

17183 I-45 S, Suite 410
The Woodlands, TX 77385
(281) 602-7380 / (281) 602- 7386 Fax

PATIENT INFORMATION

Name (as it appears on your insurance card): _____

Preferred Name: _____

DOB: _____ Social Security #: _____

Address: _____

City/State/Zip: _____

Hm #: _____ Work #: _____ Cell #: _____

Employer: _____ Email: _____

How did you hear about us? _____

Primary Care Physician: _____

Preferred Pharmacy: _____ Pharm#: _____

SPOUSE INFORMATION

Name: _____ DOB: _____ SSN#: _____

Contact Phone #: _____

EMERGENCY INFO

Name: _____ Phone #: _____

Relationship: _____

****Please be advised that we are NOT Medicaid providers, if at any time you apply or become eligible to receive Medicaid, we will no longer be able to provide services to you. ****

**** Please remember to bring your insurance card and picture ID with you to your appointment. ****

PRIMARY INSURANCE INFORMATION

Insurance Company: _____
Member ID: _____ Group #: _____
Mailing Address for Claims: _____

PRIMARY INSURED/RESPONSIBLE PARTY

Name: _____ DOB: _____ SS #: _____
Address (if different): _____ City/Zip: _____
Hm #: _____ Work #: _____ Cell #: _____
Employer: _____ Email: _____
Relationship to Patient: Self Spouse Significant Parent

SECONDARY INSURANCE INFORMATION

Insurance Company: _____
Member ID: _____ Group #: _____
Mailing Address for Claims: _____

SECONDARY INSURED/RESPONSIBLE PARTY

Name: _____ DOB: _____ SS #: _____
Address (if different): _____ City/Zip: _____
Hm #: _____ Work #: _____ Cell #: _____
Employer: _____ Email: _____
Relationship to Patient: Self Spouse Significant Other Parent



Medical History Form

Patient Name: _____ DOB: _____

Gynecologic History

What was the first day of your last period?	Are you currently sexually active? Yes / No If no, have you ever had sex? Yes / No
At what age did your periods start?	Any abnormal vaginal discharge? Yes / No
At what age did you periods stop?	Have you ever tested positive for HPV? Yes / No
How often do you have a period? Every _____ days	Have you ever been treated for a pelvic infection? Yes / No
How many days does your period last? _____ days	Any pain with sex? Yes / No
Any pain with your periods? Yes / No	Have you ever been treated for infertility? Yes / No
Any changes in your periods? Yes / No	Have you ever had herpes? Yes / No
When was your last pap test?	Your present method of birth control is:
Have you ever had an abnormal pap? Yes / No If yes, when..... If yes, explain.....	Are you trying to get pregnant? Yes / No

Obstetrical History

	Number		Number		Number
Total Pregnancies		Abortions		Miscarriages	
Preterm Births (<37 weeks)		Term Births		Living Children	

No.	Birth Date	Weight	Baby's Sex	Number of weeks @ Delivery	Vaginal or C-Section	Complications
1						
2						
3						
4						
5						
6						

Any history of diabetes, high blood pressure or pre-eclampsia with your pregnancies?
Any history of postpartum depression? Prescribed medication?
History of chicken pox or chicken pox vaccination?
History of rheumatic fever or heart disease?
History of shoulder dystocia?
History of gestational diabetes mellitus?
History of 4 th degree laceration?

Medical History

Are you allergic to any medications?	Yes / No
If so, please provide name and list reaction...	

Any History of.....

Asthma	Yes / No	Heart Failure	Yes / No
Diabetes	Yes / No	Heart Attack	Yes / No
Eating Disorder	Yes / No	High Blood Pressure	Yes / No
Bowel Problems	Yes / No	Abnormal Heart Rhythm	Yes / No
Ulcer or Gastritis	Yes / No	Blood Clots in legs/lungs	Yes / No
Liver Problems	Yes / No	Lupus	Yes / No
Thyroid Problems	Yes / No	Sexually Transmitted Disease	Yes / No
Blood Problems	Yes / No	If yes, what?	
Kidney Problems	Yes / No	Cancer	Yes / No
		If so, where?	

Do you have any medical problems you take medication for? If yes, explain...
Hospitalization? If yes, explain...
Blood Transfusion? If yes, explain...
Surgeries? If yes, list along with date...
Recent Immunizations: Hepatitis B? Tetanus?

Social History

Marital Status: Single Married Partner Widowed Divorced
 Same sex partner

Tobacco: Never smoked Quit
 Smoker (years smoked, packs per day)

Alcohol: Never <1 week 1-5 per week Other

Drug Use: Yes, No

Seat belt use: Yes No

Regular exercise: Yes No

Do you take calcium or dairy products: Yes No

Have you been hurt by anyone: Yes No

Do you have an advance directive (living will): Yes No

Family History

Any history of these in a parent, sibling, child, grandparent or other relative?

Stroke	Yes / No	Osteoporosis	Yes / No
Diabetes	Yes / No	Bleeding Tendencies	Yes / No
Heart Problems	Yes / No	Sickle Cell or Thalassemia	Yes / No
Heart Attack	Yes / No	Hereditary Defects	Yes / No
High Blood Pressure	Yes / No	Cystic Fibrosis	Yes / No
Abnormal Heart Rhythm	Yes / No	Arthritis or Gout	Yes / No
Blood Clots in legs or lung	Yes / No	Mental Illness	Yes / No
High Cholesterol	Yes / No	Cancer	Yes / No
Tuberculosis	Yes / No	If so, where?	
		___ Breast	___ Other
		___ Ovarian	
		___ Uterine	

Medications (include over the counter medications, herbal remedies, and vitamins)

Name	Dose	Times per day	Why do you take it?

Preferred Pharmacy

Preferred Pharmacy Name: _____

Preferred Pharmacy Address: _____

City/State/Zip: _____

Pharmacy Phone number: _____

Pharmacy Fax number: _____

Signature of Patient/Legal Guardian: _____

Date: _____

What is an Annual Well-Woman Exam?

With current health insurance guidelines regarding preventive care coverage, it is important to keep routine preventive visits separate from visits that address specific medical concerns. This helps ensure that your insurance processes your annual well-woman exam correctly and that you receive the full preventive benefits covered under your plan.

What is Included in an Annual Well-Woman Exam?

An annual well-woman exam is a preventive visit for patients who are not experiencing new or ongoing medical problems. This visit may include:

- *Preventative screening and counseling appropriate for your age and risk factors
- *Breast exam and pelvic examination (if indicated)
- *Pap smear and/or HPV testing (if indicated)
- *Ordering routine screening test (such as mammogram, bone density, or standard screening labs)
- *Contraception counseling requiring detailed discussion or medication management

What is Not Included?

Concerns that require evaluation, diagnosis, or management are considered problem-focused visits. Examples include:

- *Hormone imbalance or menopause symptom management
- *Irregular or heavy bleeding
- *Pelvic pain
- *Breast concerns
- *Vaginal infections
- *Any new or ongoing medical condition

These concerns require additional time, evaluation, medical decision-making, and sometimes additional testing. Insurance companies classify this as a separate service.

***If a specific health-related problem is addressed at your annual exam, please be aware you will be charged an additional copay and visit. This determination is made by your insurance company based on the services provided.**

By signing, I acknowledge that I have read and understood the above information.

Patient Signature

Printed Name

Date



All About Women
OBSTETRICS & GYNECOLOGY

Dear valued patient,

Effective January 1, 2024, The Centers for Medicare and Medicaid Services (CMS) approved the use of CPT code 99459 to help with the ever-increasing costs of providing healthcare to women, specifically the additional costs associated with the use of a speculum, during a pelvic exam, and the cost of needing a chaperone for most of our exams.

Using CPT language, this code is considered a practice expense add-on code and is added to your Evaluation and Management (E &M) or problem visit, or your Well Women visit. Unfortunately, commercial insurance carriers often set their own rules and may not pay for this code, therefore, they may pass the cost of this code on to you. In some instances, this cost could be as high as \$50.

As you know, the availability of quality women's healthcare has become more and more difficult to find. This issue, which is seen in most specialties, has been made worse by the high incidence of retirements and closures after the public health emergency caused by Covid-19.

We are determined to continue to serve you, our valued patients, despite ever decreasing Medicare reimbursement as well as double digit inflation. Please understand, we feel this is a cost that should be covered by your insurance company, but if they refuse, the responsibility will be transferred to you.

PATIENT NAME: _____

DOB: _____

SIGNATURE: _____

Thank you,

All About Women OB Gyn

All About Women
OBSTETRICS & GYNECOLOGY

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I, _____ give
(Print Patient Name)

authorization to release my protected health information including laboratory test(s),
biopsy results, and/or other test results to the following designated representative(s).

Patient Initials

_____ Spouse: (Name) _____ DOB: _____

_____ Child(ren): (Name) _____ DOB: _____

_____ Other: (Name) _____ DOB: _____

Mark all that apply and initial:

May leave detailed voicemail on cell and/or home number on file _____
Initial

May leave detailed voicemail on work number on file _____
Initial

Do not release any of my protected health information to anyone other than
myself _____
Initial

Patient Signature

Date

Witness

Date

THIS AGREEMENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING



Patient Consent for Use of Disclosure of Protected Health Information

I hereby give my consent for All About Women Obstetrics and Gynecology to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and health care Operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. All About Women Obstetrics and Gynecology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy may be obtained by forwarding a written request to **17183 I-45 S, Suite 410, The Woodlands, TX 77385**.

With this consent, All About Women Obstetrics and Gynecology may call, mail, email, leave a message on voicemail or in person, to my home or other alternative location in reference to any items that assist the practice in carrying out TPO. Such items include: appointment reminder calls and cards, patient statements, insurance items and any calls pertaining to my clinical care, including laboratory test results.

I have the right to request that All About Women Obstetrics and Gynecology restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I authorize my insurance carrier to release information regarding my coverage to All About Women Obstetrics and Gynecology. I also authorize agents of any hospital, treatment center or previous physicians to furnish All About Women Obstetrics and Gynecology copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews with in this office.

By signing this form, I am consenting to allow All About Women Obstetrics and Gynecology to use and disclose my PHI to carry our TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, All About Women Obstetrics and Gynecology may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Relationship to Patient

Print Patient's Name

Print Name of Legal Guardian (if applicable)

Date



FINANCIAL POLICY AND PROCEDURES

All About Women Obstetrics and Gynecology believes all patients deserve the best medical care that can be provided. In order to provide the highest quality medical care and current technology, we must ensure we are able to meet the expenses necessary to operate this facility. To ensure these expenses are met, we provide you with this agreement to acquaint you with our financial policy.

Payment At Time of Service

- As a courtesy, we will bill your insurance for all office visits, procedures, surgeries and obstetrical care and delivery. We ask that you pay any portion not covered by your insurance due to deductibles or copayments on the day of service.

Appointment Policy

- Due to the nature of our busy obstetric practice, if you are more than 15 minutes late you will be asked to reschedule. Should you need to cancel your appointment, please give 24-hour prior notice in consideration to other patients. Failure of 24-hour notification will result in a \$25.00 fee.

Insurance Claims

- We will submit your insurance claims to your insurance company. However, it is important to remember your insurance is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays.

Balances Due After Insurance Pays

- Any remaining balance after your insurance carrier pays is due in 30 days. We attempt to collect these balances prior to any services, but this is an estimate. You will receive a statement from our office regarding any balance due.

Outstanding Balances

- We encourage you to keep your account current. Outstanding balances will need to be cleared before appointments can be made. Account balances past due will be sent to an outside agency for collections. At this point the account is out of our hands. To make appointments after accounts have been sent to an outside agency, you will need to clear your account with the collection agency. You will be responsible for the full amount of our account balance and any charges incurred with the agency. It is your responsibility to contact our business office if there are special circumstances regarding your account before your account is turned over to an outside agency.

Payment Options

- Our office accepts VISA, MasterCard, Discover, American Express, cash or check. A \$35.00 fee is charged for returned checks.

I have read the above statements and accept the terms.

Patient's Signature

Date

Responsible Party's Signature

Date

Relationship to patient