circle: none occasional moderate heavy
Do you use any illicit or recreational drugs?	Circle: Yes No If yes, which one?
What is your level of caffeine consumption?	Circle: none occasional moderate heavy
What is your relationship status?	Circle: married single divorced separated widowed domestic partner other
Are you sexually active?	Circle: Yes No
Have you been to an area known to be high risk for COVID-19?	Circle: Yes No
In the last 14 days have you had close contact with a lab confirmed COVID-19 case?	Circle: Yes No
In the last 14 days have you had close contact with a person who is under investigation for COVID-19?	Circle: Yes No
Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep a night)?	Circle: Yes No
Do you use your seat belt routinely?	Circle: Yes No
What is your exercise level?	Circle: None Occasional Moderate Heavy
How many days of moderate to strenuous exercise did you do in the last 7 days?	Answer:
Gender identity?	
Assigned sex at birth?	
Pronouns preferred?	
First name used?	
Sexual orientation?	

Surgical History

Have you had…	**Yes**	**Year**	**Notes**
Hysterectomy			If yes, do you still have your ovaries? Yes/No
LEEP/Conization of cervix			
Sterilization			If yes, what method?
Pelvic Surgery			
Bladder Surgery			
Insertion of Medical Device?			If yes, please list:
C-Section			

Last name:_____

Breast surgery			If yes, explain:
Appendix removal			
Other:			

Past Medical History			
Have you ever had…	Yes	No	Explain
Anemia or blood disorder			
Anxiety			
Arthritis			
Asthma			
Birth defects or inherited disease			
Blood clots			
Breast problems			
Cancer of breast			
Cancer other			
Cancer of ovaries			
Convulsions/seizures			
Depression			
Diabetes			
Eye problems/Glaucoma			
Fainting			
Gastrointestinal problems			
Heart problems			
Hepatitis			
High blood pressure			
HIV or AIDS			
Kidney or bladder problems			
Lung disorder			
Nose or throat problems			
Osteoporosis			
Other:			
Pacemaker			
Sleep apnea			
Stroke			
Thyroid problems			
Trauma			

Review of Systems	
	Circle all that apply
Constitutional	fatigue fever weight gain weight loss
Skin	moles rashes
Eyes	irritation vision changes
Ear/nose/throat/ mouth	hearing loss ear pain sinus problems sore throat snoring dry mouth mouth ulcers

Last name:_____

Respiratory	shortness of breath cough wheezing coughing blood/sputum
Cardiovascular	chest pain palpitations exercise intolerance
Gastrointestinal	heartburn difficulty swallowing nausea vomiting abdominal pain diarrhea constipation changes in bowel movements
Genitourinary	blood in urine abnormal bleeding flank pain trouble urinating painful urination nocturia urinary frequency urinary urgency incontinence rash lesion discharge odor itching
Endocrine	Menstrual: irritability tension/anxiety depressed mood breast pain/tenderness bloating feeling out of control or overwhelmed Menopausal: hot flashes night sweats vaginal dryness impaired memory impaired concentration Sexual: decreased libido orgasmic dysfunction painful sex vaginismus
Musculoskeletal	muscle aches weakness arthritis back pain
Neurological	headaches dizziness weakness numbness seizures
Psychological	depression alcoholism sleep problems
Please add any other information you would like your healthcare provider to know:	
Patient Signature: Date:	

Last name:_____