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

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: _____

4028 Holcomb Bridge Road, Suite 200/202 Peachtree Corners, GA 30092
Phone: 678-580-1736 Fax: 877-296-3813

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

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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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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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

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

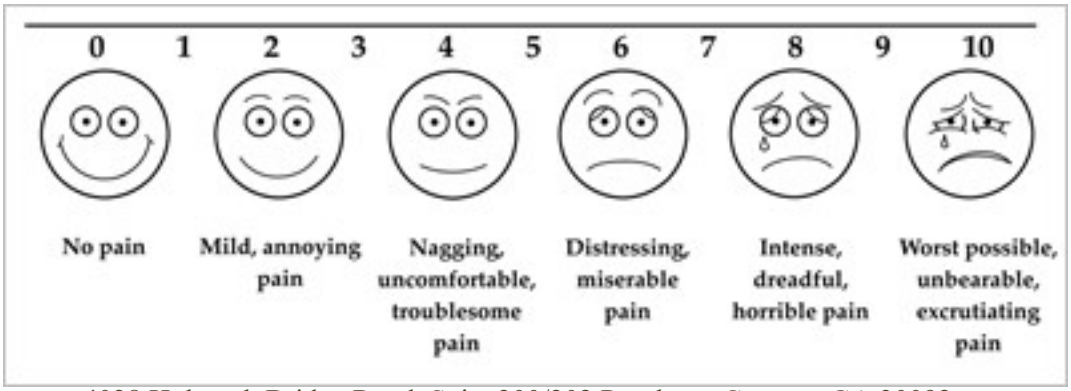
_____ Painful Urination
_____ Blood in Urine
_____ Incontinence

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:



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

Office Policies and Financial Payment Agreement

Fibroid and Pelvic Wellness Center of Georgia (also known as Hawkins MD, 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 isyour responsibility (since we have not asked for payment in full) to send us the check (endorsed over to Hawkins MD, LLC), along with the Explanation ofBenefits 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:_____

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

Surgery Cancellation Policy

Please note we here at *Fibroid and Pelvic Wellness Center of Georgia* consider your upcoming surgery date to be very important and we're here to guide you through this process. However, we understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least a 2 week notice for cancellations or rescheduling of your surgery date.

Please understand that when you forget, cancel, or change your surgery without giving enough notice, we miss the opportunity to fill that date, and clients on our wait list miss the opportunity to receive services.

In addition, we will honor rescheduling or canceling your surgery date **once as a courtesy**. Thereafter, our staff will not be permitted to add you back to the surgery schedule. You will then have to find another provider to preform your surgery.

Thank you for viewing and supporting our cancellation and rescheduling policy criteria!

Signature of patient or guardian: _____ ***Date:*** _____

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Fibroid and Pelvic Wellness Center of Georgia
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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
4028 Holcomb Bridge Road, Suite 200/202
Peachtree Corners, GA 30092
Phone: 678-580-1736
Fax: 877-296-3813

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 <u>ANY</u> questions regarding the content of this form, please see a member of our front office staff for clarification, <u>PRIOR TO SIGNING</u>!!

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

PRIVACY POLICY ACKNOWLEDGMENT STATEMENT

I have been made aware that Fibroid and Pelvic Wellness Center of Georgia (also known as Hawkins MD, 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 (Hawkins MD, 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*

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Fibroid and Pelvic Wellness Center of Georgia
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

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

I hereby authorize Fibroid & Pelvic Wellness Center (Hawkins MD, LLC) to release information to any medical facility or physician to which this office may refer me.

I authorize Fibroid & Pelvic Wellness Center (Hawkins MD, LLC) 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 (Hawkins MD, LLC) 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

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Fibroid and Pelvic Wellness Center of Georgia
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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

Directions

4028 Holcomb Bridge Rd. Suite 200 and 202 Peachtree Corners, GA 30092
Fibroid and Pelvic Wellness Center of Georgia is located in Peachtree Corners, about 20 minutes from the Perimeter and 30 minutes from Buckhead.

From the South:
Follow I-75/85 North to 285 West; Merge to Peachtree Industrial Blvd Exit 31B; Take exit towards GA-140/Jimmy Carter Blvd; Exit toward GA-140/Jimmy Carter Boulevard; Continue on Peachtree Industrial; Exit Jimmy Carter Blvd/GA-140, Turn Left; Proceed approx. 2 miles. Location will be on the Right, immediately after you pass the Animal Clinic & across the street from the Dunkin Donuts. We are located around the back of the building.

From the North:
Follow 85 South to Exit 102 Beaver Ruin Rd. toward Lilburn; Merge toward Norcross; Process 2.93 Miles, Turn left on Buford Hwy/US23/GA-13; Proceed 1.41 Miles; Turn right on Jimmy Carter Blvd/GA140; Continue to Follow GA/140; Location is 3.38 Miles on the Right, immediately after you pass the Animal Clinic & across the street from the Dunkin Donuts. We are located around the back of the building.

From the East:
Take I-285 West, Exit 31B Peachtree Industrial Blvd/GA-141 N; Exit toward GA-140/ Jimmy Carter Boulevard. Continue on Peachtree Industrial, then Exit Jimmy Carter Blvd/GA-140, Turn Left; Proceed approx. 2 miles. Location will be on the Right, immediately after you pass the Animal Clinic & across the street from the Dunkin Donuts. We are located around the back of the building.

From the West:
Take I-285 East, Exit 31B Peachtree Industrial Blvd/GA-141 N; Exit toward GA-140/ Jimmy Carter Boulevard. Continue on Peachtree Industrial, then Exit Jimmy Carter Blvd/GA-140, Turn Left; Proceed approx. 2 miles. Location will be on the Right, immediately after you pass the Animal Clinic & across the street from the Dunkin Donuts. We are located around the back of the building.

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