

ADVANCED GYNECOLOGY

Today's date:

First Name  MI  Last Name

Referred By:

Religious Preference:  E-mail Address:

Married  Spouse's Name  Single  Widowed  Divorced  Separated

Date of Birth  Age  Sex

Street Address  Home Phone

City/State  Zip  Cell Phone

Patient Employed By:  Work Phone

Occupation  Patient's Social Security #:

Primary Insurance Company:

Insurance Company Address:  State:  Zip

Insured's Name:  Insured's Social Security #:  & date of birth:

Policy/Group #:  Employer:

Insured's Day Phone #:  Relationship to Patient:

Secondary Insurance Company:  Address:

Insured's Name:  Insured's Social Security #:  & date of birth:

Policy/Group #:  Employer:

Insured's Day Phone #:  Relationship to Patient:

Nearest Relative (not at same address), address, phone #:

Current Medications

1.  3.

2.  4.

Drug Allergies:

1.  3.

2.  4.

Previous Surgeries:

1.  Date:  3.  Date:

2.  Date:  4.  Date:

Have You Had Any of the Following:

	Yes	No		Yes	No		Yes	No
Anesthesia or lung prob.	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>			

Have you had the HPV vaccine? Yes  No  Have you had the Hepatitis B vaccine? Yes  No

Additional Medical History

Family History of:

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Fever with Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer of Bowel, Uterus, Ovaries & Breast	<input type="checkbox"/>	<input type="checkbox"/>
			Blood Clots (in legs or lungs)	<input type="checkbox"/>	<input type="checkbox"/>

Other Inherited Diseases

Number of Pregnancies

**I authorize** insurance payments to be made directly to my physician for medical and/or surgical care provided under my insurance agreement and otherwise payable to me. I understand I am responsible for any amounts that may not be paid by my insurance.  
**I authorize** the release of medical information relating to my care to my insurance company.  
**Office policy:** In the event my account is turned over to collections, I agree to pay all reasonable attorney's fees and cost of collections.

Patient or Guardian Signature

Date:

**Advanced Gynecology**  
**Adolescent Review of Systems**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE REVIEW ALL OF THESE SYSTEMS – CIRCLE ANY PROBLEM AREAS;  
EXPLAIN IF NECESSARY**

**General:** Recent Illness; Fatigue; Weight Gain; Weight Loss; Other: \_\_\_\_\_

**Skin:** Acne (face / back / shoulders); Skin Discoloration (under arm / neck / arm creases);

Unusual Hair Growth (face / chest / abdomen); Other: \_\_\_\_\_

**Head/Eyes/Ears/Nose/Throat:** Headaches; Blurred Vision; Ear Pain; Frequent Nosebleeds;

Hoarseness; Other: \_\_\_\_\_

**Respiratory:** Asthma; Other: \_\_\_\_\_

**Breast:** Lumps; Discharge; Other: \_\_\_\_\_

**Cardiovascular:** Fainting Episodes; Irregular Heart Beat; Other: \_\_\_\_\_

**Gastrointestinal:** Abdominal Pain; Constipation; Diarrhea; Vomiting; Other: \_\_\_\_\_

**Genitourinary:** Dysuria; Vaginal Itching; Rash; Vaginal Discharge; Menstrual Irregularities; Severe

Menstrual Cramps; Rectal Itching; Rectal Bleeding; Rectal Pain; Other: \_\_\_\_\_

**Neurologic:** Seizure; Loss of Consciousness; Other: \_\_\_\_\_

**Psychiatric:** Difficulty Sleeping; Depression; Anxiety; Other: \_\_\_\_\_

Signature: \_\_\_\_\_

**ADVANCED GYNECOLOGY PROF., LLC**

2222 NORTH NEVADA AVE, SUITE 4003

COLORADO SPRINGS, CO 80907

(719) 633-8773 FAX (719) 633-1905

ROY C. STRINGFELLOW, M.D. \*-\* CHER P. MOSEMAN, M.D. \*-\* STEVEN A. FOLEY, M.D.  
D. DIANE FOLEY, M.D. \*-\* KATHY DAVIDSON, RNC, NP

**CONSENT FORM TO TREAT MINORS**

I (We) request and authorize ADVANCED GYNECOLOGY PROF, LLC and its personnel to deliver medical care to my child, listed below:

PLEASE PRINT

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please try to contact me (us) regarding health care for my child at the following phone number (s):

Parent(s)/Guardian(s) name (s): \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

\_\_\_\_\_

Work Phone: \_\_\_\_\_

\_\_\_\_\_

Cell Phone: \_\_\_\_\_

Responsible Billing Parent/Guardian (if different from above)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

\_\_\_\_\_

Work Phone: \_\_\_\_\_

\_\_\_\_\_

Cell Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ADVANCED GYNECOLOGY, Prof, LLC**  
Notice of Privacy Practices – Acknowledgement

We at Advanced Gynecology are committed to safeguarding the privacy and confidentiality of your medical record including the personal information that you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) through our office policies and the administrative and technical procedures that we have in place.

To assist us in protecting your privacy, please complete the following:

Patient Name (Please Print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_

May we leave a voice mail message? Y N

Cell Phone: \_\_\_\_\_

May we leave a voice mail message? Y N

Work Phone: \_\_\_\_\_

May we leave a voice mail message? Y N

May we speak to someone else regarding your medical care? Y N

Name of Person:

Relationship:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have been made aware of the privacy policies of Advanced Gynecology, Prof. LLC, and have received (or reviewed or been given the option to receive) a copy of the HIPAA Notice of Privacy Practices.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

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D. DIANE FOLEY, M.D. \*-\* MAUREEN J. SWEZEY, MD

**FINANCIAL RESPONSIBILITY**

Fee Structure: Our fees are based on our specialty and geographical area.

Usual, Customary, and Reasonable (UCR)—Over the past few years, we have noticed insurance companies are paying according to their own UCR's/ Please check with your insurance company before any diagnostic or surgery is done, as you are expected to pay the difference between our charges and your insurance company's UCR amount. Our charges are well within the normal range for this geographical area.

THE PATIENT IS PERSONALLY RESPONSIBLE FOR PAYING THE ACCOUNT. YOU ARE EXPECTED TO PAY YOUR CO-PAYMENT AT THE TIME OF SERVICE. YOU WILL BE BILLED FOR ANY DEDUCTIBLE AND/OR CO-INSURANCE. WHILE WE WILL DO ALL WE CAN TO HELP YOU COLLECT YOUR INSURANCE MONEY, WE SO CONSIDER YOUR COVERAGE TO BE A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. (SHOULD YOUR PERSONAL CHECK BE RETURNED TO *ADVANCED GYNECOLOGY* AS NON-SUFFICIENT FUNDS, ACCOUNT CLOSED, OR BANK RE-DEPOSITING, A \$25.00 FEE WILL BE ASSESSED TO YOUR ACCOUNT AND YOU AGREE TO PAY ALL REMAINING MONIES DUE TO *ADVANCED GYNECOLOGY* BY CASH, CREDIT CARD, MONEY ORDER, OR BANK CASHIER'S CHECK.)

Insurance Filing: We will file claims for our patients. It is the patient's responsibility to provide us with the correct insurance. If at any time your insurance coverage changes, please let us know. Some insurance companies **do not cover** *Family Planning, Infertility, and/or Preventative Visits*. It is customary to have labs and Fecal Occult Testing performed during a yearly examination and when symptoms dictate. The tests may not be a covered benefit. Please inform your doctor if you DO NOT want these tests. If you have the test performed YOU are responsible for all the charges not covered by your insurance. Please contact your insurance carrier prior to your visit so you will be aware of your coverage and can make an informed consent.

Medicare Participation: Medicare does not pay for laboratory tests associated with routine screening and/or annual physicals. Medicare will deny payment for a *screening pap smear* if you have had one during the last two years. If Medicare denies payment, you agree to be personally responsible for payment.  
Champus Participation: The patient is responsible for her deductible and cost share.

HMO, PPO, & Contract Insurance: If we have a contract with your insurance company such as a PPO or HMO, you are still responsible for your co-pay and/or deductible if one should apply. Also, if applicable, you are required to obtain a referral from your primary care physician prior to your visit and to verify your insurance company has been notified and has approved this referral.

Release of Medical Information: I hereby authorize payment directly to ROY C. STRINGFELLOW, M.D., CHER P. MOSEMAN, M.D., STEVEN A. FOLEY, M.D., D. DIANE FOLEY, M.D., and/ or MAUREEN J. SWEZEY, MD. I agree to be personally and fully responsible for payment. This instruction to you is as an assignment of my rights under my medical coverage and therefore acts as a "signature on file" for all billing and insurance purposes.

I state and agree that a Photostatic copy of this document shall be as effective and valid as the original for all parts of this contract.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Please make a note of our new office policy:

Advanced Gynecology is responsible for providing timely care for many patients who often have urgent problems. Missed appointments adversely affect our ability to provide needed care for our patients.

Because it is extremely important to keep your appointment and to be on time, beginning January 14, 2008 there will be a \$50 fee if you do not arrive for your appointment and do not call at least 24 hours in advance to let us know.

Please keep in mind that insurance will not cover charges for no show/late cancellation fees, therefore they will not be filed with your insurance company.

We understand that circumstances beyond your control may arise, causing you to miss your appointment. In this case, please call us as soon as you can so that we can fill your appointment time with someone who needs care.

All outstanding no show/late cancellation charges must be paid by the responsible party prior to their next appointment.

Signature

Date

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