Bruce Crawford, M.D. / Patricia Yost, M.D.

THE FOLLOWING IS NECESSARY FOR BILLING AND COLLECTION AND WILL BE UPDATED ANNUALLY

Patient Name_____ Birth Date_____/_____/_____

Social Security Number: _____ Marital Status: Single / Married / Divorced / Widowed

Mailing Address_____

City_____ State_____ Zip_____

Phone_____ Alternate Phone_____

Email_____ Preferred Language_____

Please circle one for Ethnicity: Hispanic / Non -Hispanic decline to report

Please circle one for Race: White/ African American/ Black / Asian/ Pacific Islander/ American Indian or

Emergency Contact_____ Phone Number_____

Preferred Pharmacy_____ Pharmacy Location_____

Preferred Laboratory (circle one): Renown / Lab Corp / Quest

It is the patient's responsibility to be aware of the preferred lab within their insurance coverage.

Primary Insurance _____ Policy ID Number_____

Policy Holder's Name_____

Policy Holder's Birth Date_____ Relationship to Policy Holder_____

Secondary Insurance _____ Policy ID Number_____

Policy Holder's Name_____

Policy Holder's Birth Date_____ Relationship to Policy Holder_____

FINANCIAL AGREEMENT

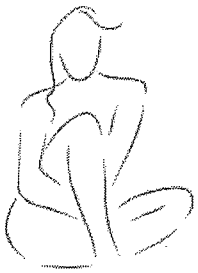
I understand that I am financially responsible for all charges for services rendered to myself. I hereby authorize Bruce Crawford, MD or Patricia Yost, M.D. to furnish my insurance carrier all information which is requested concerning my diagnosis and treatment for payment purposes. I hereby assign to Bruce Crawford, MD or Patricia Yost, MD all monies from my insurance carrier for services rendered. I understand and acknowledge that I am responsible to for my deductibles and charges not covered or not required to be discounted by this agreement.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

GUARDIAN SIGNATURE IF PATIENT IS A MINOR DATE



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Acknowledgement of Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledgement of receipt of said Practices. *You may refuse to sign this form.*

Family & Friends Release of Information

List family and friends, *if any,* whom we may inform about your <u>general medical condition and your diagnosis</u>

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ I do not want my medical condition discussed with any family or friends

By signing this I confirm that I have received a Notice of Privacy Practices and recognize that Gyn Specialists of Reno can release my medical information to the individuals designated above:

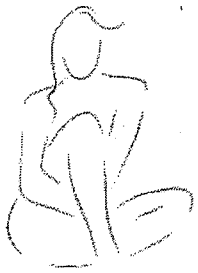
Print Name:_____

Sign Name:_____

Date:_____

Written Acknowledgement was Not Obtained:

- ☐ Patient Refused to sign
- ☐ Emergency Situation
- ☐ Unable to communicate with patient
- ☐ Other_____



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We look forward to providing you with the highest quality medical care and service. These patient policies are designed to help you understand how our office operates so you can most efficiently access the healthcare you need. We greatly appreciate any feedback that you feel would help us serve you better.

Scheduling Appointments

Appointments can be scheduled over the phone or in the office. Our staff will do the best to accommodate the day and time of your preference; however, this is not always guaranteed and your understanding is greatly appreciated. If you have a medical concern and need to be seen the same day, we will make every effort to find an open appointment that day. If an appointment is not available you do have the option to wait for the provider but a specific time cannot be guaranteed.

The Appointment

There are several administrative and clinical tasks that must be completed on every visit before you can see the provider. We need your help completing these items so you can be seen at your scheduled appointment time. Depending on your visit type, these administrative tasks may take 15-30 minutes and the medical assistant check-in tasks may take an additional 15 minutes.

Order Patients are Seen

Patients are here for a variety of reasons and are rarely "taken back" in the order they arrive and the sequence of being taken to an exam room does not correlate with the order the providers see patients. Our goal is to keep every patient as close to their scheduled appointment time as possible and to inform you if we are experiencing any delays.

Office Delays

At times, for reasons beyond our control the office may run behind schedule. We make every effort to maintain our schedule and minimize any inconvenience to you. If a delay occurs we will inform you as soon as possible and we will gladly reschedule your appointment if you would prefer not to wait.

Appointment Reminder Calls

Our staff will make every effort to call and remind each patient of their appointment the day before, however this is not a guarantee. Please feel free to call at any point to confirm an appointment or to check on an upcoming date.

Cancelled/Missed Appointments and Fees

If you are unable to keep a scheduled appointment, please notify our office as soon as possible so we can use that appointment time for another patient. If you miss or are late for multiple scheduled appointments without notice, we may elect to release you from the practice.

If you have a new patient appointment and are unable to make the appointment we require 24 hour notice. If you are unable to provide 24 hour notice this will be considered a no show and a fee of $50 will be assessed to you. This fee is not billable to your insurance and is the patient's responsibility.

Surgeries

If you are scheduled for a surgery but need to cancel or reschedule for any reason we require notification within 72 hours of the check in time. If adequate notice is not provided you may be assessed a fee of $350. This fee is not billable to your insurance and is the patient's responsibility.

Urgent After Hours Calls

If you believe you have a TRUE MEDICAL EMERGENCY, PLEASE CALL 911 IMMEDIATELY.

Prescription Refills

Prescription refills are completed during office hours only. To request a refill of a medication our office has prescribed, please **CALL YOUR PHARMACY DIRECTLY.** Your pharmacy will send the official refill request. It will be reviewed by your provider and then filled. Prescription refills received from the pharmacy after NOON on Fridays may not be filled before the weekend.

Test Results

Depending on the laboratory and/or type of test you have performed, it takes anywhere from a few hours to weeks for our office to receive results. Please feel free to contact us to check on the status of your test results. Please be aware that it is our policy to not send test results to patients until the results have been discussed between the provider and the patient. This ensures that there are no miscommunications regarding the test or lab.

Medical Paperwork/Records and Fees

Please be aware that we require a minimum of **7 business days** in order to complete any paperwork.

We require **7 business days** to complete request for medical records. If your medical records are greater than 30 pages there will be a charge of $20 to be paid prior to records being printed.

Questions/Complaints/Grievances

All staff at Gyn Specialists of Reno are dedicated to the delivery of quality care and patient satisfaction. However, we recognize that concerns may arise so at any point you may contact the Practice Manger to discuss any concerns. You also have the right to notify any state or federal regulatory agencies governing healthcare organizations.

Termination

As a patient, our physicians have an ethical and legal obligation to provide medical services. There are occasionally instances when we will no longer be able to provide these services to you. Our medical practice reserves the right to terminate the physician- patient relationship. The steps involved in such a termination will include: notification, a brief explanation of the reason(s) for termination, availability for the patient to continue to receive medical care and services for 30 days following notification, recommendations for finding another physician in the area, and an offer to transfer medical records to a newly-designated physician upon signed patient authorization to do so.

Acknowledgement of Receipt of Patient Policies

By initialing by each item and signing below, I acknowledge that I have read, understand and agree to the above policies.

Patient Name: _____ **D.O.B:** _____

_____ **Scheduling Appointments**

_____ **Appointment Reminder Calls**

_____ **Cancelled/Missed Appointments and Fees and Surgeries**

_____ **Test Results**

_____ **Urgent After Hours Calls**

_____ **Prescription Refills**

_____ **Medical Paperwork/Records and Fees:**

$20 for FMLA/Disability Paperwork for patient or family members per form and $20 for Medical Record printout outs greater than 35 pages

_____ **Questions/Complaints/Grievances**

_____ _____

Signature Date

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Dear Patients:

In an effort to ensure surgeries are available in a timely manner we ask that patients provide at least 72 hours' notice if they need to cancel or change a scheduled surgery. If 72 hours' notice is not provided or if the patient fails to arrive at their scheduled check in time there with be a fee of $350. This is not payable by insurance companies and is the patient's or guarantor's responsibility. This fee must be paid in full before a second surgery will be scheduled.

Thank you for your assistance in this matter,

Gyn Specialists of Reno

By signing below I agree that I will be charged a fee of $350, if 72 hours' notice is not given to change/cancel an appointment or if I fail to arrive.

_____ _____

Printed Name Signature

_____

Date

GYNECOLOGIC INTAKE HISTORY

PT. NAME _____ ACCOUNT NUMBER _____ DATE _____

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, OR IN THE PAST OR OFTEN

1. CONSTITUTIONAL	NONE	CURRENTLY	PAST	NOTES
Weight loss	☐	☐	☐	
Weight gain	☐	☐	☐	
Fever	☐	☐	☐	
Fatigue	☐	☐	☐	
2. EYES				
Double vision	☐	☐	☐	
Spots before eyes	☐	☐	☐	
Vision changes	☐	☐	☐	
3. ENT/MOUTH				
Ear Aches	☐	☐	☐	
Ringing in ears	☐	☐	☐	
Sinus problems	☐	☐	☐	
Sore throat	☐	☐	☐	
Mouth sores	☐	☐	☐	
Dental Problems	☐	☐	☐	
4. CARDIOVASCULAR				
Painful breathing	☐	☐	☐	
Chest pain	☐	☐	☐	
Difficult breathing on exertion	☐	☐	☐	
Swelling of legs	☐	☐	☐	
Palpitations of heart	☐	☐	☐	
5. RESPIRATORY				
Wheezing	☐	☐	☐	
Spitting up blood	☐	☐	☐	
Shortness of breath	☐	☐	☐	
Cough, chronic	☐	☐	☐	
6. GASTROINTESTINAL				
Diarrhea, frequent	☐	☐	☐	
Bloody stool	☐	☐	☐	
Nausea/vomiting	☐	☐	☐	
Constipation	☐	☐	☐	
7. GENITOURINARY				
Blood in urine	☐	☐	☐	
Pain with urination	☐	☐	☐	
Urgency	☐	☐	☐	
Frequency of urination	☐	☐	☐	
Incomplete emptying	☐	☐	☐	
Leaking of urine	☐	☐	☐	
Abnormal periods	☐	☐	☐	
Painful intercourse	☐	☐	☐	
8. MUSCULOSKELETAL				
Muscle weakness	☐	☐	☐	

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN

9. SKIN/BREAST	NONE	CURRENTLY	PAST	NOTES
Pain in breast	☐	☐	☐	
Discharge	☐	☐	☐	
Masses	☐	☐	☐	
Rash	☐	☐	☐	
Ulcers	☐	☐	☐	
10. NEUROLOGICAL				
Dizziness	☐	☐	☐	
Seizures	☐	☐	☐	
Numbness	☐	☐	☐	
Trouble walking	☐	☐	☐	
11. PSYCHIATRIC				
Depression	☐	☐	☐	
Crying, frequent	☐	☐	☐	
12. ENDOCRINE				
Dry skin	☐	☐	☐	
Abnormal thrist	☐	☐	☐	
Hot flashes	☐	☐	☐	
13. HEMATOLOGIC/LYMPHATIC				
Bruises, frequent	☐	☐	☐	
Cuts do not stop bleeding	☐	☐	☐	
Enlarged lymph nodes	☐	☐	☐	
14. ALLERGIC/IMMUNOLOGIC				
Allergies	☐	☐	☐	
Drugs, Other	☐	☐	☐	

PERSONAL PAST HISTORY

MAJOR ILLNESS	YES	NO		YES	NO
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression/anxiety		
Kidney Infections/stones			Anemia/Blood transfusions		
Tuberculosis			Seizures/convulsions/epilepsy		
Veneral Disease			Bowel trouble		
Heart Trouble/murmur			Glaucoma		
Diabetes			Fracture		
Stroke			Hepatitis/Yellow jaundice		
Rheumatic Fever			Thyroid Disease		
			High Blood Pressure		

Age at first menstrual period..... _____
No. of days in cycle..... _____
No. of period days..... _____
Menstruation painful..... _____
Menstruation excessive..... _____
Bleeding between periods..... _____
Bleeding after intercourse..... _____
Intercouse painful..... _____
Any abnormal pap smear..... _____
Previous genital herpes..... _____
Previous blood transfusions..... _____

Vaginal discharge..... _____
Irritating discharge..... _____
Vaginal itching..... _____
Pain in female organs..... _____
Previous IUD..... _____
Previous pelvic infection..... _____
Type of birth control..... _____
Husband - Vasectomy..... _____
Age of menopause..... _____
Bleeding after menopause..... _____

OPERATIONS/HOSPITALIZATIONS

Reason	Date	Reason	Date

PT. NAME _____ ACCOUNT NUMBER _____ DATE _____

OB/HISTORY

Pregnancies	Number	Miscarriages	Number
Normal Vaginal Deliveries		Abortions	
C-Sections		Living Children	
Complication:			

FAMILY HISTORY

Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		
Osteoporosis			Uterine Cancer		
Thyroid disease					

SOCIAL HISTORY

Habits

Smoking	☐ Yes	☐ No	Packs per day _____	Years _____
Alcohol	☐ Yes	☐ No	Drinks per day _____	Drinks per week _____
Drug Use	☐ Yes	☐ No		
Seat Belt Use	☐ Yes	☐ No		
Regular Exercise	☐ Yes	☐ No		

Personal Profile

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Number of living and ages of children _____/ _____ _____ _____ _____ _____

Number of people in household _____

School completed ☐ High School ☐ College ☐ Graduate Degree ☐ Other

Current or most recent job _____

Have you ever been or are you currently involved in an abusive relationship? ☐ Yes ☐ No

Are you satisfied with your sex life? ☐ Yes ☐ No

Do you have any regular religious, spiritual or relaxation practice? _____

Religious Preference (Optional) _____

Completed by: ☐ Patient ☐ Office Nurse ☐ Physician

Signature of patient: _____

Date reviewed by physician with patient: _____

Physician Signature: _____

Annual Review History

Date reviewed _____ Physician Signature: _____

Date reviewed _____ Physician Signature: _____

Date reviewed _____ Physician Signature: _____

Date reviewed _____ Physician Signature: _____

MEDICATION LIST

DATE	MEDICATION	DOSAGE	PRESCRIBED BY

*** PLEASE INCLUDE ALL MEDICATIONS AND VITAMINS.**