

PATIENT REGISTRATION FORM

Dr. Patricia A. Frey welcomes you to our practice! Please fill out all the information requested.

Patient's Name: _____	Date of Birth _____	Age _____
Address: _____ City, _____ TX, Zip _____		
Home Phone (____) _____	Marital Status: (Circle one) M S D W SEP	Race _____
Cell Number(____) _____	Social Security # _____	TDL# _____
Employer _____	Work Phone #: (____) _____	
Address _____	Occupation _____	
School (if student) _____	Phone #: (____) _____	

Primary Insurance _____	Phone #: (____) _____
Policy Holder's Name _____	Relation _____
Date of Birth _____	Social Security # _____
Employer _____	Work Phone #: (____) _____
Group # _____	ID # _____

Secondary Insurance _____	Phone #: (____) _____
Policy Holder's Name _____	Relation _____
Group # _____	ID # _____

Who should we notify in case of emergency? _____

Relationship to patient _____ Phone # _____

Who referred you to this practice? PLEASE LIST BELOW (Example: Doctor, Friend, Family, Phone Book, or Newspaper)

(Please provide us with a full name and address of the person who referred you to Dr. Patricia A. Frey)

I hereby authorize Patricia A. Frey, M.D to furnish information to my insurance carriers concerning my illness and treatments. I hereby assign the above provider all payments for medical services rendered to my dependent or myself. I understand that **I am fully responsible for any amount not covered (including pre-existing) by the insurance carrier.**

Signature _____ Date _____

Payment is due at the time service is rendered, unless prior arrangements are made.

FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at anytime. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy or your responsibility.

YOUR RESPONSIBILITIES AS A PATIENT

All patients must complete our "Patient Information Form" before seeing the doctor. It is **the patient's responsibility to inform us of any changes** in this information including: address, telephone numbers, employment, insurance coverage, etc., and we will ask to make a copy of your insurance card each time you visit our office.

FULL PAYMENT IS DUE AT TIME OF SERVICE

CO-PAYMENTS ARE DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, AND VISA/MASTERCARD. THERE IS A \$25 FEE FOR ALL RETURNED CHECKS.

PATIENTS WHO DO NOT SHOW FOR AN APPOINTMENT WILL BE CHARGED \$25.

THERE IS A \$25 CHARGE FOR EACH DISABILITY FORM.

In compliance with Texas Laws, the practice will send a copy of your medical records to other physicians with your consent. There is a copy service fee of \$25 for the first twenty pages and .50 for every page after.

You are responsible for the timely payment of your account. We realize that temporary financial problems may arise, and, if this should happen, we encourage you to contact us promptly for assistance in the management of your account.

Large balances may be placed on a payment plan. Payments must be made on time and in full each month. Interest will be added monthly on all overdue accounts until the balance is paid in full.

Balances older than 30 days may be subject to additional collection fees and service charges.

REGARDING YOUR INSURANCE

If you have insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. You must realize, however; that:

- Your insurance is a contract between you, your employer; and the insurance company. We are NOT a party to that contract.
- Not all services are covered benefits in all contracts. Your employer selects and defines the services that are covered in your plan. You are responsible for paying for services not covered in your plan.
- We will collect all portions of your bill which you are responsible for paying at the time of service.

We must emphasize that as medical providers, our relationship is with you, NOT your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are still your responsibility from the date the services are rendered.

FOR OUR OBSTETRICS AND SURGERY PATIENTS

We will contact your insurance company to attempt to determine what portion of your bill the insurance company is likely to pay, and what portion of your bill you must pay yourself. Please understand that insurance companies often will NOT give us accurate information on the exact dollar amount that they will pay for any given procedure. In addition, you may incur other costs such as sonograms (ultrasounds) and other tests and procedures which may or may not be covered by insurance, and which will affect your total bill. We will estimate the amount you are responsible for; which should be paid at the time of service, prior to delivery or surgery. Monthly payment arrangements are available for maternity patients.

We hope that this policy will clarify the relationship between you, your physician, your insurance and our office so that we can best serve your individual needs while you are a patient in our practice.

Responsible Party Signature

Date

(August/1999)

I. PATIENT IDENTIFICATION (PLEASE PRINT)

Patient's Name: _____ Date of Birth: ____ / ____ / ____ Age: _____
 Address: _____ Marital Status: S M D Sep W
 _____ Race: _____ Occupation: _____
 Home Telephone No.: (____) _____ Referring Physician: _____
 Work Telephone No.: (____) _____ Primary Physician: _____

II. REASON FOR SEEING DOCTOR: _____

III. MEDICAL HISTORY:

Do you or anyone in your family have:

	You	Your Family
1. High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
2. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
3. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
4. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
5. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
6. Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
7. Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
8. Stomach or Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>
9. Kidney or Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
10. AIDS (HIV)	<input type="checkbox"/>	<input type="checkbox"/>
11. Hepatitis (Type ____)	<input type="checkbox"/>	<input type="checkbox"/>
12. Anemia / Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
13. Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
14. Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
15. Cancer (Who and what type?)	<input type="checkbox"/>	<input type="checkbox"/>
16. Birth Defects or Inherited Diseases	<input type="checkbox"/>	<input type="checkbox"/>
17. Sexual Abuse / Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>
18. Depression or Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>
19. Other Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>
20. No Known Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>

Physicians Use Only

IV. HOSPITALIZATIONS Please list those operations or serious illnesses that you have had which required hospitalization. If you have had more than six, check this box. Do not include pregnancies here.

Month/Year	Illness or Operation	Attending Physician's Name	Complications	
			No	Yes
/			<input type="checkbox"/>	<input type="checkbox"/>
/			<input type="checkbox"/>	<input type="checkbox"/>
/			<input type="checkbox"/>	<input type="checkbox"/>
/			<input type="checkbox"/>	<input type="checkbox"/>
/			<input type="checkbox"/>	<input type="checkbox"/>
/			<input type="checkbox"/>	<input type="checkbox"/>

V. PREGNANCY HISTORY (Complete all information)

# of Pregnancies		# of Premature Births		# of Spontaneous Abortions		# of Elective Abortions		# of Living Children
# of Term Births	Born Month/Year	Baby's Sex	Weight at Birth	Weeks Pregnant (Term=40 Wks)	Hours in Labor	Type of Delivery	Type of Anesthesia	Complications No Yes
1	/		lbs. oz.					<input type="checkbox"/> <input type="checkbox"/>
2	/		lbs. oz.					<input type="checkbox"/> <input type="checkbox"/>
3	/		lbs. oz.					<input type="checkbox"/> <input type="checkbox"/>
4	/		lbs. oz.					<input type="checkbox"/> <input type="checkbox"/>
5	/		lbs. oz.					<input type="checkbox"/> <input type="checkbox"/>
6	/		lbs. oz.					<input type="checkbox"/> <input type="checkbox"/>

Patient's Signature: _____

Physician's Signature: _____

PAST GYN HISTORY:

1. When was your last pap smear? _____ Where? _____
2. When was your last mammogram? _____
3. When was your last period? _____
4. How old were you when you first started menstruating? _____
5. How many days pass in between menstrual periods? _____
6. How long do your periods last? _____ days
7. Are your periods painful? _____ Mild Moderate Severe
8. What do you use to treat your pain? _____
9. Do you do self-breast exams? _____ How often? _____
10. Have you noticed any lumps, pain, or discharge? _____
11. Do you have any vaginal discharge, odor, or itching? _____
12. Are you sexually active? _____
13. How old were you when you first had sexual intercourse? _____
14. How many sexual partners have you had in your lifetime (total)? _____
15. Do you use birth control? _____ What type(s)? _____
16. Have you had problems with birth control in the past? _____
17. Have you ever had Gonorrhea, Chlamydia, HPV, or any other sexually transmitted diseases? _____
If yes, when? _____

If you are postmenopausal, when did you go through menopause? _____

Do you have:

Hot Flashes? _____

Night Sweats? _____

Vaginal Dryness? _____

Mood Changes? _____

Do you leak urine? _____ When? _____ How often? _____

MEDICATIONS: Please list all medications / vitamins / herbs / supplements that you are currently taking:

ALLERGIES: Please list all medications you are allergic to and what happens if you take them, such as hives, rash, vomiting, etc.

SOCIAL HISTORY:

Do you smoke? _____ How many packs a day? _____

How many years have you been smoking? _____

Do you drink alcohol? _____ What kind? _____

How much alcohol do you drink in a week? _____

Do you use street drugs? What kind? _____

How much per day? _____

Patient's Signature: _____

Physician's Signature: _____



Patricia A. Frey, M.D.
4201 Garth Road, Suite 290
Baytown, Texas 77521

Consent form for HALO Breast Pap Test

Breast cancer is a significant health issue for women. Some important statistics are:

- 1 in 8 women is expected to develop breast cancer during her lifetime.
- Breast Cancer is the leading cause of death for women between the ages of 20-59.
- 8 out of 9 women who develop breast cancer do not have an affected mother, sister, or daughter with the disease.
- 95% of breast cancers begin in the milk ducts.
- 70% of women who develop breast cancer have no identifiable risk factors other than age.

Like the pap smear, which has substantially reduced the cervical cancer death rate in this country, this test will look for cellular abnormalities in your breasts. The test takes five minutes to complete and is non-invasive. A combination of warmth, compression, and mild vacuum is used to collect fluid from the breasts. Most women report no discomfort or mild discomfort during the test. I believe this is an important test to help understand your risk of breast cancer, as well as providing us our best chance of developing a successful care path if your test shows any abnormalities. The HALO test does not replace the mammogram and self-exam, but rather provides another piece of the puzzle to help identify high-risk women. Unlike the mammogram, which is not recommended until age 35 to 40, the HALO Pap Test is available for women as young as 25.

Like any other test or procedure, it may rarely involve risks or complications. The HALO will not be performed until you have all questions answered. You have the right to consent to or refuse this test. If you request to terminate this procedure prior to its completion, you will be required to pay \$100.00 for the cost of supplies which were used.

Your signature below acknowledges that you authorize and consent to this test. The cost of the HALO Pap Test is \$100.00. If your test produces fluid, which is the case about 50% of the time, the specimen will be sent to the lab for analysis by the pathologist.

_____ Yes, I authorize Patricia A. Frey, M.D. and staff to perform
the HALO Pap Test, and I accept financial responsibility for this test.

OR

_____ No, I choose not to have the HALO Pap Test at this time.

Patient Signature

Date

Patricia A. Frey, M.D.

Consent for Treatment

I _____ authorize and direct Patricia A. Frey, M.D. to examine me and perform those procedures necessary for prenatal and/or family planning care and/or women's health care and/or general medical care. *The nature of the procedure has been explained to me and no warranty or guarantee has been made to me as to the result.* Procedures that may be performed include, but are not limited to:

- Medical history and physical examination, including pelvic and breast examination
- Blood draws to screen for syphilis, anemia, rubella, diabetes, hepatitis, AIDS or HIV, herpes and other blood work determined to be necessary
- Urinalysis, urine pregnancy tests, urine culture and drug screen
- Gonorrhea/Chlamydia culture
- Pap Smear and HPV (Human Papilloma Virus) testing
- Other appropriate lab work
- Ultrasound
- Necessary immunizations

I authorize release of any information required for payment of provider and/or hospital charges for services rendered by Patricia A. Frey, M.D., P.A.. I further authorize release of information to any hospital or medical facility I present myself for medical care.

Patient Signature

Date

Guardian Signature

Date

Patricia A. Frey, M.D.
4201 Garth Road, Suite 290
Baytown, Texas 77521
281-422-5535

Dear Patient:

In the practice of medicine, every physician reviews new therapies and procedures ensuring that patients always benefit from the state-of-the-art thinking. For over 50 years, the Pap Smear has been used in the practice of gynecology to detect abnormalities of the cervix. One limitation of the traditional Pap Smear is that it may not always detect very early changes in the cervix that may lead to cancer. It is important to see those changes as early as possible, because early detection followed by appropriate treatment is important to successful therapy for cervical cancer.

****Papsure** is a new test that combines the traditional pap smear with an enhanced ability to view the cervix with Speculite, a disposable light for vaginal illumination, during a routine examination. The advantage of Papsure is that it significantly improves the ability to identify cervical abnormalities.

Because Papsure is a new product, **IT IS NOT COVERED BY INSURANCE,** which means **YOU WILL HAVE A FEE OF \$40.00** if you decide to have the visual exam as part of your routine check-up. This fee will cover the cost of Speculite and the Papsure visual exam.

Cordially,

Patricia A. Frey, M.D.

Please indicate by signing and dating this form, whether you want to have the Papsure exam.

Yes, I authorize Patricia A. Frey, M.D. to do the Papsure exam together with my normal pap smear, and I accept financial responsibility for the Speculite and the Papsure visual exam.

No, I choose not to have the Papsure exam.

Name (Please Print) _____

Signature _____ Date _____

Patient Receipt of “Notice of Privacy Practices”

I have received a copy of Patricia A. Frey’s Notice of Privacy Practices describing the practice commitment to privacy, my rights to privacy and how Patricia A. Frey, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

By signing this form, I am acknowledging that Patricia A. Frey, M.D. will use and disclose my protected health information to provide my medical care, receive payment for services provided to me and to conduct its business.

I have the right to review the Notice of Privacy Practices prior to signing this acknowledgement.

Patient/Legal Guardian Signature

Date

Printed Patient Name

Relationship to Patient

***Due to patient confidentiality, we are unable to relay any information regarding your healthcare to anyone but you, the patient. Therefore, when a question arises regarding your appointments, billing, test results or medical advise in general, we will only respond to you unless we are given prior permission to give information out to other people as indicated below.

You may give **any confidential** medical information regarding my care to the following person(s).

NAME

RELATIONSHIP

_____	/	_____
_____	/	_____
_____	/	_____
_____	/	_____
_____	/	_____

My signature below indicates that I have read and understand the above statement.

Signature

Date