Dr. Gebel Patient

Lone Star Clinic
Robert M. Lenington, MD, FACS, RVT
Tiffany Gebel, MD, FACOG

PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ City,State,Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ **Email Address**: _____

Date of Birth: _____ SSN: _____

Gender: *MALE* *FEMALE* Marital Status: *SINGLE* *MARRIED* *WIDOWED* *DIVORCED*

Race: _____ Ethnic Group: _____ Language Spoken _____

Primary Care Physician: _____ Phone Number: _____

Pharmacy: _____ Phone Number: _____

Responsible Party

Name: _____ Date of Birth: _____ SSN: _____

Employer of Responsible Party: _____ Employer Phone: Number _____

EMERGENCY CONTACT

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Alternate Phone: _____

INSURANCE INFORMATION:

I am presenting the office of Lone Star Surgery with a copy of my insurance card(s) which contain all necessary information for billing purposes, authorizations for any/all procedures and imaging___(Initial)

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits including Major Medical and Medicare for services rendered by LONE STAR SURGERY. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize said assignee to release all information necessary to process my insurance for payment. I authorize payment of medical benefits to LONE STAR SURGERY and understand that I am responsible for any balance that my insurance does not cover.

I do not have insurance and understand I am responsible for the total charges for any/all procedures and imaging.
_____(Initial)

Signature: _____ Date: _____

GYNECOLOGIC HISTORY QUESTIONNAIRE

Name:_____ DOB: _____ Date: _____

Chief reason for today's visit: _____

First day of last menstrual period: _____

Date of last pap smear: _____Results: _____

Type of birth control currently using: _____
(including vasectomy, tubal ligation, condoms, abstinence, or natural family planning methods)

Are you happy with this method of birth control? _____

Were you referred to our office? If so please tell us by who._____

OBSTETRICAL HISTORY

Are you currently pregnant? **Y** **N** If so, on what date was first positive pregnancy test? _____

Total number of times pregnant (include miscarriages and abortions): _____

Total number of live births (include dates and type of delivery): _____

_____

Total number miscarriages: _____ Total number abortions: _____

Any complications during your pregnancies? If so, please explain: _____

_____

Did you have a Caesarean Section? If so, when: _____

Any family history of inherited disorders (i.e. Tay Sachs, Spina Bifida, Down Syndrome, other genetic disorder)?

_____

GYNECOLOGICAL HISTORY

Age at first period: _____ How many days do your periods last? _____

How often do your periods come? □ Every 28-30 days □ More frequently □ Less frequently

How heavy is your menstrual flow? □ Light □ Moderate □ Heavy □ Extremely Heavy

Do you have bad cramps? **Y** **N** Do you have any PMS symptoms? **Y** **N**

Any bleeding between periods? **Y** **N** Any bleeding after intercourse? **Y** **N**

Any problems with urination (loss of urine while coughing, sneezing, etc.)? **Y** **N**

Check any of the following problems that you have had either in the past or currently:

□ Gonorrhea □ Pelvic Inflammatory Disease (PID) □ Herpes □ Vaginal Infections

□ History of physical or sexual abuse □ IUD Related problems

□ Abnormal pap smears (what abnormality and when)? _____

MEDICAL HISTORY

How is your health in general? □ Excellent □ Good □ Fair □ Poor

Do you smoke? **Y** **N** How much? _____packs per day How many years have you smoked?_____

Are you a past smoker? **Y** **N** When did you quit? _____ How many years did you smoke? _____

Do you drink alcohol? **Y** **N** How many alcoholic beverages do you have in a week? _____

Social drug use? **Y** **N** If so, what type of drugs do you use? _____

Have you ever been diagnosed with a MEDICAL or PSYCHOLOGICAL condition? If so, what was the diagnosis and when? _____

_____

Have you ever been hospitalized for a medical illness? If so, please explain: _____

_____

What surgeries have you had? (please give year of surgery, including cosmetic): _____

_____

_____

Do you have any allergies to medications? **Y** **N** Do you have any other allergies? **Y** **N**

Please List: _____ Please list: _____

_____ _____

_____ _____

Do you have any history of a bleeding disorder? **Y** **N** Had a blood transfusion? **Y** **N**

Do you use medication on a regular basis? Please list name and dose of medication: _____

_____

Have you had a mammogram? **Y** **N** Date & result of last mammogram: _____

Do you have any problems with your breasts? (lumps, discharge, or pain)? _____

FAMILY HISTORY (Please check if anyone in your family has any of these conditions and tell us who has it)

□ Breast Cancer □ Uterine Cancer □ Ovarian Cancer □Colon Cancer

□ Diabetes □ Heart disease □ High Blood Pressure □ Stroke

□ Osteoporosis □ Thyroid disease □ Autoimmune □ Other

SOCIAL HISTORY

Marital status: **M** **S** **D** **W** **P** Sexual Orientation? **Heterosexual** **Homosexual**

Occupation: _____ Religion: _____

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RELEASE OF PATIENT INFORMATION CONSENT

In the event we are unable to reach you by phone and speak with directly to you, please check the *PREFFERED* method for our office to communicate with you:

_____ Leave a message on my answering machine or voicemail.

_____ Send notification in writing to my home address.

If you would like to assign others the privilege of accessing medical information, please indicate below the type of information accessible for each person:

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT	FULL DISCLOSURE	MEDICAL REPORTS ONLY	APPOINTMENT & SURGICAL INFORMATION

I understand that I may revoke or amend my consent for any individual listed above by providing such notice in writing to Lone Star Surgery, PLLC.

_____ _____ _____

Signature of Patient or Responsible Party | Relationship to Patient | Date

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Consent to Use and Disclose Protected Health Information

HOW MAY WE USE AND DISCLOSE YOUR HEALTH INFORMATION?
Your protected health information will be used by Lone Star Clinic or disclosed to others for the purpose of treatment or supporting the day-to day healthcare operations of the practice.

THE NOTICE OF PRIVACY PRACTICES:
Lone Star Clinic is required to provide to you a notice that describes how information about you maybe used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies are defined int eh "Notice of Privacy Policies and Practices" display in the front lobby/waiting area. **PLEASE REVIEW IT CAREFULLY.** If you need a copy of this notice, please chick with the front desk.

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION:
You may request a restriction on the use or disclosure of your protected health information. However, Lone Star Clinic may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative if you would like additional information or clarification.

It is a violation of the federal privacy standards if Lone Star Clinic agrees and fails to comply with your request. The restrictions requests will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the "Notice of Privacy Policies and Procedures", please consult with a practice representative.

YOU AMY REVOKE THIS CONSENT AT ANY TIME:
You may revoke this consent at any time, however, Lone Star Clinic requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of the request.

CHANGES TO PRIVACY PRACTICES:
Lone Star Clinic reserves the right to change or modify the privacy practice outline in the "Notice of Privacy Policies and Procedure". Lone Star Clinic will notify you of any changes of privacy practices either by mail, at your next appointment or any other pre-approved method that you request.

Signature:

I understand the "Notice of Privacy Policies and Procedures" and give my permission to Lone Star Clinic to use and disclose my health information in accordance with this consent and the notice provided.

_____ _____
Name of Patient (Printed) Signature of Patient Date

_____ _____
Patient Parent/Guardian/Representative Signature of Parent/Guardian/Representative

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LONE STAR CLINIC FINANCIAL POLICY

It is the policy of Lone Star Surgery, PLLC to have a Financial Policy that clearly outlines patient practice financial responsibilities. Lone Star Surgery is committed to providing our patients with the best possible medical care while also minimizing administrative costs. The Financial Policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

- It is the patient's responsibility to provide us with correct insurance and demographic information and to bring the insurance cards and a photo id to each visit.
- Our office participates with numerous insurance companies and managed health care programs. For patients that are members of one of these plans, our business office will submit a claim for services rendered. All necessary insurance information, including special forms, must be completed by the patient prior to leaving the office.
- If a patient has insurance that we do not participate with their network, our office will be happy to file the claim upon request, however, payment is full is expected at the time of service.
- It is the patient's responsibility to pay any deductible, co-payment, co-insurance or any portion of the charges as specified by the insurance plan at the time of the visit. Any medical services not covered by a patient's insurance policy is due in full at the time of the visit.
- Payment for professional services can be made with cash, check, debit card or credit card.
- Payment arrangements can be made for established patients. Balances must be paid on a monthly basis with payment made in full within six months with a pre-arranged payment plan. If a patient feels he/she may qualify for assistance, the practice receptionist should be notified for referral to the appropriate individual. Patients that do not have insurance are expected to pay for professional services at the time of service unless prior arrangements have been made with us.
- It is the patient's responsibility to ensure that any required referrals for treatment is provided to the office prior to the visit. The patient may reschedule the appointment or accept financial responsibility due to the lack of referral.
- Our staff is happy to help with insurance questions relating to how a claim was filed or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company member services department which can be located on the insurance card.
- The adult accompanying a minor and the parents (or guardian of the minor) is responsible for payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized by credit card, check, or cash has been paid at the time the service was scheduled.

Our practice believes that a good physician/patient relationship is based on understanding and good communication. Questions about financial arrangements should be directed to the physician's office. We are here to help you.

I understand the above information and agree to these terms.

Signature of Patient/Representative	Relationship to Patient	Date

903-885-2820

Fax: 903-885-2989

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified to Lone Star Clinic upon request in person or by mail to the address specified at the time of the request.

Provider: (name and address)	Patient: _____
_____	SS#:
_____	
_____	DOB: _____

RECORDS AUTHORIZED TO BE RELEASED:

- ☐ Admission history and physical
- ☐ Discharge summary
- ☐ Complete hospital chart
- ☐ Office notes
- ☐ Outpatient records
- ☐ Psychiatric and other mental health records
- ☐ Lab reports
- ☐ Radiological images
- ☐ Consultation notes or reports
- ☐ Complaints or grievances filed, with responses or dispositions
- ☐ Records relating to drug or alcohol abuse (must specify the extent or nature of the records to be released)
- ☐ Medication administration logs, dietary logs, staff contact or service logs, and other records that may not be part of my individual medical record, but which contain information relating to me (These records should be redacted to protect information pertaining to other patients.)
- ☐ Other (specify): _____

Extent or nature of records to be released: _____
(example, specific hospitalization or visit)

This information will be used for the purpose of :

- ☐ Investigating an allegation of abuse
- ☐ Providing advocacy services
- ☐ Other activities at the request of the individual
- ☐ Verifying my eligibility for services offered by the Lone Star Clinic
- ☐ Legal representation

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider or to the facility, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Lone Star Surgery may redisclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

_____
Patient or Representative Date

_____
Name of Representative (print)

_____
Relationship to Patient