PATIENT INFORMATION

FIRST NAME _____ LAST NAME _____ DATE OF BIRTH ____/____/____

STREET ADDRESS _____ APT/# _____ CITY _____ ZIP _____

WORK # (_____)_____ CELL # (_____)_____ HOME # (_____)_____

BEST EMAIL ADDRESS _____ OFFERS/SAVINGS VIA EMAIL? ___ YES ___ NO

PREFERRED COMMUNICATION METHOD: ___ WORK ___ CELL ___ HOME ___ EMAIL ___ NONE

SOCIAL SECURITY # _____-_____-_____ MARITAL STATUS _____

RACE _____ ETHNICITY: _____ HISPANIC _____ NON-HISPANIC (SELECT ONE)

CURRENT OR PAST PATIENT? _____ YES _____ NO \\ WHEN LAST SEEN ____/____/_____

REFERRING PHYSICIAN _____ FRIEND/FAMILY REFERRAL? _____

PRIMARY CARE PHYSICIAN _____ OFFICE PHONE (_____)_____

PHARMACY NAME _____ ADDRESS _____ CITY _____

EMPLOYER NAME _____ PHONE # (_____)_____ CITY _____

YOUR OCCUPATION _____ SPOUSE NAME _____

SPOUSE ADDRESS _____ PHONE # (_____)_____

SPOUSE DATE OF BIRTH _____/_____/_____

PRIMARY INSURANCE

PRIMARY INSURANCE POLICY HOLDER: _____ PATIENT _____ SPOUSE _____ PARENT

NAME OF POLICY _____ CONTRACT # _____ GROUP NAME/# _____

POLICY HOLDER NAME _____ DATE OF BIRTH _____/_____/_____

POLICY HOLDER SOCIAL SECURITY # _____-_____-_____ PHONE # (_____)_____

SECONDARY INSURANCE

SECONDARY INSURANCE POLICY HOLDER: _____ PATIENT _____ SPOUSE _____ PARENT

NAME OF POLICY _____ CONTRACT # _____ GROUP NAME/# _____

POLICY HOLDER NAME _____ DATE OF BIRTH _____/_____/_____

POLICY HOLDER SOCIAL SECURITY # _____-_____-_____ PHONE # (_____)_____

ASSIGNMENT OF INSURANCE BENEFITS

PLEASE CAREFULLY REVIEW AND SIGN BELOW TO ACCEPT

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a certain percentage of the charge. It is your sole responsibility to pay any deductible amount, co-insurance, or other balance not paid for by your insurance.

I directly assign all medical benefits to MiBella Gynecology, LLC and understand that I am financially responsible for all charges whether or not paid by insurance. l hereby authorize MiBella Gynecology, LLC to release all information necessary to secure the payment of benefits.

l further agree that a photocopy of this original shall be valid as an original.

SIGNATURE OF PATIENT (OR LEGAL REPRESENTATIVE) _____

DATE _____/_____/_____ **PRINTED NAME OF SIGNEE** _____

APPOINTMENT CANCELLATION POLICY

PLEASE CAREFULLY REVIEW AND SIGN BELOW TO ACCEPT

To better serve our patients and ensure the availability of appointments, the following policy is necessary: There will be a $30 charge if you fail to cancel your scheduled appointment 24-hours prior to your appointment time. If your appointment is on a Monday, please call the Friday before your scheduled appointment to cancel or reschedule to avoid the cancellation fee.

For frequent missed appointments, we may require a non-refundable and non-transferable deposit for all future appointments will be set. Your credit card on file will be billed $30 on the day of your visit if you fail to cancel your appointment prior to the scheduled time. In the event, no credit card is on file, you will be billed the $30 cancellation fee, which must be paid prior to any future appointments.

In the event that you are unable to complete a pre-paid treatment program/regimen, you will be allowed up to one calendar year (from the date of your first missed appointment), to complete it as prescribed/recommended by Dr. Cowan.

SIGNATURE OF PATIENT (OR LEGAL REPRESENTATIVE) _____

DATE _____/_____/_____ **PRINTED NAME OF SIGNEE** _____

HIPAA INFORMATION AND CONSENT

PLEASE CAREFULLY REVIEW AND SIGN BELOW TO ACCEPT

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly'' version. A more complete text is posted in the office and will be provided in its complete form, upon request.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the non-secure interchange of information necessary to provide you with office services. HIP AA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

MiBella Wellness Center and Dr. Mia Cowan have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record.

2. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

3. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

4. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

5. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

6. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

7. Your confidential infonnation will not be used for the purposes of marketing or advertising of products, goods or services without your consent.

8. We agree to provide patients with access to their records in accordance with state and federal laws.

9. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

10. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I (PRINTED NAME OF PATIENT) _____ DATE _____/_____/_____

Do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

I give my consent to the office of MiBella Wellness Center, MiBella Gynecology LLC, to release any test results ordered by this office to the following person if I am unavailable.

NAME _____ RELATIONSHIP _____ PHONE (_____)_____-_____

DATE _____/_____/_____ SIGNATURE _____

PREVENTIVE CARE SERVICES

PLEASE CAREFULLY REVIEW AND SIGN BELOW TO ACCEPT

Preventive Care, also known as a Well Woman Exam or Checkup, includes an age appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions and the ordering of laboratory/ diagnostic procedures. Preventive Care Services may or may not have a copayment and it is the individuals' responsibility lo know their coverage guidelines.

Important Note:

If an abnormality is encountered or a pre-existing problem is addressed in the process of performing the Preventive Care Services, an additional evaluation and management (office visit and/or outpatient visit) may be necessary (and billable) in addition to the Preventive Care Service. In this instance, the applicable office visit and/or outpatient visit co-pay may be applicable.

Affordable Care Act for Women's Preventive Services are listed below:

(List should not be considered accurate and/or comprehensive and are listed as examples only.)

- Cervical screening or Pap smear, also known as Cervical Dysplasia Screening Chlamydia Infection Screening
- Routine Cholesterol Screening
- Colorectal Cancer Screening
- Gonorrhea Screening
- High Blood Pressure Screening

- HIV Screening
- Human Papilloma Virus (HPV) Screening
- Immunizations
- Iron Deficiency Anemia Screening
- Mammography and Dlugllizatlon
- Osteoporosis In Postmenopausal Women Screening
- Sexually Transmitted Infections (STI) Screening
- Syphilis lnfectlon Screening
- Tobacco Use and Tobacco-Caused Disease Counseling
- Preconception Counseling
- Contraceptive Methods and Counseling

A copy of the Preventive Care Services Disclaimer has been provided to me and I understand that my insurance may apply a co-payment for the additional services rendered outside of the scope of Preventive Care Services.

SIGNATURE OF PATIENT (OR LEGAL REPRESENTATIVE) _____

DATE _____/_____/_____ **PRINTED NAME OF SIGNEE** _____

BHRT CHECKLIST FOR WOMEN

PLEASE CHECK MARK ANY AND ALL SYMPTOMS THAT APPLY

SYMPTOM	NEVER	MILD	MODERATE	SEVERE
Depressive mood (feeling down, sad, lack of drive)				
Memory loss (forgetfulness)				
Mental confusion (feeling in a mental fog)				
Decreased sex drive and/or libido (decreased desire for sex)				
Sleep problems (difficulty falling, staying asleep, waking up tired)				
Mood changes and/or irritable				
Tension				
Migraines and severe headaches				
Difficult to climax sexually				
Feeling of and/or bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and/or wrinkled skin				
Hair is falling out				
Feeling cold all the time				
Swelling all over the body				
Joint pain				

PLEASE LIST OTHER SYMPTOMS YOU ARE CONCERNED ABOUT: _____

_____

_____

_____

_____

REVIEW OF SYMPTOMS AND HISTORY

PLEASE PROVIDE COMPLETE INFORMATION SO WE CAN BETTER SERVE YOU

BREASTS				**FEMALE GENITALIA CONT.**				**FEMALE GENITALIA CONT.**			
Discharge	YES	or	NO	Discharge	YES	or	NO	Itching	YES	or	NO
Tenderness	YES	or	NO	Vaginal dryness	YES	or	NO	Menstrual pain	YES	or	NO
Lumps	YES	or	NO	Irregular bleeding	YES	or	NO	Herpes	YES	or	NO
Pains	YES	or	NO	Malodorous discharge	YES	or	NO	Skip periods	YES	or	NO
CONSTITUTIONAL				Hx of abnormal paps	YES	or	NO	Hx of sexually trans. infections	YES	or	NO
Chills	YES	or	NO	Bleeding b/t periods	YES	or	NO	**ENDOCRINE**			
Fatique	YES	or	NO	Change in periods	YES	or	NO	Weakness	YES	or	NO
Fever	YES	or	NO	Lesions	YES	or	NO	Cold intolerance	YES	or	NO
Weakness	YES	or	NO	Painful intercourse	YES	or	NO	Goiter	YES	or	NO
Weight loss	YES	or	NO	Hot flashes	YES	or	NO	Sweats	YES	or	NO
Weight gain	YES	or	NO	Decreased libido	YES	or	NO	Weight gain	YES	or	NO
CARDIOVASCULAR				Heavy cycles	YES	or	NO	Excessive urination	YES	or	NO
Chest pain	YES	or	NO	Insomnia	YES	or	NO	Flank pain	YES	or	NO
Heart murmur	YES	or	NO	Pelvic pain	YES	or	NO	Frequency	YES	or	NO
High blood pressure	YES	or	NO	Period duration	YES	or	NO	Incontinence	YES	or	NO
Hx. of heart attack	YES	or	NO	Fertility issues	YES	or	NO	Retention	YES	or	NO
FEMALE GENITALIA				Menopause	YES	or	NO	Stones	YES	or	NO
Birth control	YES	or	NO	Post-Menopause bleeding	YES	or	NO	Urgency	YES	or	NO
Change in periods/flow	YES	or	NO	Night sweats	YES	or	NO	Color/Odor	YES	or	NO

GASTROINTESTINAL

Abdominal pain	YES	or	NO
Rectal bleeding	YES	or	NO
Stool color	YES	or	NO
Hemorrhoids	YES	or	NO
Rectal pain	YES	or	NO
Blood in stool	YES	or	NO
Constipation	YES	or	NO
Black/tarry stools	YES	or	NO
Decreased appetite	YES	or	NO
Laxative use	YES	or	NO
Vomitting	YES	or	NO
Diarrhea	YES	or	NO
Frequency of bowels	YES	or	NO
Gallbladder disease	YES	or	NO
Nausea	YES	or	NO
Vomitting blood	YES	or	NO

HEAD

Dizziness	YES	or	NO
Migraines	YES	or	NO

HEAD CONTINUED

Fainting	YES	or	NO
Headaches	YES	or	NO

HEMATOLOGIC/LYMPH

Anemia	YES	or	NO
Bleeding easily	YES	or	NO
Blood clots	YES	or	NO
Easy bruising	YES	or	NO
Swollen glands	YES	or	NO
Transfusion reaction	YES	or	NO

MUSCULOSKELETAL

Arthritis	YES	or	NO
Joint stiffness	YES	or	NO
Joint pain	YES	or	NO
Weakness	YES	or	NO
Back problems	YES	or	NO

PSYCHIATRIC

Anxiety	YES	or	NO
Disturbing thoughts	YES	or	NO
Mood changes	YES	or	NO

PSYCHIATRIC CONTINUED

Suicidal ideation	YES	or	NO
Depression	YES	or	NO
Excessive stress	YES	or	NO
Nervousness	YES	or	NO
PMS	YES	or	NO
Disorientation	YES	or	NO
Memory loss	YES	or	NO
Psychiatric disorders	YES	or	NO
Difficulty Concentrating	YES	or	NO

RESPIRATORY

Asthma	YES	or	NO
Sputum	YES	or	NO
Wheezing	YES	or	NO
COPD	YES	or	NO
Short of breath	YES	or	NO

REVIEW OF HEALTH HISTORY

NEW PATIENTS: Fill out form below completely. Thank you.

EXISTING PATIENTS: Complete applicable changes/updates and last menstrual date.

FIRST NAME _____ LAST NAME _____ DATE OF BIRTH ____/____/____

ALLERGIES _____ MEDICATIONS _____

CURRENT PHARMACY _____ PHONE (_____)_____-_____ ZIP _____

LAST MENSTRUAL CYCLE (1ST DAY OF LAST PERIOD) _____/_____/_____

FREQUENCY OF PERIODS: (EX: 28 DAYS) _____ CYCLE REGULAR? _____ YES _____ NO

MENARCHE (AGE OF FIRST PERIOD) _____ BIRTH CONTROL METHOD _____

HYSTERECTOMY _____ VAGINAL _____ ABDOMINAL TODAY _____ ABDOMINAL PARTIAL

DATE OF LAST PAP _____/_____/_____ RESULTS (NORMAL? ETC) _____

DATE OF LAST

MAMMOGRAM _____/_____/_____ COLONOSCOPY _____/_____/_____

BONE DENSITY _____/_____/_____

IMPORTANT HISTORY

MEDICAL _____

SURGICAL _____

OBSTETRIC _____

FAMILY _____

SOCIAL _____

PREGNANCY _____ LIVING _____ MISCARRIAGE(S) _____ ABORTION(S) _____

VAGINAL BIRTHS _____ C-SECTION BIRTHS _____

DRINK ALCOHOL _____ YES _____ NO

FREQUENCY _____ INFREQUENT _____ MILD _____ MODERATE _____ SEVERE

SMOKING _____ YES _____ NO

FREQUENCY _____ INFREQUENT _____ 1 PACK _____ 1+ PACKS _____ EX-SMOKER

PATIENT RESPONSIBILITIES

PLEASE REVIEW CAREFULLY AND ACCEPT BY SIGNATURE BELOW

MiBella strives to provide the highest quality service to all of our patients. However, we cannot do it alone. We need your assistance in making that possible.

Please take note of the following things:

1. Be prepared to pay a co-pay for services outside of preventive care.
2. Any existing balances need to paid prior to seeing Dr. Cowan.
3. Please make sure that you provide us with current information at each appointment (i.e. 2 minimum telephone numbers, new ID, new medication).
4. Activate your patient health portal within 24 hours of receiving the activation email to have access to reviewed lab and radiology results, future appointment times, medical record, and more. If your link has expired or if you cannot locate the email, please contact us to resend the email.
5. Results will not be discussed over the phone. They can be viewed on the patient portal. Please schedule a follow up appointment if you would like to discuss the results with the doctor.
6. You will be contacted about test results that need immediate attention.
7. Please inform us if you need a 30 day or 90 day supply for your prescriptions, per your insurance coverage.
8. Patients who require referrals: please make sure that you have a physical copy of your referral or that your previous provider has faxed over a copy prior to your appointment.
9. All prescriptions will be called in by the end of the business day for patients who have same day appointments unless it is a specialty drug or requires a Prior Authorization. Prescriptions for narcotics must be written out and taken to the pharmacy. No prescriptions will be called in after business hours.
10. Prescriptions that are requested by phone will be sent within 48 hours.

11. A no-show fee of $30 will be charged to your account if your appointment is not cancelled within 24 hours. If you have a Monday appointment, you need to cancel it by Friday before noon.

12. Please make sure you are aware of what services your insurance covers. Insurance coverage is always changing so it is safest to communicate with your insurance company in regards to this.

SIGNATURE OF PATIENT (OR LEGAL REPRESENTATIVE) _____

DATE _____/_____/_____ **PRINTED NAME OF SIGNEE** _____