Obstetrics and Gynecology

50 Medical Drive Suite 100 (806) 467.5880
Borger, TX. 79007

PATIENT INFORMATION

First Name_____ MI ____ Last Name_____ Date of Birth _____

Age: _____ Social Security # _____ Race _____ Ethnicity: _____ Sex: Female / Male Marital Status: S M W D

Email Address:_____

Mailing Address _____ City _____ State_____ Zip_____

Physical Address_____ City _____ State_____ Zip_____

Home Phone # _____ Cell Phone # _____

Patient Employer_____ Phone # _____ Occupation _____

Emergency Contact Name_____ Emergency Contact Phone # _____

Personal Physician_____ Referred by Dr. _____ Dental Provider: _____

RESPONSIBLE PARTY / BILLING INFORMATION ☐ *Same as PATIENT information*

First Name_____ MI ____ Last Name_____ Date of Birth _____

Age: _____ Social Security # _____ Sex: Female / Male Relation to Patient:_____

Mailing Address _____ City _____ State_____ Zip_____

Home Phone # _____ Cell Phone # _____

Employer_____ Phone # _____ Occupation_____

INSURANCE INFORMATION Do you have Insurance? [ ] Yes [ ] No Is this an on the job injury? [ ] Yes [ ] No Date of injury? _____

*You must provide our office with a current Insurance card.

1) Insurance Carrier Name_____ 2) Insurance Carrier Name_____

INSURED / POLICY HOLDER INFORMATION ☐ *Same as PATIENT information* ☐ *Same as RESPONSIBLE PARTY information*

First Name_____ MI ____ Last Name_____ Date of Birth _____

Age: _____ Social Security # _____ Sex: Female / Male Relation to Patient:_____

Mailing Address _____ City _____ State_____ Zip_____

Home Phone # _____ Cell Phone # _____

Employer_____ Phone # _____ Occupation_____

AUTHORIZATIONS AND ACKNOWLEDGEMENT

Do you have an advanced directive? [ ] Yes [ ] No If so we will need a copy for your file. Copy provided [ ] Yes [ ] No

Do you have a Durable Power of Attorney for Healthcare? [ ] Yes [ ] No If so we will need a copy for your file. Copy provided [ ] Yes [ ] No

I voluntarily request that Borger Obstetrics and Gynecology and such assistants as they may deem necessary, manage/treat my condition and I hereby release Borger Obstetrics and Gynecology, Golden Plains Community Hospital and any other participating health care providers from any and all liability. The duration of this consent is identified and continues until revoked in writing.

BENEFITS TO PHYSICIAN: I hereby authorize the release of information relating to all claims for referral and benefits submitted on behalf of myself and/or dependents I hereby authorize payments directly to Golden Plains Community Hospital and/or the health care provider of the medical and/or surgical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company.

I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicated that I have read the above and grant the request of authorizations.

X_____ _____ _____

Signature of Patient or legal guardian **Printed Name** **Date**

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PATIENT HISTORY FORM

NAME: _____ **Date** ____/____/____

DOB: _____ **Age:** _____ **PREFERRED PHARMACY:** _____ **PERSONAL PHYSICIAN:** _____

A. REVIEW OF SYSTEMS

YES	NO	GENERAL
		1. Unexplained weight loss more than 10 lbs. in the past year?
		2. Night sweats
CARDIO-RESPIRATORY		
YES	**NO**	
		3. Hypertension (high blood pressure)
		5. Chest Pain
		6. Blood Clots
		7. Swelling of legs or feet
		9. Shortness of breath
GASTROINTESTINAL		
YES	**NO**	
		11. Constipation
		12. Diarrhea
		13. Blood in stools
		14. Liver Problems
		15. Gallbladder Problems
		16. Trouble Swallowing
MUSCULOSKELETAL		
YES	**NO**	
		22. Swollen or painful joints / Where? _____
		23. Osteoporosis
		24. Gout
SKIN		
YES	**NO**	
		25. Acne
		26. Rash
NEUROLOGICAL		
YES	**NO**	
		27. Headache
		28. Seizures
		29. Dizziness
PHYCHOLOGICAL		
YES	**NO**	
		30. Depression / Anxiety
		31. Bipolar Disorder
YES	**NO**	**ENDOCRINE**
		30. Thyroid problems
		31. Diabetes
YES	**NO**	**PREVENTATIVE**
		32. Colonoscopy after age 50? Date: _____
		33. Mammogram after age 40? Date_____
HEMATOLOGICAL / LYMPHATIC		
YES	**NO**	
		34. Anemia
		35. Blood clotting disorder

ALLERGY *(please list)*

1.

2.

B. Obstetrical History

(please list **ALL** pregnancies in order, including miscarriages, premature births, stillbirths, ectopic (tubal) and abortions

Year	M / F	Wt.	Type of Delivery	Length of pregnancy	Problems	Age

GYN HISTORY (Check ALL that apply)

Age of first Period? _____ | Last Menstrual period? _____

Cycle length every _____ days | Lasting _____ days

Periods are: ❑Regular ❑Irregular ❑Painful ❑not bothersome | **Flow is:** ❑Light ❑Light to moderate ❑Moderate to heavy ❑Very Heavy

Date of last PAP Smear _____ ❑Normal ❑ Abnormal

METHOD OF BIRTH CONTROL

❑	Condoms	❑	Pills	❑	Patch	❑	Vaginal Ring
❑	Tubal	❑	Essure	❑	IUD	❑	Other
❑	Partner with Vasectomy			❑	Natural family planning		

SEXUAL HISTORY

YES	NO	
		Are you sexually active?
		Virginal?
		New partners?

Number of lifetime partners? _____

Sexual preference?

❑	Heterosexual (Opposite sex)	❑	Same Sex	❑	Bi-sexual

MEDICATION LIST

1.

2.

3.

4.

5.

HOSPITALIZATION AND SURGERIES

Year	Reason

COMMENTS:

CONTINUED NEXT PAGE

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3.	
4.	

PATIENT HISTORY FORM

NAME: _____ **Date** ____/____/____

DOB: _____ **Age:** _____ **PREFERRED PHARMACY:** _____ **PERSONAL PHYSICIAN:** _____

C. FAMILY HISTORY			
Are you adopted? ☐Yes ☐ No			
Have your biological (parents, brothers, sister) had any of the following?			
YES	**NO**	**Diagnosis**	**RELATIVE**
		Heart disease/ heart attack/stroke before age 50	
		High blood cholesterol	
		Genetic problems	
		Cancer What Type?	
		Diabetes	
		Osteoporosis	
		Blood Clots	
Race			
Ethnicity			
Preferred Language			

D. SOCIAL HISTORY	**E. EDUCATION**		
ALCOHOL HISTORY: ☐Current ☐ Former *Type* _____ ☐ None	Education	High School / College	Year
Per Day #_____ Years Used_____ Years Quit_____			
SMOKING HISTORY: ☐Current ☐ Former *Type* _____ ☐ None			
Per Day #_____ Years Used_____ Years Quit_____			
DRUG USE: ☐Current ☐ Former *Type* _____ ☐ None			
Per Day #_____ Years Used_____ Years Quit_____			
EXPOSURE TO SECOND HAND SMOKE ☐ YES ☐ NO			
☐ In the home ☐ Other:			

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Welcome to our practice!

We want to ensure the timely management of your account and help you in obtaining reimbursement from your insurance company. To accomplish this, we need your understanding and acceptance of our financial policy.

PARTICIPATING PROVIDER

We are providers for a select group of major PPO and HMO networks. However due to the complexity of managed care plans, it is difficult for us to know the details of each patient's plan. Therefore it is **your** responsibility to ensure that your physician and ancillary providers are participating providers in your plan. You should verify this information by contacting your insurance plan or reviewing your provider list before an appointment. You will be responsible for payment in full for services rendered by a physician if he/she is not in your plan.

YOU MUST PRESENT A VALID ID CARD AND INSURANCE CARD AT THE TIME OF SERVICE IN ORDER FOR US TO FILE A CLAIM FOR YOU.

REFERRALS

It is ***your*** responsibility to obtain from your primary care physician referrals required by your insurance company to see a specialist, as well as to track the number of your visits and keep your referrals current. Without a current referral at the time of the visit, your appointment will have to be rescheduled.

CO-PAYMENTS

We are required to collect your co-payment at the time of service. If the co-pay amount is not listed on your card, or you have a standard traditional plan, we will collect the percentage of the services rendered that is applicable to your plan.

NON-MANAGED CARE

For non-managed care of traditional plans, we will file a claim as a courtesy. However, the contract with your insurance company is between you and this company. We are not a party to that contract. You are ultimately responsible for your bill, regardless of any non-payment by the insurance carrier. If within 45 days payment is not relieved by your insurance company, payment will be due by you, regardless of the status of your claim.

DEDUCTIBLE

If you have a deductible, and it is likely that the services rendered will go toward your deductible, payment in full must be made at the time of service. Unless other arrangements have been made with our office

PRECERTIFICATION OF HOSPITAL ADMISSION OR SPECIAL SERVICES

Pre-certification of hospital admissions and other special services is an area in which we strive to help. With the exception of some HMO plans, it is ultimately the patient's responsibility to inform this office when pre-certification is a requirement of your plan. Due to the varying policy provisions of all the different plans, it is impossible for us to know each patient's specific plan provisions. If you fail to disclose pre-certification requirements PRIOR to services being rendered, you will be responsible for payment of all related fees in full.

FOR ALL SERVICES PROVIDED OUTSIDE OF OUR OFFICE, YOU MUST BE AWARE OF; AND INFORM US, WHICH MEDICAL FACILITIES ARE APPROVED BY YOUR PLAN. THIS INCLUDES X-RAY, LABORATORY, DIAGNOSTIC, AND REHABILITATION FACILITIES.

SECONDARY INSURANCE

We will file secondary insurance as a courtesy for you. Please keep in mind that payment of your account is ultimately your responsibility, and we will look to you for payment of your account if we are unsuccessful in obtaining reimbursement by your insurance.

RESPONSIBLE PARTY (GUARANTOR)

The guarantor of the account is the patient who comes in for treatment or the adult who brings in the minor child for treatment, regardless of any court decisions or insurance coverage. If someone other than the guarantor brings in the minor child, that person will be required to pay for services rendered and they will be provided a receipt. It is not the policy of our office to become involved in medical bill disputes resulting from divorce, etc.

LIABILITY OR AUTO ACCIDENT CLAIMS

We do not become involved in automobile or liability lawsuits, nor do we file liability claims or wait on "settlements". You will be required to pay in full for services rendered. We will provide you with the information necessary to file your claim.

PAYMENT PLANS

We understand that from time to time unexpected circumstances may arise which make paying for medical care difficult. With this understanding, we provide payment plans to assist you in the management of your account. Please notify us if you need this service.

NSF CHECKS

Once a check is returned for NSF, we will accept only cash or money orders for future visits.

NON-PAYMENT OF ACCOUNTS / NON-COMPLIANCE

Accounts for which we are unable to collect, the balance will be discharged. Our physicians reserve the right to discontinue patient care for non-payment or non-compliance. In this instance, a sufficient prior notice will be given and records provided.

ACCEPTANCE OF FINANCIAL POLICY

The undersigned hereby certifies that he/she has read, understood, and agrees to the policy of this office.

X_____ _____

Signature of patient or legal guardian **Date**

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ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I acknowledge that **Golden Plains Community Hospital** provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient Signature	Date
Personal Representative Signature (if applicable)	Relationship to Patient

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Permission to Disclose Information
To those involved in my care

Patient Name: _____ DOB: _____

I hereby allow Borger Obstetrics and Gynecology to disclose the following information to the people listed below.

(Please give full name)

- ❑ Spouse: _____
- ❑ Family friend(s): _____
- ❑ Children: _____
- ❑ Others: _____

_____

In the following forms of communications

- ❑ Home Telephone
- ❑ Work Telephone
- ❑ Home voice messaging system
- ❑ Work voice messaging system
- ❑ Cellular phone
- ❑ Cellular voice messaging system
- ❑ Other: _____
- ❑ All of the above

• I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department. Revocation will not apply to information that has already been disclosed in response to this authorization.

_____ _____
Patient / Guardian Signature Date:

_____ _____
Witness Date:

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Edinburgh Postnatal Depression Scale

Instructions
Please circle the response that comes closest to how you have been feeling IN THE PAST 7 DAYS. Please answer all questions.

Here is an EXAMPLE already completed.
I have felt happy:
0 Yes, all the time
1 (Yes, most of the time) This would mean: "I have felt happy most of the time" during the past week.
2 No, not very often Please complete the other questions in the same way.
3 No, not at all

Please answer all questions below:
(Circle one answer in each question)

In the past 7 days

1. I have been able to laugh and see the funny side of things
   0 As much as I always could
   1 Not quite so much now
   2 Definitely not so much now
   3 Not at all

2. I have looked forward with enjoyment to things
   0 As much as I ever did
   1 Rather less than I used to
   2 Definitely less than I used to
   3 Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   3 Yes, most of the time
   2 Yes, some of the time
   1 Not very often
   0 No, never

4. I have been anxious or worried for no good reason
   0 No, not at all
   1 Hardly ever
   2 Yes, sometimes
   3 Yes, very often

5. I have felt scared or panicky for no very good reason
   3 Yes, quite a lot
   2 Yes, sometimes
   1 No, not much
   0 No, not at all

6. Things have been getting on top of me
   3 Yes, most of the time I haven't been able to cope at all
   2 Yes, sometimes I haven't been coping as well as usual
   1 No, most of the time I have coped quite well
   0 No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   3 Yes, most of the time
   2 Yes, sometimes
   1 Not very often
   0 No, not at all

8. I have felt sad or miserable
   3 Yes, most of the time
   2 Yes, quite often
   1 Not very often
   0 No, not at all

9. I have been so unhappy that I have been crying
   3 Yes, most of the time
   2 Yes, quite often
   1 Only occasionally
   0 No, never

10. The thought of harming myself has occurred to me
    3 Yes, quite often
    2 Sometimes
    1 Hardly ever
    0 Never

For Office Use Only	Screen Administration	Screened During	Score
Patient #_____	Self Administered:_____	Week/Date:_____	Total:_____
Administered/Reviewed by_____	Assisted: _____	Week/Date:_____	#10 Score:_____
		Week/Date:_____	

Source: Cox, J.L. Holden J.M. and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburg Postnatal Depression Scale. British Journal of Psychiatry 150:782-786.
Source: K.L Wisner, B.L Parry, C.M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199.

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Patient Label

GOLDEN PLAINS COMMUNITY HOSPITAL

CONDITION OF ADMISSION

AUTHORIZATION FOR TREATMENT AND /OR SURGERY

The patient and others whose signatures are attached below do hereby consent to any and all medical surgical treatments, including anesthetics and operations, which may be deemed advisable by his or her physicians or surgeons serving on the staff of Golden Plains Community Hospital, the intention hereof being to grant authority to administer and to perform all and singular examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the course of the patients care be deemed advisable or necessary. We also agree that the patient when admitted is to remain in the HOSPITAL until his or her physicians recommend the patient's discharge, and when the physicians decide that the patient no longer needs HOSPITAL care, we consent to and authorize patient's transfer to his or her home or place of abode. In witness of our consent and agreement of the matters stated in the two preceding sentences, we have subscribed our signature below.

ASSIGNMENT OF BENEFITS – HOSPITAL

I/We hereby transfer, assign and convey all my/our rights, title and interest in and all benefits due me/us, if any, by reason of services described in the statements rendered, and as provided for in any contract or policy of insurance under which I/we may be an insured or beneficiary and I direct said insurance company(s) to pay directly to Golden Plains Community Hospital, at Borger, Hutchinson County, Texas, all of such benefits. I/We also assign my/our causes of action against any and all third parties who may be responsible or liable for the injuries requiring admission to or treatment by Golden Plains Community Hospital, up to but not to exceed the amount of charges described in the statements rendered. I agree to pay the HOSPITAL any remaining balance after insurance payment or denial of coverage under this assignment of benefits.

AUTHORIZATION TO RELEASE INFORMATION

I authorize that any medical, mental health, HIV testing and status, and/or substance abuse information be released. I understand and agree that no liability of any nature shall attach to the releasing organization or person, to any physician or surgeon in release of this information, or to any employee of them acting upon this request.

ASSIGNMENT OF BENEFITS – PHYSICIANS

I agree to be primarily responsible for payment of physician(s) charges. I also assign to my physician(s) my right to all applicable insurance benefits and my cause(s) of action against any third party responsible or liable for the condition or injuries requiring physician services. I grant the physician(s) a lien against all settlement proceeds or recovery by judgment from any such third party – up to but not to exceed the amount of the physician's charges and reasonable attorney fees.

MEDICARE ASSIGNMENT AND AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information to release to the Social Security Administration, Health Care Financing Administration or their intermediaries any information needed for this or any related Medicare claim. I request that payment of authorized benefits be made on my behalf.

PATIENT VALUABLES

All parties are advised that valuables should not be kept in their respective HOSPITAL room. Proper and safe facilities for any valuables are offered by the HOSPITAL. The HOSPITAL is not responsible for valuables not properly registered. The HOSPITAL cannot be held responsible for personal belongings and it is strongly urged that you not keep any personal items of significant value in your room.

AUTHORIZATION/PRECERTIFICATION

If my group or private insurance policy requires prior certification, authorization, second opinions, or any other types of utilization review function, I understand that I am responsible for compliance with these and all other terms of my policy.

PATIENT FINANCIAL RESPONSIBILITY

The HOSPITAL's election to pursue one or more forms of collection shall not constitute a waiver of its right to pursue other collection measures it deems advisable or necessary. All such remedies shall be cumulative in nature. Venue for collection shall be Hutchinson County, Texas. This agreement shall not require payment any person in contravention of any state or federal statue, rule or regulation.

Do you give Golden Plains Community Hospital permission to contact you on the numbers you provided? Yes_____ No_____

_____ I have read/received a copy of the **PATIENT RIGHTS AND RESPONSIBILITIES.**

_____ _____

Signature of Patient or Legally Authorized Representative Date Registration Clerk Signature

ADVANCE DIRECTIVES

Do you have an Advance Directive?	Yes_____	No_____	Booklet Given_____
Declaration for Mental Health?	Yes_____	No_____	Booklet Given_____

If yes, please give a copy to your RN.

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Patient's Name: _____ Today's date_____

PELVIC PAIN and URGENCY/FREQUENCY PATIENT SYMPTOM SCALE

Please circle the answer that best describes how you feel for each question.

		0	1	2	3	4	SYMPTOM SCORE	BOTHER SCORE
1	How many times do you go to the bathroom during the day?	3-6	7-10	11-14	15-19	20+		
2	a. How many times do you go to the bathroom at night?	0	1	2	3	4+		
	b. If you get up at night to go to the bathroom, does it bother you?	Never Bothers	Occasionally	Usually	Always			
3	a. Do you now or have you ever had pain or symptoms during or after sexual intercourse?	Never	Occasionally	Usually	Always			
	b. Has pain or urgency ever made you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
4	Do you have pain associated with your bladder or in your pelvis (vagina, labia, lower abdomen, urethra, perineum,	Never	Occasionally	Usually	Always			
5	a. If you have pain, is it usually		Mild	Moderate	Severe			
	b. Does your pain bother you?	Never	Occasionally	Usually	Always			
6	Do you still have urgency after going to the bathroom?	Never	Occasionally	Usually	Always			
7	a. If you have urgency, is it usually		Mild	Moderate	Severe			
	b. Does your urgency bother you?	Never	Occasionally	Usually	Always			
8	Are you sexually active? Yes No							

SYMPTOM SCORE = (1, 2a, 3a, 4, 5a, 6, 7a)	
BOTHER SCORE = (2b, 3b, 5b, 7b)	
TOTAL SCORE (Symptom Score + Bother Score) =	

Revised 11/17/2003

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How did you hear about us??

Please check one:

Newspaper		**United Pharmacy Bags**	
Commercial/Morley		Circulars(postcards)	
Google Ads		Website	
Radio		Facebook	
Billboard		Other --- Football program	---

Provider

Dr. Landers
Dr. Patel X
Dr. Garrett-Price
Dr. Daneshfar

Golden Plains Specialty Clinic

Tel 806-467-5350

50 Medical Drive
Borger, TX 79007

goldenplains.org