# 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: (Cirlce 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)

**PATRICIA A. FREY, M.D., P.A.**
4201 Garth Road, Suite 290
Baytown, TX 77521

Today's Date:______ / ______ / ______

## I. PATIENT IDENTIFICATION (PLEASE PRINT)

Patient's Name: ______________________________

Address: ______________________________

______________________________

Home Telephone No.: (_____) ______________________________

Work Telephone No.: (_____) ______________________________

Date of Birth: _____ / _____ / _____ Age: ____________

Marital Status: ❑ S ❑ M ❑ D ❑ Sep ❑ W

Race: ____________ Occupation: ____________

Referring Physician: ______________________________

Primary Physician: ______________________________

## II. REASON FOR SEEING DOCTOR: ______________________________

______________________________

## III. MEDICAL HISTORY:

Do you or anyone in your family have:

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

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 | Complications Yes |
|---|---|---|---|---|
| / | | | ❑ | ❑ |
| / | | | ❑ | ❑ |
| / | | | ❑ | ❑ |
| / | | | ❑ | ❑ |
| / | | | ❑ | ❑ |
| / | | | ❑ | ❑ |

## 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 | Complications Yes |
|---|---|---|---|---|---|---|---|---|---|
| 1 | / | | lbs. oz. | | | | | ❑ | ❑ |
| 2 | / | | lbs. oz. | | | | | ❑ | ❑ |
| 3 | / | | lbs. oz. | | | | | ❑ | ❑ |
| 4 | / | | lbs. oz. | | | | | ❑ | ❑ |
| 5 | / | | lbs. oz. | | | | | ❑ | ❑ |
| 6 | / | | lbs. oz. | | | | | ❑ | ❑ |

Patient's Signature: ______________________________ Physician's Signature: ______________________________

**PATRICIA A. FREY, M.D., P.A.**
4201 Garth Road, Suite 290
Baytown, TX 77521

Patient Name: ______________________________
DOB: ______________________________
Date: ______________________________

**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., P.A.**
4201 Garth Road, Suite 290
Baytown, TX 77521

Patient Name: ____________________
DOB: ____________________
Date: ____________________

**IF YOU ARE PREGNANT, PLEASE ANSWER THE FOLLOWING:**

1. Excluding iron and vitamins, have you taken any medications or recreations drugs since being pregnant or since your last menstrual period? (Include nonprescription drugs.) Yes ______ No ______

   If yes, give name of medication and time taken during pregnancy: ____________________

2. Will you be 35 years or older when the baby is due? Yes ______ No ______
3. Have you, the baby's father, or anyone in either of your families ever had any of the following disorders?
   - Down syndrome Yes ______ No ______
   - Other chromosomal abnormality Yes ______ No ______
   - Neural tube defect, ie, spina bifida (meningomyelocele or open spine), anencephaly Yes ______ No ______
   - Hemophilia Yes ______ No ______
   - Muscular dystrophy Yes ______ No ______
   - Cystic Fibrosis Yes ______ No ______

   If yes, indicate the relationship of the affected person to you or to the baby's father: ____________________
4. Do you or the baby's father have a birth defect? Yes ______ No ______

   If yes, who had the defect and what is it? ____________________
5. In any previous marriages, have you or the baby's father had a child, born dead or alive, with a birth defect not listed in question 2 above? Yes ______ No ______
6. Do you or the baby's father have any close relatives with mental retardation? Yes ______ No ______

   If yes, indicate the relationship of the affected person to you or to the baby's father: ____________________

   Indicate the cause, if known: ____________________
7. Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal abnormality not listed above? Yes ______ No ______

   If yes, indicate the condition and the relationship of the affected person to you or to the baby's father: ____________________
8. In any previous marriages, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses? Yes ______ No ______

   Have either of you had a chromosomal study?

   If yes, indicate who and the results: ____________________
9. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease? Yes ______ No ______

   If yes, indicate who and the results: ____________________
10. If you or the baby's father are black, have either of you been screened for sickle cell trait? Yes ______ No ______

    If yes, indicate who and the results: ____________________
11. If you or the baby's father are of Italian, Greek, or Mediterranean background, have either of you been tested for ß-thalassemia? Yes ______ No ______

    If yes, indicate who and the results: ____________________
12. If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for a-thalassemia? Yes ______ No ______

    If yes, indicate who and the results: ____________________
13. Do you have cats? Yes ______ No ______
14. Have you had Chicken Pox? Yes ______ No ______

Patient's Signature: ____________________ Physician's Signature: ____________________

# Patricia A. Frey, M.D.

**4201 Garth Road, Suite 290**
**Baytown, Texas 77521**
**Ph: 281-422-5535**
**Fax: 281-422-4801**


## OB Policy

**I, the undersigned obstetric patient for Dr. Frey, understand that if I fail to keep my obstetric care appointments my physician-patient relationship will be terminated. I understand that Dr. Frey cannot be responsible for the care of my unborn child if I fail to keep my scheduled appointments.**

**If you become inactive for Medicaid or Private Health Insurance during your pregnancy, we need to make you aware of the office policy:**

**Your prenatal care and delivery need to be paid in full by your 28$^{th}$ week of pregnancy. If you are less than 28 weeks, a payment plan can be discussed with you. If this is not possible, you may be terminated from our practice. If you go to Labor & Delivery or to the Emergency Room you will be considered a "Drop-In" patient and will not be cared for by Dr. Patricia Frey. You will be cared for by the Family Practice physicians of San Jacinto Methodist Hospital.**

**Please communicate with our office staff to avoid any disruptions in your prenatal care.**

____________________________________ __________________

**Patient Name** **Date**

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

# Patient Consent Form

Recent recommendations from the American College of Obstetricians and Gynecologists (ACOG) suggests that specific fetal structures be examined during your ultrasound examination. While every effort will be made to identify birth defects of the brain, chest, heart, abdomen, kidneys and extremities, not all birth defects will be necessarily detected.

I have been informed of the limitations of the ultrasound examination Dr. Frey and/or her ultrasound technician will be performing and understand that not all birth defects may be detected, even if they are present. However, I agree to the ultrasound examination and do not wish to be referred to a specialist for a more detailed evaluation.

Patient's Signature________________________________Date___________________

Because of these limitations, I prefer to be referred to specialist who may have a higher detection rate for serious birth defects.

I also understand that my insurance may not cover the cost for such a referral, and I am willing to pay for the cost of the ultrasound.

Patient's 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