CHATTAHOOCHEE GYNECOLOGY, P.C.

Laura A. Tsakiris, M.D.

Dear Patient,

Thank you for choosing us for your gynecological care. Please complete all enclosed information and personal family history forms. For your convenience, we have enclosed a medical records release form in order for you to obtain your medical records prior to your appointment. Bring these completed forms to your appointment. Please arrive 15 minutes prior to your scheduled appointment time.

Please be advised that payment is expected at the time service is rendered. If we are contracted with your particular insurance company as an HMO or PPO provider, we will file to your carrier. Normal gynecological examinations usually average **$220.00 to $370.00**; however, if you are having problems, fees may increase. Should you have questions regarding whether or not we are contracted as providers please contact your insurance company to ensure we are in your network.

If you need to cancel or reschedule an appointment please call the office **24 hours prior** to your appointment. A **fee of $25.00** will be charged if notification is not given.

For more information, you can visit our website at www.chattgyn.net . We look forward to seeing you soon.

Thank you,

Darla J Perrott
Business Manager

6610 McGinnis Ferry Road ● Suite 100 ● Duluth, Georgia 30097 ● (770) 813-8742

Chattahoochee Gynecology, P.C.

Laura A. Tsakiris, M.D.
Board Certified

To:_____
Physician or Practice Name

_____ _____ _____ _____
Address *City* *State* *Zip*

_____ _____
Phone Number *Fax Number*

Please release the items noted below from my medical record:

☐ Last Problem Visit	☐ Last Annual Exam	☐ Pap Smear (last 2 years)
☐ Blood Work (last 2 years)	☐ Colposcopy	☐ All abnormal Pap Smears
☐ All Records (last 2 years)	☐ Operative Notes	☐ Discharge Summary
☐ Pathology Reports	☐ Biopsy Results	☐ Other:_____

Please MAIL these records to:

Chattahoochee Gynecology, P.C.
6610 McGinnis Ferry Road
Suite 100
Duluth, GA 30097
(770)813-8742

I understand this authorization will include any medical records including HIV records, psychiatric or drug or alcohol abuse records, venereal disease and/or any other statutory protected diseases. This authorization and consent will expire 60 days following the date signed. I understand that I may revoke this authorization and consent at any time extent that action has previously take in reliance hereof.

_____ _____
Print Name ***Date of Birth***

_____ _____
Patient Signature ***Date*** ***Social Security Number***

If you are transferring your care, please mail or fax this request to your previous doctor before your appointment.

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Patient Name:	Birth Date:	Date:

Address:	
City:	State/Zip:
Email:	Cell Phone:
Home Phone:	Work Phone:
Employer:	Insurance:
Insurance Id:	Group No:
Name you would like us to use:	Primary Language:
Name of Spouse/Partner:	Emergency Contact:
Spouse/Partner Date of Birth:	Relationship:
	Telephone:
Referred by:	Pharmacy Name Street:
Reason for your visit?	Pharmacy Phone: City:

If you are here for an Annual Exam, this is a Primary care visit or Gynecology only
Is this a new problem? YES NO
Please describe your problem, including where it is, how severe it is, and how long it has lasted:
If you are uncomfortable answering any questions, leave them blank: you can discuss them with your doctor or nurse.

Gynecology History

Last normal menstrual period:		Sexual partners are Men Women Both	
Age periods began:		Present method of birth control:	
Length of periods (number of days bleeding)		Have you ever used an IUD or birth control pills?	
Number of day between periods:		If yes, for how long?	
Any recent changes in periods:		When was your last PAP test?	
Are you currently sexually active:		What was the result?	
Have you ever had sex?		Do you do breast self-examinations?	
Number of sexual partners(lifetime):		Have you been exposed to Diethylstilbestrol (DES)?	

Obstetric History

	Number		Number		Number
Pregnancies		Abortions		Miscarriages	
Premature births <37wks		Live Births		Living Children	

No.	Birth Date	Birth Weight	Baby's Gender	Weeks Pregnant	Delivery Type

Any pregnancy complications?
Diabetes Hypertension/High blood pressure Preeclampsia/Toxemia Other
Any history of depression before or after pregnancy? No Yes, how treated?

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Patient Name:	Birth Date:	Date:

Current Medications

Including hormones, vitamins, herbs, nonprescription medications

Drug Name	Dosage	Who Prescribed	Drug Name	Dosage	Who Prescribed

Family History

Mother Living Deceased-Cause Age			Father Living Deceased-Cause Age		
Siblings: Number Living Number Deceased: Cause(s)/Age(s):					
Children: Number Living Number Deceased: Cause(s)/Age(s):					
Illness	Yes	Which relative(s) Age of onset	Illness	Yes	Which relative(s) Age of onset
Diabetes			Hepatitis		
Stroke			HIV/AIDS		
Heart Disease			Tuberculosis		
Blood clots in lungs or legs			Birth defects		
High blood pressure			Alcohol or drug problems		
High Cholesterol			Breast Cancer		
Osteoporosis			Colon Cancer		

Social History

	Yes	No
Ever Smoked? Current smoking: packs per day: no of years:		
Alcohol: Drinks per day: per week: Type:		
Drug use:		
Seat belt use:		
Regular exercise? How long: How often:		
Dairy product/and or calcium supplement daily intake?		
Health hazards at home or work?		
Have you ever been sexually abused, threatened or hurt by anyone?		
Do you have an advance directive (living will)?		
Are you an organ donor?		

Personal Profile

Sexual Orientation: Heterosexual Homosexual Bisexual
Marital Status: Married Living with partner Single Widowed Divorced
Number of Living Children:
Number of people living in household:
School complete: High School Some college/AA degree College Graduate degree Other
Current or most recent job:
Travel outside of the United States?

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Patient Name:	Birth Date:	Date:

Personal Past History of Illness

Major Illnesses	Yes (Date)	No	Not Sure		Yes (Date)	No	Not Sure
Asthma				Blood transfusions			
Pneumonia/Lung disease				Anemia			
Kidney infection/stones				Seizures/Convulsions/Epilepsy			
Tuberculosis				Bowel problems			
Fibroids				Glaucoma/Cataracts			
Sexually transmitted disease/Chlamydia				Arthritis/joint pain/Back problems			
Infertility				Broken bones			
HIV/AIDS				Thyroid disease			
Heart Attack/Disease				Hepatitis/Yellow jaundice/Liver disease			
Diabetes				Gallbladder disease			
High blood pressure				Headache			
Stroke				DES exposure			
Rheumatic fever				Infertility			
Cancer				Bleeding Disorders			
Eating disorders				Blood clots in lungs or legs			
Auto-immune disease (Lupus)				Reflux/Hiatal hernia/Ulcer			
Chickenpox				Depression/Anxiety			
Other							

Operations/Hospitalizations

Reason	Date	Hospital

Injuries/Illnesses

Type	Date	Type	Date

Immunizations/Tests

	Date		Date
Tetanus-Diphtheria Booster		Influenza Vaccine (flu)	
Hepatitis A Vaccine		Hepatitis B Vaccine	
Varicella (Chicken Pox) Vaccine		Pneumococcal (Pneumonia) Vaccine	
Measles-Mumps-Rubella (MMR) Vaccine		Tuberculosis(TB) Skin Test	

Drug Allergies

Medication	Reaction	Medication	Reaction	Medication	Reaction

Are you Allergic to Latex? YES NO

_____ _____

Patient Signature *Date*

CHATTAHOOCHEE GYNECOLOGY, P.C.
PATIENT AUTHORIZATION

Please sign the authorizations below so that we may include this in your medical record. Your signature is needed on all three lines below.

I hereby authorize Chattahoochee Gynecology, P.C. to release any information acquired in the course of my examination or treatment for processing insurance or upon my request.

_____ _____
Patient/Guardian Signature Date

I hereby authorize the direct payment of any benefits due for medical services. I fully understand that my insurance coverage is a contract between myself and the insurance company. I also understand that my coverage is subject to the terms and provisions of the contract and that ultimately I am financially responsible for payment in full for all charges incurred from services rendered by Chattahoochee Gynecology, P.C.

_____ _____
Patient/Guardian Signature Date

Many HMO/PPO policies require that diagnostic testing be performed by particular laboratories and/ or facilities. We are usually given lists of the approved providers; however, we cannot guarantee our lists are the most current due to frequent changes. Please be advised that it is your responsibility to insure that we order your tests from an appropriate facility. Failure to do so may result in the claim being denied by the insurance company, which would leave you responsible for the bill. Should you need any tests ordered (ultrasound, mammogram, blood/lab work), please check with the insurance company regarding coverage, benefits, pre authorization and/ or referral.

Also, many HMO/PPO insurance policies do not cover office visits for routine exams (not associated with a problem or illness). Some plans may allow some type of benefit for routine services, but this can vary depending on the provisions set up by YOU or YOUR EMPLOYER. As a courtesy to you, we will file for your HMO/PPO benefits if we are contracted with that company; however, if the insurance plan denies the charges, WE WILL BILL YOU accordingly.

I AGREE TO PAY ALL CHARGES INCURRED BY ME. PLEASE NOTE: FAILURE TO PROVIDE 24 HOURS NOTICE FOR CANCELLATIONS OR TO RESCHEDULE APPOINTMENTS WILL RESULT IN A FEE OF $25.00.

_____ _____
Patient/Guardian Signature **Date**

CHATTAHOOCHEE GYNECOLOGY, P.C.

Laura A. Tsakiris, M.D.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKKNOWLEDGEMNET FORM

I,_____, am aware and understand that Chattahoochee GYN creates and maintains my vital and clinical records such as medications, symptoms, diagnoses, history, physical exam, test results and consultation discussions for my current and future treatment. This information is protected and kept confidential to the extent that the federal and state laws allow under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and Chattahoochee GYN will provide me with the full notice of Privacy Practices upon request.

I understand that Chattahoochee GYN may use and disclose my records for the following:

- Treatment – such as, but not limited to – using records or test results in prescribing medications; disclosing information to a pharmacy when ordering prescriptions for you, ordering laboratory testing, using those test to reach a diagnosis; disclosing your information to other health care providers who may assist in your treatment.

- Payment. Our practice may use and disclose information in order to bill or to collect payment for services rendered in our office. We may contact your insurance to verify you are eligible for specific benefits and we may provide your insurer with details of your treatment. To determine if your insurer will cover or pay for your treatment.

- Health Care Operations. Our practice may use and disclose your information to evaluate the quality of care you receive in our office to conduct cost-management and efficiency planning for the office.

I understand that I have the right to request in writing that Chattahoochee Gynecology communicates with me about my health and related issues in a particular manner or at a certain location – such as contacting me at home instead of work. I understand that I must be specific in the method and location of contact in order to accommodate my request and Chattahoochee Gynecology will accommodate reasonable requests. I do not need to give reason for the request. Furthermore, I understand that I may request in writing certain and specific restrictions in disclosure of my information to friends and family members involved in my treatment. I may request that certain individuals be privy to my information or I may request that certain and specific information be withheld from them. Chattahoochee Gynecology is not required to agree to my request; however, if they do agree, they are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat me.

I understand that I have the right to review the formal notice of Privacy Practices before signing this consent. I understand that I may revoke this consent in writing except to the extent that Chattahoochee Gynecology has already acted. I also understand that by refusing to sign this consent or by revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that Chattahoochee Gynecology reserves the right to change their notice and practices prior to implementations in accordance with Section 164.520 of the Code of Federal Regulations. Should Chattahoochee Gynecology change their notice, they will provide a copy of the revised notice upon request.

I fully understand and (**circle one**): **Accept or Decline** the terms of this consent.

_____ _____

Patient/Guardian Signature ***Date***

☐ Consent received by_____on _____

☐ Consent refused by patient and treatment refused as permitted.