ASSOCIATES IN
OBSTETRICS & GYNECOLOGY

Jack W. Tubbs, M.D., Susan Mikaelian, M.D.
Virginia Leonard, WHNP-BC, April Dodder, WHNP-BC, Faith Nicole Brewer, FNP-C
Beth Gray, WHNP-BC, Olivia Gurizzian, WHNP

Notice of Privacy Practices - Acknowledgement

We at Assoicates in Obstetrics and Gynecology are committed to safeguarding the privacy and confidentiality of your medical record, including the personal infromation that you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) through our office policies and the administrative and technical procedures that we have in place.

To assist us in protecting your privacy, please complete the following:

Patient Name (please print): _____

Date of Birth: _____/_____/_____

Pronouns: _____ He /Him She/Her They / Them _____
Please circle pronouns you prefer

Home Phone: _____
May we leave a voicemail message for you here? Yes No

Cell Phone: _____
May we leave a voicemail message for you here? Yes No

Work Phone: _____
May we leave a voicemail message for you here? Yes No

Email: _____
May we leave a message for you here? Yes No

May we speak to someone else regarding your medical care? Yes No

Name of person	Relationship	Phone number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have been made aware of the privacy policies of Associates in Obstetrics and Gynecology, P.C. and have received (or reviewed or been given the option to receive) a copy of the HIPAA Notice of Privacy Practices.

Signed: _____ Date: _____

JACK W. TUBBS, JR., M.D.
SUSAN MIKAELIAN, M.D.
VIRGINIA LEONARD, WHNP-BC
APRIL DODDER, WHNP-BC

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BETH GRAY, WHNP-BC
FAITH NICOLE BREWER, FNP-C
OLIVIA GURIZZIAN, WHNP-BC

PATIENT INFORMATION

Patient's Full Legal Name: _____ (Last) _____ (First) _____ (MI) _____ (Maiden)

D.O.B.: ____/____/____ Age: _____ Allergies: _____

Patient's Address: _____

_____ (City) _____ (State) _____ (Zip)

Phone (H) _____ (W) _____ (C) _____

Social Security No: _____

Patient's Employer: _____ Occupation: _____

Marital Status: M S D W Student: FT___PT___ School: _____

Referred By: _____ Primary Doctor: _____

Sex: _____ Race: _____ Ethnicity: _____ Preferred Language: _____

How did you hear about Associates in OB/GYN: _____

Spouse/Parent Name: _____ Social Security Number: _____

Employer: _____ Work Phone : _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone Number: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I understand that responsibility for payment of medical services in this office for myself and my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I also assign all benefits to Provider. I authorize the submission of claims without obtaining my signature on each claim submitted. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I hereby authorize this Provider and its employees, agents, and assignees to contact me via e-mail, text messaging and to my cellular devices using automated telephone dialing systems.

Date: ____/____/____ **Signature:** _____

Insurance Information

Primary Insurance: _____ Birth Date: ____/____/____

Subscriber: _____ Group#: _____

Policy#: _____

Secondary Insurance: _____ Birth Date: ____/____/____

Subscriber: _____ Group#: _____

Policy#: _____

Medicaid Number: _____ Colorado Access: _____ PCP: _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGES TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED T
EXPEDITE INSURANCE CARRIER PAYMENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERA

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PATIENT HEALTH UPDATE

Name _____ **Date** _____

Date of last menstrual period: _____

How long is it from the start of one period to the start of the next? _____

How many days do your period last? _____

Do you use tampons (super or regular) and/or pad (light or heavy)? _____

How often do you change your pad or tampon on your heaviest day? _____

Are you interested in a simple in office procedure to control your periods? _____

What form of birth control do you use? _____

Are you interested in permanent birth control? _____

Have you had any illnesses or surgeries since your last visit? _____

Current medications and dosages (include over the counter, vitamins, herbs, supplements): _____

_____

_____

_____

Did you take the COVID vaccine_____ Flu Vaccine _____HPV Vaccine_____

Signature: _____ Date: _____

8580 SCARBOROUGH DRIVE, SUITE 100 COLORADO SPRINGS, CO 80920 PHONE: (719) 596-3344 FAX: (719) 632-6118

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Patient Visit Information

Date:_____ **Patient Name:**_____ **DOB:**_____

- *If you have a medication list with you, please have it ready for the Medical Assistant. Thank you*

Please mark any new or worsening symptoms you have had in the **LAST 90 DAYS**:

Constitutional
- Fever
- Chills
- Weight loss
- Are you taking any weight loss injectables? Y / N
- Weight gain
- Fatigue
- Recent illness

Eyes
- Blurred vision
- Vision change

GI
- Blood in stool
- Bowel problems

Respiratory
- Cough
- Shortness of Breath

Cardiovascular
- Chest pain
- Palpitations / skipping beats
- Trouble breathing while laying flat
- Leg swelling

Neurological
- Dizziness / lightheadedness
- Weakness
- Passing out / loss of consciousness

Psych
- Depression
- Anxiety
- Post menopausal symptoms

Derm
- Rash

Endo / Hem
- Diabetes
- Anemia
- Easy Bruising
- History of blood clot

Musculo
- Muscle aches or cramping

Female Genital
- Heavy periods
- Pain w/ periods
- Bleeding between periods
- History of Abnormal Pap Smear
- Frequent UTI
- Painful intercourse
- Pelvic pressure / prolapse
- Urinary incontinence
- Vaginal dryness / Discharge / Odor
- Decreased arousal / Decreased libido
- Post menopausal bleeding
- Spotting after intercourse

Current Medications:

_____

_____

8580 Scarborough Drive Suite 100 Colorado Springs, CO 80920 (719) 596-3344 – P (719) 632-6118 – F

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PATIENT REGISTRATION AND CONSENT FOR TREATMENT

1. **CONSENT FOR TREATMENT.** I voluntarily consent to inpatient and/or outpatient care and treatment performed by my physician and all other health care providers at Associates in Obstetrics and Gynecology. I also consent to routine hospital services, diagnostic procedures, medical treatment, and other services and hospital care as deemed necessary by the health care providers treating me. I understand that the practice of medicine and surgery is not an exact science, and that diagnosis and treatment may cause injury or even death. I understand that I have the right to consent to any proposed surgery, procedure or treatment, and to discuss it with my health care provider.

2. **AUTHORIZATION FOR RELEASE OF INFORMATION.** I authorize Associates in Obstetrics and Gynecology to utilize confidential medical/surgical or other information contained in my medical record as necessary for claims payment, medical management or quality of care review purposes. I further authorize the release and discharge of such confidential information to my insurance company or other health coverage plan as necessary for claims payment, medical management and quality review activities conducted by such company or plan, or its designees. This authorization includes the release of an acquired immunodeficiency syndrome (AIDS) diagnosis or a positive Human Immunodeficiency Virus (HIV) antibody test result, alcohol and/or drug abuse information, genetic testing, congenital disorders, and mental health information. I understand this authorization for release of information can be revoked by me in writing at any time but only with respect to the proposed treatment and not with respect of care and treatment that has already been rendered to me.

3. **MEDICARE, MEDICAID, OR COLORADO INDIGENT CARE PROGRAM.** I authorize and holder of medical or other information about me to release to Social Security Administration, the Department of Health and Human Services, the Colorado Department of Social Services and their intermediaries, carriers or agents any information needed for this or a related claim. I request that payment of authorized benefits be made on my behalf.

4. **PAYMENT AGREEMENT AND ASSIGNMENT.** Except as prohibited by any agreement between my insurance company and Associates in Obstetrics and Gynecology or by state or federal law, **I AGREE TO BE RESPONSIBLE FOR MY CO-PAYMENTS, CO-INSURANCE, DEDUCTIBLES AND OTHER CHARGES FOR MEDICAL SERVICES NOT COVERED OR PAID BY INSURANCE OR OTHER THIRD PARTY PAYERS.** I authorize Associates in Obstetrics and Gynecology to file claims for payment of any portion of the patient bills and assign all rights and benefits to Associates in Obstetrics and Gynecology as appropriate. I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses and interest in the event Associate in Obstetrics and Gynecology has to take action to collect same because of my failure to pay in full all incurred charges.

5. **EXPRESS CONSENT TO COMMUNICATE.** I hereby authorize this provider and its employees, agents and assignees to contact me via email and text messaging, and to my cellular devices. I consent to Associates in Obstetrics and Gynecology, P.C. and its assignees to communicate with me, by telephone, email, fax, or other means.

I HAVE READ THIS FORM AND BY SIGNING THIS FORM, I UNDERSTAND AND AGREE TO ITS TERMS

_____ ____/____/____

Patient Signature
(Or Parent/Guardian/Other authorized person if patient is a minor, mentally incompetent, or physically unable to sign this form

Date

_____ ____/____/____

Print name and relationship of person authorized to sign for patient

Date

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OFFICE POLICIES

When cancelling appointments, you must call in and give 24 hours' notice in order for us to be able to fill that appointment slot or you will be charged a $25.00 cancellation fee.

If you **NO SHOW** an appointment you will be charged a $25.00 no show fee. Consequences of "No Show" appointments. Repeat and/or excessive No Shows can lead to dismissal from our practice. Patient dismissal is at the discretion of your medical provider. If you are dismissed from the practice your remaining appointments will be cancelled. Only emergency medical treatment will be offered within the first 30 days of dismissal.

CO-PAYS are due at time of appointment or your appointment will be rescheduled.

SELF-PAY PATIENTS, payment is due at time of service.

If you are 15 minutes late for your appointment your appointment may be rescheduled. As, at this point you have run into another scheduled patient's appointment time. Our schedules cannot accommodate anyone arriving past their scheduled time.

Insurance cards and photo ID are required at each appointment.

Please be aware that there is more than one Practitioner in this office, including Ultrasound. Patients will be arriving at different times and be seen by appointment time, not arrival time depending on which Practitioner they are seeing.

If your Practitioner is running behind you are more than welcome to wait or if you would like to reschedule, we would be happy to do that for you.

We thank you for your cooperation.

Signature: _____

Date: _____/_____/_____

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____

Today's Date: _____ Health Care Provider: _____

Instructions: This is a screening tool for cancers that run in families. Please mark Y for those that apply to YOU and/or YOUR BIOLOGICAL FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family. You and the following close blood family members should be considered:

- First-degree relatives: Mother, father, full siblings, or children
- Second-degree relatives: Grandparents, grandchildren, aunts, uncles, nephews, nieces or half-siblings
- Third degree relatives: First-cousins, great-grandparents or great grandchildren

YOUR FAMILY'S Cancer History (Please be thorough and accurate)

	CANCER	YOU (age)	PARENTS / SIBLINGS / CHILDREN	AGE	MOTHER'S SIDE	AGE	FATHER'S SIDE	AGE
☐ Y ☐ N	*EXAMPLE: BREAST CANCER*		*Sister*	*41*	*Aunt* *Cousin*	*45* *61*	*Grandmother*	*53*
Y N	BREAST CANCER							
Y N	OVARIAN CANCER							
Y N	UTERINE/ENDOMETRIAL CANCER							
Y N	COLON/RECTAL CANCER							
Y N	OTHER CANCER(S) (SPECIFY):							

Y N Are you of Jewish descent?

PATIENT SIGNATURE:

Testing Criteria (office use only)

Hereditary Breast and Ovarian Cancer Syndrome

- Breast cancer diagnosed under 50*
- Ovarian cancer at any age*
- Two primary breast cancers in the same person at any age*
- Two relatives on the same side of the family with breast cancer, one diagnosed at or under age 50
- Triple negative breast cancer at or under the age of 60 (receptor status negative for ER, PR and HER2)
- Male breast cancer
- Three or more relatives on the same side of the family with any of the following cancers: breast, ovarian, pancreatic, prostate
- Ashkenazi Jewish ancestry with an HBOC-associated cancer**
- Metastatic prostate cancer*
- PERSONAL HISTORY METASTATIC BREAST CANCER (patient only)

Lynch Syndrome

- colon/rectal cancer or endometrial cancer diagnosed at or under age 50*
- A personal history of two or more Lynch syndrome cancers one being colon or endometrial cancer***
- Two or more relatives with a Lynch syndrome cancer***, one before the age of 50 and one being colon or endometrial cancer
- Three or more relatives with a Lynch syndrome cancer*** at any age and one being colon or endometrial cancer

- A previously identified BRCA1 or BRCA2 mutation, or Lynch syndrome mutation in the family

* In self, first or second degree family members
**HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*
***Lynch-associated cancers include: *colon, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas.*

Cancer Risk Assessment Review and Counseling (office use only)

Health Care Provider's Signature: _____ Date: _____

Patient meets guidelines for genetic testing ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED Results Appt Date: _____

INFORMED REFUSAL: My provider has recommended hereditary cancer testing (myRisk testing) based on my personal and/or family history of cancer. He/She has explained to me the benefits of the genetic test and the risks of not consenting to the test. Despite my provider's recommendation, I decline to consent to the genetic test. **PATIENT SIGNATURE:** _____