NEW PATIENT

Date of visit___/___/___ Referring Provider_____ Insurance_____

Patient's Legal Name_____**Birthday** ___ / ___ / ____ **Age:** _____

Best Contact Number: _____ cell home work

Address: _____ Apt ___ City _____ State____ Zip Code _____

Email: _____ **Employer:** _____

Social Security Number _____ - _____ - _____ Race _____

Pharmacy _____ **Phone** _____ **Location**_____

Reason for Visit _____
CC/HPI

Medical History (Example: hypertension, diabetes) _____

_____

Surgical History

- ☐ C- Section x _____
- ☐ Tubes Tied
- ☐ Hysterectomy
- ☐ Other _____

Family History

(Example: Breast /Ovarian Cancer)

Mother:_____

Father:_____

Social History

Do you Smoke?

- ☐ YES
- ☐ NO

How Many Pregnancies?

_____

Current form of Birth Control/ Hormones

_____

How are your Periods?

- ☐ Cramping
- ☐ Heavy
- ☐ Irregular
- ☐ Irregular Spotting
- ☐ Lasts more than 7 days
- ☐ Hysterectomy

Allergies

- ☐ No Known Drug Allergies
- ☐ _____

Urine Issues ?

☐ Leakage of urine when ...

- ☐ Coughing
- ☐ Sneezing
- ☐ Laughing
- ☐ During sleep

- ☐ Increase Urge
- ☐ Bladder pain/ spams
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Other _____

Current Medications ☐ Blood Thinner_____ ☐ Insulin Other: _____

VISIT CODE

- ☐ NEW **99205**
- ☐ EST **99215** ☐ **99214** ☐ **99213**
- ☐ No charge 99024
- ☐ Post op + 24

CPT

- ☐ UA (81002) ☐ UPT (81025)
- ☐ TAS (76856) ☐ TVUS (76830)
- ☐ PAP (Q0091) ☐ COLPO Cervix (57452)
- ☐ COLPO vulva/vagina (56820)
- ☐ Hysteroscopy + BX (58558)
- ☐ Ablation (58563)
- ☐ Cystoscopy (52000) ☐ Urosure (51725 + 51736)
- ☐ SHG (76831)
- ☐ Chemical ablation (17250)
- ☐ Biopsy CERVIX (57500) VULVA (56605)

EXAM

Abdomen

Pelvic

Diagnosis

- ☐ Adenomyosis (N80.0)
- ☐ Amenorrhea (N91.2)
- ☐ AUB (N93.9)
- ☐ Cystocele (N81.10)
- ☐ DM (E13.638)
- ☐ Dysplasia (N89.3)
- ☐ Endometriosis (N80.9)
- ☐ Endo Cancer (C54.1)
- ☐ Fibroids (D25.9)
- ☐ Hematuria (R31.9)
- ☐ HTN (I10)
- ☐ Incontinence (R32)
- ☐ Menopause (Z78.0)
- ☐ Obesity (E66.9)
- ☐ Ovarian cyst (N83.2)
- ☐ PCOS (N83.209)
- ☐ Pelvic Mass (R19.07)
- ☐ Pelvic Pain (R10.2)
- ☐ PMB (N95.0)
- ☐ Prolapse (N81.4)
- ☐ Pregnancy Z32.9)
- ☐ Vaginal Discharge (N89.8)
- ☐ Vit D Def (E55.9)

RX ORDERS

☐ Gabapentin ☐ Tramadol ☐Naproxen ☐ Provera 10/10 ☐ T. Acid. ☐ OCP: OLO / SLYD.

☐ Levofloxacin ☐Flagyl ☐Diflucan X3 ☐ Ditropan BID

WRITTEN CONSENT: I was seen by the provider & understand the purpose, risks and benefits of all the procedure(s). We discussed alternatives. I acknowledge that no guarantees or promises have been made to me concerning the results of this procedure or any treatment that may be required because of this procedure. This procedure has been explained to me in language that I understand. I have been given the opportunity to ask questions which have been answered to my satisfaction. I consent to the performance of the procedure (s) as described above.

PROCEDURE; _____ PATIENT SIGNATURE_____

PATIENT NAME _____ DATE OF BIRTH _____

POPLAR AVENUE CLINIC, PLLC

Women's Health • GYN Oncology • Pelvic Surgery

GynInfo@gyn-md.com

901-300-6713

6584 Poplar Ave Suite 400
Memphis, TN 38138

www.GYN-MD.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO SECURE FAX: 901-881-0337

Patient's Name _____

Address _____

Date of Birth _____ Social Security No. _____

I hereby authorize POPLAR AVENUE CLINIC, PLLC, to release or obtain all health information about me from:

Name _____
Address _____
Phone: _____ Fax: _____

POPLAR AVENUE CLINIC, PLLC is hereby authorized to receive my entire medical record, treatment record, and diagnostic record to the following persons or organization:

The following health information that relates to service beginning from my first visit to current, may be released:

- Entire medical records (including patient histories, office notes (expect psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers)

I further understand that my medical record may include on or more of the following:

- all medical records

I understand and agree that my health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by the law. This authorization is valid for 99 years following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/ organization has relied on the use or disclosure of my health information.

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

I have read (I have had to read to me) this authorization, and I agree to its terms as indication by my signature below. I am entitled to a copy of this authorization.

_____ _____ _____
Patient's Signature Patient's Name Date

PATIENT NAME _____ DATE OF BIRTH _____

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HIPAA Compliant Authorization Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to communicate appointments, etc?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____Date of Birth _____
(PRINT NAME PLEASE)

Signature: _____Date:_____

PATIENT NAME _____ DATE OF BIRTH _____

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Consent for Treatment / Assignment of Benefits Form

Consent for Treatment: POPLAR AVENUE CLINIC, PLLC strives to provide the best in the most reasonable care in a patient centric fashion. To achieve that I understand POPLAR AVENUE CLINIC, PLLC can deploy diagnostic and therapeutic testing or alternative modalities as indicated.

These diagnostic and or therapeutic interventions include utilization of ultrasound, tissue biopsy, gynecologic endoscopy, such as hysteroscopy, cystoscopy, anoscope, vaginoscopy, colposcopy, utilization of local anesthetic as and when needed. Other testing and or interventional procedures may be needed from time to time.

I understand that vast majority of these diagnostic and or therapeutic procedures are extremely safe nevertheless there always remains some risk of pain, infection, bleeding damage to internal organs.

I hereby give permission and consent to POPLAR AVENUE CLINIC, PLLC deploy diagnostic and/or therapeutic interventions as needed in my case to achieve the best diagnosis and treatment. This is my consent for treatment. I can withdraw my consent for treatment at any time by providing a written notice to POPLAR AVENUE CLINIC, PLLC.

Assignment of Benefits: I request payment of authorized benefits directly to the provider for services furnished to me at this facility or any other facility owned or operated by POPLAR AVENUE CLINIC, PLLC including physician services, or by any provider under contract with POPLAR AVENUE CLINIC, PLLC or participating in a provider network in which POPLAR AVENUE CLINIC, PLLC or its affiliates participate.

Important Information for Patients: I will obtain the material on each line initialed below.

- ☐ Notice of Privacy Practices www.tn.gov/hippaprivacyinfomation.com
- ☐ Federal and State Patient Rights Information available at www.hhs.gov
- ☐ Health Care Directive Brochure information available at https://www.tn.gov/health

Guarantee and Agreement to Pay NOTICE: Emergency patients are entitled to receive a medical screening examination and the necessary stabilizing treatment even if the patient (or responsible person) does not sign below. I agree to pay the charges for the care and treatment rendered to me not covered by my insurance plan, or in the absence of insurance coverage (or, if signed by someone other than the patient, to guarantee payment for the care and treatment rendered to the patient named on this document). I understand that interest per year may be added if the account balance goes to a collection agency.

_____ _____

Signature of Patient, or if Patient is unable to sign, a Representative of the Patient

Date/Time