

Patient Registration Information

Name: (Last, First, Middle Initial) _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____ Social Security # _____

DOB: _____ Age: _____ Marital Status: Single Married Divorced Widowed

Spouses Name: _____ Spouse Social Security # _____

Emergency Contact: _____ Phone: _____ Relation: _____

Pharmacy Name: _____ Street Name: _____ Phone Number: _____

Patient Responsible Party Information

Responsible Party: _____ DOB: _____

Relationship to Patient: SELF SPOUSE OTHER _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer Name: _____ Phone # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Spouse Employer: _____ Phone # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Patient Insurance Information

Name of Insured: _____ Relationship to Insured: _____

DOB: _____ Insurance Company: _____

Insurance ID Number: _____ Group Number: _____

Insurance Billing Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Company: _____ Relationship to Insured: _____

Insurance ID Number: _____ Group Number: _____

Insurance Billing Address: _____

City: _____ State: _____ Zip: _____

Medical History

Please complete the following information before your first visit

Date of Visit: _____ / _____ / _____

Name: _____, _____, _____ Date of Birth: _____ / _____ / _____
(Last) (First) (MI)

Chief Complaint (What problem(s) brings you to our office?)

Past Medical History: Please circle Y or N

- | | | | |
|-----------------------------|---------------------------|------------------------|--------------------|
| Y / N Asthma | Y / N Pneumonia | Y / N Ulcers | Y / N Tuberculosis |
| Y / N Lung Disease | Y / N Depression/Anxiety | Y / N Kidney Infection | Y / N Lupus |
| Y / N Seizures / Convulsion | Y / N Venereal Disease | Y / N Kidney Stones | Y / N Arthritis |
| Y / N Heart Disease | Y / N High Blood Pressure | Y / N Arrhythmia | Y / N Migraines |
| Y / N Stroke | Y / N Fibromyalgia | Y / N Osteoporosis | |

- Y / N Cancer – If yes, what type? _____
- Y / N Stomach Problems – type? _____
- Y / N Glaucoma – type? _____
- Y / N Thyroid Disease – type? _____
- Y / N Diabetes – type? _____
- Y / N Hepatitis – type? _____

Past Surgical History (List ALL surgeries with the date, if possible)

Previous incontinence / bladder surgeries: _____NO _____YES Type: _____

Other surgeries (Include any abdominal or plastic surgery procedures)

Procedure:	Date:	Surgeon:	Surgical Facility:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies (Please list any allergies along with the type of reaction you experienced):

Medical History – Page 2

Name: _____,
(Last) (First) (MI)

Medications (Please list all medications you currently take, including dosage and how often you take it. Also include over-the-counter medications & herbal supplements):

Social History

Occupation: _____ Race: _____ Religion: _____

Marital Status: _____ Married _____ Single _____ Divorced _____ Widow _____ Separated

Spouse Name: _____ Spouse Occupation: _____

Regular Exercise: _____ Yes _____ No How Often? _____

Sexually active? _____ Yes _____ No How Often? _____ Birth Control Method? _____

Cigarettes: Have you **ever** smoked Cigarettes? _____ Yes _____ No How many years? _____

Packs per day? _____ Are you currently smoking? _____ Yes _____ No

Caffeine: Coffee – cups per day _____ Caffeinated drinks (tea /soda) – cups per day _____

Alcohol: _____ Yes _____ No How often? _____ What is consumed? _____

Illegal Drugs: _____ Yes _____ No How often? _____ Which Drugs? _____

Family History (Check any conditions in your family & indicate their relationship to you)

Condition Relationship (Include (M)aternal or (P)aternal and (L)iving or (D)eceased)

____ Heart Disease _____

____ High Blood Pressure _____

____ Stroke _____

____ Breast Cancer _____

____ GYN Cancer (Ovarian) _____

____ Colon Cancer _____

GYN History

Last PAP Smear _____ Normal? _____ Last Mammogram _____ Normal? _____

Last GYN Exam _____ / _____ / _____ Last Menstrual Period _____ / _____ / _____

Prior Menstrual Period _____ / _____ / _____ Problems with period? _____

Date of last Colonscopy _____ Date of Menopause _____ / _____ / _____

of Pregnancies _____ # of Deliveries _____ # of Vaginal Deliveries _____ # of C-Sections _____

Date and Location of last Dexa Scan: _____



Office Policies and Financial Payment Agreement

Fibroid and Pelvic Wellness Center of Georgia (also known as Medical Therapy Specialist, LLC) welcomes you. In order to provide you with the best service, we have the following Office Policies:

ARRIVAL TIME: Please arrive 15 minutes before your scheduled appointment time to complete paperwork necessary for your visit, helping us to stay on schedule. Patients arriving between 15-30 minutes late are considered a late arrival and will be worked back into the schedule as soon as possible. Patients arriving more than 30 minutes late may be rescheduled.

MISSED APPOINTMENTS: Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least 24 hours prior to the scheduled time is considered a "missed appointment," which may be charged \$40.00, as set by the Practice, for failure to show. A patient who has missed four appointments may be dismissed from the Practice.

MEDICAL RECORDS: An Authorization to Release Medical Records form must be signed for all requests. There is no charge for sending records to other physicians for a continuation of care. However, there is a fee for all other requests (personal or otherwise). For more information, please refer to the following link or contact our office. <https://dch.georgia.gov/medical-records-retrieval-rates>

PATIENT FORMS: It is necessary that you complete the Patient Medical History Questionnaire and other Questionnaires provided prior to your office visit. Failure to provide this information may result in a missed appointment. If you need assistance completing the forms, you may choose to arrive 45 minutes before your scheduled appointment and someone will assist you.

DISABILITY FORMS / FMLA: We will be glad to review and assist our patients with their FMLA, Short Term Disability and Disability paperwork. We require a minimum of two (2) weeks to review and complete these forms. If we are not able to assist; you will be notified within 48 hours of our office receiving the form. We do not keep copies of these forms on file, as you must obtain these individually from your Employer, School or your Disability Insurance Carrier. Should you require any additional type of letter from our physicians, you may request this with our staff.

Fees to have your FMLA/Disability form completed:

- \$30 Standard form, no rush
 - \$50 Rush Completing (form needed sooner than the two week turn time)
 - \$15 For any updates/changes needed after completion of initial paperwork
- **Please note - Spouse and/or guardian paperwork will be charged separately**

FINANCIAL RESPONSIBILITY: IN NETWORK insurance companies: **Blue Cross Blue Shield, Cigna, Humana, United Healthcare, Medicare, etc.** If you have a plan with out of network benefits, we will file on your behalf. As a courtesy to you, we will attempt to obtain a pre-certification and file insurance claims for medically necessary procedures, but all charges (including consultation fees, deductibles, co-insurance, amounts charged in excess of reasonable and customary) are your responsibility. It is important that you read and understand YOUR insurance coverage and benefits and the requirements of your insurer. We expect patients or their guardian to be fully



responsible for all charges regardless of insurance coverage. It is your responsibility to follow up with your insurer regarding the payment of your claim.

- Please be advised we will not become involved in disputes between you and your insurance company, however, we will provide you with necessary, factual information regarding the services rendered, as necessary to assist you with your claim for benefits.
- In the event the insurance company sends the reimbursement check directly to you, it is your responsibility (since we have not asked for payment in full) to send us the check (endorsed over to Medical Therapy Specialist, LLC), along with the Explanation of Benefits to our office.

FINANCIAL ESTIMATES: An estimate of proposed surgical procedures and corresponding fees will be provided to you in advance of scheduling your surgery. While every attempt is made to provide you with an accurate estimate, it is possible that additional and/or different procedures may be necessary.

FINANCIAL PAYMENTS: Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal laws. Deductibles and estimated co-insurance amounts are collected at the time of the pre-operative office visit. The remainder of your bill is **due and payable within 60 days** (even if your insurance company has not paid their portion of your bill).

UNINSURED PATIENTS: Payment in full is expected at the time of service. (Payment methods accepted: Cash, Money Orders, Cashier's Checks, Visa, MasterCard, Amex, Discover) Please note: No personal checks over \$3500.

COLLECTIONS: I understand that in the event my account becomes past due (over 30 days) and all attempts to arrange payment have failed, my account may be placed for collection. I also understand that I will be responsible for all costs of collection including agency fees, court cost and/or attorney fees. Please be aware that if a balance remains unpaid, you and/or your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

OUTSTANDING BILLS: There will be a 5% late fee for balances not paid when due unless other arrangements have been made. A patient with a delinquent account (balance is in excess of 120 days) may have services refused.

RETURNED CHECK or CREDIT CARD CHARGE BACK FEE: \$35.00 for each check returned for insufficient funds or credit card charge back.

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

Signature of patient or guardian: _____ Date: _____



Physician Payment Authorization

Patient Name: _____

Primary Insurance Policy Holder: _____

Primary Holder Date of Birth: _____

Insurance ID#: _____ Group #: _____

I hereby authorize my above named insurance provider to mail payment directly to said physician at Fibroid and Pelvic Wellness Center of Georgia, on my behalf. These payments should be made payable and mailed to:

**Fibroid and Pelvic Wellness of Georgia
3400 Old Milton Parkway
Building C, Suite 330
Alpharetta, GA 30005**

Should my insurance company send payment directly to me, the patient, I will endorse and forward all payments to Fibroid and Pelvic Wellness Center of Georgia, for the services rendered. All checks will be forwarded to the address above.

I authorize Fibroid and Pelvic Wellness Center of Georgia to release any information pertinent to the resolution of claims and receiving payment to all my insurance carriers or attorney working on my behalf.

A photocopy of this assignment shall be considered as valid and effective as the original.

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!!

PRIVACY POLICY ACKNOWLEDGMENT STATEMENT

I have been made aware that Fibroid and Pelvic Wellness Center of Georgia (also known as Medical Therapy Specialist, LLC) has a Privacy Policy in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a patient of Fibroid and Pelvic Wellness Center of Georgia, I understand and acknowledge the following:

- 1. Fibroid and Pelvic Wellness Center of Georgia have a privacy policy in effect in their offices.*
- 2. Fibroid and Pelvic Wellness Center of Georgia have made this policy available to me for review, if requested.*
- 3. Fibroid and Pelvic Wellness Center of Georgia have made me aware that I am entitled to a copy of this Privacy Policy.*

This practice participates in research studies. Your chart may be reviewed by the staff at Fibroid and Pelvic Wellness Center of Georgia to gather data so that we can continue to provide our excellent quality of care. You will not be identified Fibroid and Pelvic Wellness Center of Georgia (Medical Therapy Specialist, LLC) follows all HIPAA regulations.

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by Fibroid and Pelvic Wellness Center of Georgia and have read and understand this acknowledgment form. If you desire a copy of the Privacy Policy, please request one at this time.

_____ *NO, I do not want a copy, but acknowledge that the Privacy Policy exists.*

_____ *YES, I do want a copy of the Privacy Policy.*

Patient Name

Patient Signature

Date



AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____

I hereby authorize Fibroid & Pelvic Wellness Center (Medical Therapy Specialists) to release information to any medical facility or physician to which this office may refer me.

I authorize Fibroid & Pelvic Wellness Center (Medical Therapy Specialists) to release information to any medical facility or physician to which I may be referred by this office to obtain copies of medical information from any medical facility or physician, which may be related to my care and or treatment.

I also authorize Fibroid & Pelvic Wellness Center (Medical Therapy Specialists) to release information to any medical facility or physician to which I may be referred by this office to release medical records from this office, related to my medical history, physical examination, or surgery to other physicians who care for me to provide continuity of care and communication between my physicians on my behalf.

I hereby release this office and its employees, agents, officers and affiliates from any and all liability, responsibility, claims and damages which may arise as a result of the release of information authorized by this Consent Form.

I have read and understand this Consent for Release of Medical information and have voluntarily and knowingly signed such consent.

Patient Signature

Date

Parent/Guardian Signature

LIST OF PHYSICIANS WHO CARE FOR YOU:

Name	Specialty	Address & Phone Number
_____ Name	_____ Specialty	_____ Address & Phone Number
_____ Name	_____ Specialty	_____ Address & Phone Number
_____ Name	_____ Specialty	_____ Address & Phone Number



AUTHORIZATION TO RECEIVE MEDICAL RECORDS

Patient Name: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____

Name & Address of Physician Sending Records:

The above named physician(s) are hereby authorized to release to:

Dr. Soyini Hawkins, MD

I, _____, hereby authorize the above named facility/physician to release my medical records, including any psychiatric, alcohol or drug abuse information. Specifically, the following:

- | | |
|---|---|
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Progress Reports | <input type="checkbox"/> Psychiatric Notes |
| <input type="checkbox"/> History / Physical | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Special Diagnostic Reports (EKG, EEG, etc) |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other: _____ |

The information is needed for the following purpose (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Continued care by the receiving facility/physician | <input type="checkbox"/> Legal proceedings or advise |
| <input type="checkbox"/> Claims settlement with insurance company | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Needed to receive aid by the above named agency | <input type="checkbox"/> Other: _____ |

SIGNATURE: *(This authorization is valid for a period of 90 days from the date signed)*

I have read and understand this Consent for Release of Medical Information, and have voluntarily and knowingly signed such consent.

Signature

Date

Directions

Atlanta (Alpharetta) Office

Fibroid and Pelvic Wellness Center of Georgia is located in Alpharetta, about 25 minutes from the Perimeter and 40 minutes from Buckhead.

From the South:

Take I-85 North, and take the exit for GA. Highway 400. Take the exit for Old Milton Parkway (exit #10). Turn right onto Old Milton Parkway. Turn left at the first traffic light- onto Morris Road. Take the first right into the North Crescent Medical Center. We are located in the building to the left. You can park in the front, or circle round to the back doors. We are conveniently located on the first floor, suite 140.

From the North:

Take Highway 400 South, and take Old Milton Parkway (exit #10). Turn left onto Old Milton Parkway. Turn left at the second traffic light onto Morris Road. Take the first right into the North Crescent Medical Center. We are located in the building to the left. You can park in the front, or circle round to the back doors. We are conveniently located on the first floor, suite 140.

From the East:

Take I-285 West, and take the exit for 400 North. Continue on 400 North, and take the exit for Old Milton Parkway (exit #10). Turn right onto Old Milton Parkway. Turn left at the first traffic light- onto Morris Road. Take the first right into the North Crescent Medical Center. We are located in the building to the left. You can park in the front, or circle round to the back doors. We are conveniently located on the first floor, suite 140.

From the West:

Take I-285 East, and take the exit for Ga. Hwy. 400 North. Continue on 400 North, and take the exit for Old Milton Parkway (exit #10). Turn right onto Old Milton Parkway. Turn left at the first traffic light- onto Morris Road. Take the first right into the North Crescent Medical Center. We are located in the building to the left. You can park in the front, or circle round to the back doors. We are conveniently located on the first floor, suite 140.

