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

ASSOCIATES IN OBSTETRICS & GYNECOLOGY

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: _____
Subscriber: _____ Birth Date: ____/____/____
Policy#: _____ Group#: _____
Secondary Insurance: _____
Subscriber: _____ Birth Date: ____/____/____
Policy#: _____ Group#: _____
Medicaid Number: _____ Colorado Access: _____ PCP: _____

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

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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: _____/_____/_____

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

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NEW OB INTAKE FORM

Name _____

Date of Last Menstrual Period: _____

Total # of Pregnancies: _____ Total # of Living Children: _____ Total # Deliveries after 20 weeks: _____

Pregnancy History:

Date: _____ Vaginal/Cesarean (circle one) Birth weight: _____Complications:_____

Date: _____ Vaginal/Cesarean (circle one) Birth weight: _____Complications:_____

Date: _____ Vaginal/Cesarean (circle one) Birth weight: _____Complications:_____

Date: _____ Vaginal/Cesarean (circle one) Birth weight: _____Complications:_____

Date: _____ Vaginal/Cesarean (circle one) Birth weight: _____Complications:_____

Date: _____ Vaginal/Cesarean (circle one) Birth weight: _____Complications:_____

Medications/drugs/alcohol since last menstrual cycle: _____

_____

_____

Do you have concerns today with: (circle one)

Vaginal Bleeding	yes / no	Nausea	yes / no
Vaginal Pain	yes / no	Vomiting	yes / no
Vaginal Discharge	yes / no	Abdominal Cramping	yes / no

Do you have any significant medical history (diabetes, hypothyroidism, etc)?_____

_____

Other Concerns: _____

_____

Signature _____ Date: ____/____/____

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☐ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things

- ☐ As much as I always could
- ☐ Not quite so much now
- ☐ Definitely not so much now
- ☐ Not at all

2. I have looked forward with enjoyment to things

- ☐ As much as I ever did
- ☐ Rather less than I used to
- ☐ Definitely less than I used to
- ☐ Hardly at all

3. I have blamed myself unnecessarily when things went wrong

- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ Not very often
- ☐ No, never

4. I have been anxious or worried for no good reason

- ☐ No, not at all
- ☐ Hardly ever
- ☐ Yes, Sometimes
- ☐ Yes, very often

5. I have felt scared or panicky for no very good reason

- ☐ Yes, quite a lot
- ☐ Yes, sometimes
- ☐ No, not much
- ☐ No, not at all

*6. Things have been getting on top of me

- ☐ Yes, most of the time I haven't been able to cope at all
- ☐ Yes, sometimes I haven't been coping as well as usual
- ☐ No, most of the time I have coped quite well
- ☐ No, I have been coping well as ever

*7. I have been so unhappy that I have had difficulty sleeping

- ☐ Yes, most of the time
- ☐ Yes, sometimes
- ☐ Not very often
- ☐ No, not at all

*8. I have felt sad or miserable

- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Not very often
- ☐ No, not at all

*9. I have been so unhappy that I have been crying

- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Only occasionally
- ☐ No, never

*10. The thought of harming myself has occurred to me

- ☐ Yes, quite often
- ☐ Sometimes
- ☐ Hardly ever
- ☐ Never

Administered/Reviewed by _____ Date _____

[1] Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786

[2] Source: K. L. Wisner, B. L. Parry, C.M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199