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:_______________ __________

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: ____________

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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):**

____

____

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Soyini Hawkins, MD, MPH, FACOG

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: ____

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Wellness Center of Georgia
Soyini Hawkins, MD, MPH, FACOG

Medical History – Page 3

Name:_____________________________, ___________________________________
(Last) (First) (MI)

Review of Symptoms (Check any conditions present today)

Constitutional

______ Fever

______ Chills
______ Weight Loss

Gastrointestinal

______ Nausea

______Vomiting
______Diarrhea
______ Constipation
______ Blood in Stool
______ Difficulty Swallowing

Psychiatric

______ Depression

______Nervousness
______Anxiety
______Mood Swings

Skin

______ Bruise Easily
______ Rash
______ Change in Mole
______ Non-healing Sore
______ Dizziness

Neurological

______Headache
______Blurred Vision
______Numbness
______Tingling

Endocrine / Metabolic

______Hot Flashes
______Night Sweats
______Excessive Thirst
______Excessive Hunger
______Excessive Urine Output

Cardiovascular

______ Heart Fluttering
______ Chest Pain

Respiratory

______Cough
______Shortness of Breath

Blood / Lymph

______Swollen Glands
______Bleeding Problems

Genital / Urinary

______ Painful Urination
______ Blood in Urine
______ Incontinence

Female Genitalia

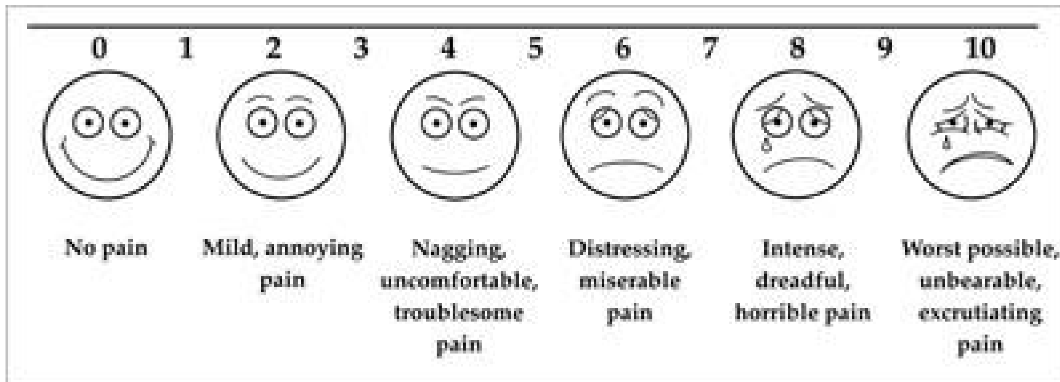
______Discharge
______Pelvic Pain
______Heavy bleeding
______ Menstrual Pain
______ Pain with Intercourse

______**I have none of these problems today**

Please indicate your level of pain today by circling the appropriate number below:

Fibroid and Pelvic Wellness Center of Georgia

Soyini Hawkins, MD, MPH, FACOG



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 RESPONSIBILTY: 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
11975 Morris Road, Suite 140
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!!

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Fibroid and Pelvic Wellness Center of Georgia
Soyini Hawkins, MD, MPH, FACOG

PRIVACY POLICY ACKNOWLEDGMENT STATEMENT

I have been made aware that Fibroid and Pelvic Wellness Center of Georgia (also known as Urogynecology, PC) 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 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*

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: ____

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

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

I authorize Fibroid & Pelvic Wellness Center 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 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
____________________	_________________	____________________________________
____________________	_________________	____________________________________
____________________	_________________	____________________________________
____________________	_________________	____________________________________

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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:*

____Laboratory Reports ____Pathology Reports

____Progress Reports ____Psychiatric Notes

____History / Physical ____Operative Reports

____Radiology Reports ____Special Diagnostic Reports (EKG, EEG, etc)

____Discharge Summary ____Other: ________________________

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

____Continued care by the receiving facility/physician ____Legal proceedings or advise

____Claims settlement with insurance company ____Personal Use

____Needed to receive aid by the above named agency ____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

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Fibroid and Pelvic Wellness Center of Georgia

Soyini Hawkins, MD, MPH, FACOG

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 1-85 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.

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