

Roy C. Stringfellow, MD Steven A. Foley, MD
Cher P. Moseman, MD D. Diane Foley, MD
Kathy Davidson, NP

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 #: | | | | | |

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
Review of Systems

Name: _____ Date: _____

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

General: Fatigue, Weight Gain, Weight Loss, other: _____

Skin: Acne, Rash, Skin lesion, Skin cancer
other: _____

HEENT: Blurred Vision, Ear Pain, Eye Discharge, Eye Pain, Hearing Loss, Lesion, Obstruction,
other: _____

Respiratory: Asthma, Cough, Emphysema, Pneumonia, Shortness of Breath, Tuberculosis,
Wheezing, other: _____

Breast: Breast Biopsy, Breast Cancer, Breast Lump, Breast Pain, Breast Swelling, Nipple
Bleeding, Nipple Discharge, Skin Changes, other: _____

Cardiovascular: Aneurysm, Chest Pain, Heart Disease, Heart Attack, Hypertension, Irregular
Heart Beat, Rapid Heart Rate, Rheumatic Fever, Stroke, other: _____

Gastrointestinal: Bloody Stool, Bowel Cancer, Constipation, Diarrhea, Diverticulitis, Gall
Bladder Disease, Irritable Bowel, Jaundice, Nausea, Ulcer, Vomiting,
other: _____

Female Genitourinary: Abnormal Pap, Clots, Cramps, Dropped Uterus, Excessive Menstrual
Bleeding Fibroids, Frequent Kidney/Bladder infections, Infertility, Leak of Urine when
Sneezing/Coughing/Exercising, Menstrual Irregularities, Ovarian Growth, Painful Intercourse,
Painful Urination, Pressure in Vaginal Area, Tumor or Cyst, Urinary Frequency, Vaginal
Dryness, Vaginal Discharge, Vaginal itching/burning, Vulvar Lesion, Vulvar Pain, Sexually
Transmitted Disease, Stones, Tubal Infection or Obstruction, other: _____

Musculoskeletal: Fracture After Age 45, Loss of Height, Muscle Tenderness, Muscle
Weakness, Osteoporosis, other: _____

Neurological: Headaches, Migraines, Numbness, Seizures, Weakness, other: _____

Psychiatric: Anxiety, Depression, Personality Disorder, Psychiatric Admission, Suicidal
Ideation, Suicidal Planning, other: _____

Endocrine: Diabetes, Excessive Thirst, Hair Growth on Face, Hot Flashes, Hypoglycemia,
Mood Swings, Trouble Sleeping, Thyroid Disease, Thyroid Problems, Unusually Emotional,
other: _____

Hematology: Abnormal Platelets, Anemia, Blood Clots Easy Bruising, Enlarged Lymph Nodes,
Sickle Cell, Hemophilia, Lymphoma, Leukemia, other: _____

Please sign _____ Date: _____

Check here if no changes

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: _____

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. *-* 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: _____

ESTABLISHED PATIENT/ ANNUAL EXAM

PATIENT TO COMPLETE THIS SIDE:

Name: _____

Menstrual History:

Age at onset _____ Age at Menopause _____
 Regular? Yes No
 Frequency of periods: _____ days from start to start
 Is this a change for you? Yes No
 Duration: _____ days
 Flow: Light Moderate Heavy
 Is this a change in flow? Yes No
 Pain or Cramps? Yes No
 Currently bleeding between periods? Yes No
 Other symptoms with periods? Yes No
 Current method of birth control: _____
 Date of last menstrual period: _____

ALLERGIES (Including non-medical):

 What Medications are you currently taking?

Personal History:

Current weight: _____ Weight changes in last year? No Yes (explain) _____ #gained _____ #lost
 Have you previously had a "dexa scan" (bone density test)? No Yes (date) _____
 Previous surgeries? What? When? Where? _____

 Any hospitalizations other than for pregnancy or surgery?

Alcoholic beverages: Never Occasionally Moderate Daily Cigarettes/Tobacco: _____ packs per day

Pregnancy History: (Include miscarriages and abortions)

| Year | Hours of Labor | Sex | Infant Weight | Type of Delivery | Complications | Anesthesia | Gestation Age at Delivery (No. of Weeks) |
|------|----------------|-----|---------------|------------------|---------------|------------|--|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Review of Symptoms: DO YOU NOW HAVE, OR HAVE YOU HAD IN THE LAST 5 YEARS:

| Symptom: | No | Yes | Date | Symptom: | No | Yes | Date |
|-----------------------------------|----|-----|------|----------------------------------|----|-----|------|
| Joint Problems | | | | Tuberculosis | | | |
| Skin/Hair Changes | | | | Jaundice/Hepatitis/Liver disease | | | |
| Epilepsy | | | | Ulcers | | | |
| Meningitis | | | | Stomach/Intestinal Problems | | | |
| Head Injury/Fainting/Convulsions | | | | Rectal Bleeding | | | |
| Severe Headaches | | | | Kidney/Bladder Infections | | | |
| Depression/Psychiatric Care | | | | Kidney Stones/Disease | | | |
| Problems With Hearing | | | | Urine Loss w/Cough or Sneeze | | | |
| Eye/Vision Problems | | | | Gonorrhea/Syphilis/Chlamydia | | | |
| Thyroid Problems | | | | Herpes/Condyloma/Warts | | | |
| Cancer | | | | Blood Transfusions | | | |
| Diabetes/Hypoglycemia | | | | AIDS/HIV | | | |
| Anemia | | | | DES Exposure | | | |
| High Blood Pressure | | | | Abnormal Pap Smears | | | |
| Rheumatic Fever | | | | Cautery (freezing) of Cervix | | | |
| Heart Disease or Murmur | | | | Pelvic/Vaginal Infections | | | |
| Varicose Veins | | | | Fibroid/Ovarian Cysts | | | |
| Phlebitis (blood clots in leg) | | | | Breast Problems/Cysts | | | |
| Asthma/Bronchitis/Lung Disease | | | | Major Accidents/Injuries | | | |
| Chronic Cough/Shortness of Breath | | | | Anesthetic complications | | | |
| Pregnancies/Abortions | | | | Other: | | | |

Family History: Has any relative ever had:

| | No | Yes | Family Member | | No | Yes | Family Member |
|-------------------------|----|-----|---------------|-------------------------------|----|-----|---------------|
| Breast Cancer | | | | Heart Disease | | | |
| Cancer of Female Organs | | | | High Blood Pressure | | | |
| Other Cancer | | | | Kidney Disease | | | |
| Diabetes | | | | Bleeding Disorder/Sickle Cell | | | |
| TB | | | | Congenital Malformations | | | |
| Osteoporosis | | | | Other: | | | |

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
