Ozark Pelvic Health

Date: _____/_____/_____

First Name: _____ MI_____ Last Name: _____

SSN: _____-_____-_____ Gender (***circle***): **M** or **F** Date of Birth: _____/_____/_____

Address: _____ City: _____

State: _____ Zip: _____

Home #: _____ Cell #: _____

Appointment Reminder Preference (*circle one*): Call or Text

Primary Language Spoken: _____ Primary Care Physician: _____

Race: Caucasian Hispanic Other: _____ Marital Status (***circle***): S M W D

Pt. Employer_____ Phone #: _____

Guarantor Information— *Person responsible for payment in account (skip if same as Pt.)*

First Name: _____ MI_____ Last Name: _____

SSN: _____-_____-_____ Gender (***circle***): **M** or **F** Date of Birth: _____/_____/_____

Address: _____ City: _____

State: _____ Zip: _____

Home #: _____ Cell #: _____

Insurance Information

Primary: _____

ID#_____

Group#_____

Address: _____

City_____ ST_____

ZIP_____

Phone#_____

Secondary: _____

ID#_____

Group#_____

Address: _____

City_____ ST_____

ZIP_____

Phone#_____

Patients Portal Information: Ozark Pelvic Health will communicate with you through the outpatient portal. This is how you will request prescription refills, communicate with our nurses and providers, and receive important education regarding any symptoms or conditions you may have. To sign up for the patient portal, please provide a valid email address that you check often, or please ask if you need assistance obtaining an email account.

Email Address: _____@_____.com

FILL OUT FORM FRONT TO BACK

Release of Patient Medical Information:

I_____ give Ozark Pelvic Health permission to release information regarding my medical healthcare and to discuss my account with the following individuals:

Name/Relationship: Phone #:

_____ _____

_____ _____

_____(***initials***) Ozark Pelvic Health may leave protected health information on my answering machine.

Consent to Receive Medical Treatment, Release of Treatment, Communication Authorization, and Assignment:

I, the undersigned, do hereby consent to receive medical treatment for myself (or my dependent) at Ozark Pelvic Health by the provider on duty. I, the undersigned, certify that I (or my dependent) have insured coverage with the above-mentioned company (or the company listed on the insurance cards I have provided) and assign directly to Ozark Pelvic Health all insurance benefits. I understand that an insurance policy is a contract between me and an insurance carrier and that I am personally responsible for charges resulting from services rendered by Ozark Pelvic Health regardless of the status of a third-party claims. I agree to all the terms set forth herein. All the items have been fully explained.

Financial Agreement—The undersigned agrees, and hereby accepts financial responsibility and agrees to pay any applicable deductibles, co-payments, and/or estimated self-pay dollars and to pay arrears the facility's rates and terms for services rendered to the patient upon receipt of a statement for such charges. The undersigned further agrees that if such indebtedness is placed in the hands of a collector or an attorney for the collection, the undersigned will pay reasonable attorney fees, interest court costs and/or other collection cost expenses.

Communication Regarding my Account— I agree that Ozark Pelvic Health, to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers. I understand, acknowledge, and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voicemail messages. I further agree that the collectors may contact me using email at any email address I provide to the facility or is otherwise associated with my account. I consent to receiving auto-dialed and/or artificial or prerecorded messages call or texts to my number provided during my registration process from the clinic or its affiliates and their agents, without limitation, any account management companies, and independent contractors. This authorization will remain in effect until individually withdrawn by me in writing. I agree to receiving phone/mail surveys regarding my experience at Ozark Pelvic Health. I agree to participate in secure and confidential shared medical records programs to improve access to vital health information when I am away from Ozark Pelvic Health.

Patient Name: _____Date: _____/_____/_____

Patient/Responsible Party Signature_____

FILL OUT FORM FRONT TO BACK

Late Arrivals and Missed Appointments:

We try very hard to be respectful of your time and work diligently to stay on schedule. Our healthcare providers encounter many situations and emergencies that may cause them to need to spend extra time with a patient, and we will try to communicate with you if that occurs. Because we have so many patients waiting for appointments, it is very important that you arrive at your appointment on time with everything needed. If you are more than 15-mintues late, do not have your lab or imaging studies completed, or have not completed your required paperwork, we may have to reschedule you to another time so that other patients can be seen in a timely manner.

Ozark Pelvic Health will maintain a waiting list for patients who need an appointment sooner than our next available time slot. It is very important that you let us know at least 24 hours in advance if you will not be able to keep your scheduled appointment so that we can give that time to another patient.

To ensure that we are able to provide care for our patients, patients who fail to give the required 24-hour notice or arrive more than 15-minutes late to an appointment are subject to a ***$25.00 no show fee***. At discretion of their provider, established patients who fail to give the required 24-hour notice or arrive more than 15-minutes late to an appointment more that two times in one year may be dismissed from the practice and no further appointments will be scheduled. At discretion of their provider, new patients who miss their first scheduled appointment may be deemed ineligible to be scheduled for another appointment.

Patient Responsibilities:

We expect our staff and providers to treat you with courtesy and respect, and a strong working relationship requires cooperation on both sides. Your healthcare needs are best addressed in a safe and friendly environment. If you are unhappy with your care, please discuss it with your provider or clinic manager. If we cannot resolve the conflict, it is in your best interest to find a provider that better meets your needs. Some examples of unacceptable behaviors that may result in dismissal from our practice are: *displaying a hostile or threatening attitude, refusal to pay, and refusal to cooperate or follow recommended treatments or self-care plans.*

Patient Name: _____Date: _____/_____/_____

Patient/Responsible Party Signature_____

FILL OUT FORM FRONT TO BACK

Medication List: **Preferred Pharmacy:** _____

1. _____Dose: _____Frequency: _____
   I. Reason for taking: _____
2. _____Dose: _____Frequency: _____
   I. Reason for taking: _____
3. _____Dose: _____Frequency: _____
   I. Reason for taking: _____
4. _____Dose: _____Frequency: _____
   I. Reason for taking: _____
5. _____Dose: _____Frequency: _____
   I. Reason for taking: _____
6. _____Dose: _____Frequency: _____
   I. Reason for taking: _____
7. _____Dose: _____Frequency: _____
   I. Reason for taking: _____
8. _____Dose: _____Frequency: _____
   I. Reason for taking: _____
9. _____Dose: _____Frequency: _____
   I. Reason for taking: _____
10. _____Dose: _____Frequency: _____
    I. Reason for taking: _____
11. _____Dose: _____Frequency: _____
    I. Reason for taking: _____
12. _____Dose: _____Frequency: _____
    I. Reason for taking: _____

Allergy List: (Please list Medications, Food, et. Cetera)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Past Medical History: (Please list on lines provided)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

FILL OUT FORM FRONT TO BACK

Social History:

Alcohol Type: _____ Frequency: _____

Treatment: _____

Tobacco Type: _____ Frequency: _____

Treatment: _____

Substance Abuse: _____ Frequency: _____

Treatment: _____

Personal Health History

Primary Care Physician: _____ Cardiologist: _____

OB/GYN: _____ Pulmonologist: _____

Gastroenterologist: _____ Urologist: _____

Optometrist: _____ Other: _____

Other: _____ Other: _____

Other: _____ Other: _____

Surgical History:

1. _____

Date: _____/_____/_____ Hospital: _____

2. _____

Date: _____/_____/_____ Hospital: _____

3. _____

Date: _____/_____/_____ Hospital: _____

4. _____

Date: _____/_____/_____ Hospital: _____

5. _____

Date: _____/_____/_____ Hospital: _____

6. _____

Date: _____/_____/_____ Hospital: _____

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Hospitalizations:

1. _____

Date: _____/_____/_____ Hospital: _____

2. _____

Date: _____/_____/_____ Hospital: _____

_____

Date: _____/_____/_____ Hospital: _____

3. _____

Date: _____/_____/_____ Hospital: _____

4. _____

Date: _____/_____/_____ Hospital: _____

5. _____

Date: _____/_____/_____ Hospital: _____

6. _____

Date: _____/_____/_____ Hospital: _____

Family History: (Cancers, Diabetes, Heart Diseases, Pulmonary or kidney diseases, et cetera)

FAMILY MEMBER	Deceased? Cause of Death	AGE	MEDICAL ISSUES
FATHER:			
MOTHER:			
SIBLING(S):			
GRANDPARENTS:			

Date of the first day of your last menstrual cycle/period: _____/_____/_____

Contraception Type: _____

Please list deliveries below:

Date of Delivery	Type: C-section or Vaginal	Weight & Gender of Baby