Unified Premier Women's Care
574 Church Street NE, Marietta, GA 30060
P: 770-427-0285 F:770-424-5037

New Patient Paperwork

It is your responsibility to present your insurance card & notify us of any changes at each appointment

Please print your full legal name

First_____M.I._____ Last_____DOB: ____/____/_____

Address_____Apt#_____SSN:_____

City_____State_____Zip_____

Employer/School_____

Home#_____ Work#_____ Cell#_____

What number is your preferred first contact number? Home Work Cell Other:_____

Race:_____Marital Status: Single Married Divorced Widowed

If married, spouse's name:_____

Email_____Pharmacy Name and Number_____

EMERGENCY CONTACT INFORMATION

Name_____Relationship_____

Cell#_____Home#_____Work#_____

INSURANCE INFORMATION

Primary Insurance_____ID#_____

Policyholder's Full Name_____MI____Last_____

DOB:____/____/_____ Group#_____Employer_____

Relationship of patient to Insured: Self Spouse Child

Secondary Insurance_____ID#_____

Policyholder's Full Name_____MI____Last_____

DOB:____/____/_____ Group#_____Employer_____

Relationship of patient to Insured: Self Spouse Child

Who referred you to us?_____

ASSIGNMENT OF BENEFITS/GUARANTEE OF PAYMENT: I authorize payment of medical benefits to Unified Premier Women's Care for services rendered. I understand that if I have provided valid insurance information that my charges will be filed (including out of network) and do hereby agree to pay for these services in full.

Notice of special charges: New Patient missed appointment fee is $75.00. Established Patient Missed appointment fee is $50.00. Return Check fee is $35.00. Disability/FMLA Forms at $10 per page or $50 for max per submission.

Signature_____ Date_____

Unified Premier Women's Care

COMMUNICATION CONSENT

Patient confidentiality is a top priority of Unified Premier Women's Care and due to HIPAA guidelines, we are not allowed to give out your personal medical information to anyone without your consent. If there is someone you would like to have access to your medical information, please provide below:
Patients 17 years old and younger will need their parent or guardian to complete this information

Please contact me at _____ with any test results.
(Daytime phone number)

If I am unavailable at this number, you **May** or **May Not** leave a message on my voicemail.
(Circle one)

Consent to text appointment reminders? **YES** or **NO** (circle one) Cell number:_____

If there Is any other person that we may talk to regarding your test results or any other medical information if you are not available, please list them below,

If you wish us only to speak with you, please circle NO ONE (here).

Person's Name	Relationship to you	Their Daytime phone number	Mav we leave a voicemail message on this number? YES or No

I understand that If the status of any of the above Information changes, it will be my responsibility to inform the doctor or staff.

_____

Print Name Date of Birth

_____

Patient Signature Today's Date

GUARDIAN SIGNS BELOW FOR PATIENTS 17 YEARS OLD OR YOUNGER

_____

Parent/Guardian Signature Today's Date

Unified Premier Women's Care, LLC
Practice Policies

Patient Name_____ Date of Birth_____

Thank you for choosing us as your health care provider. We are committed to your medical care. Our goal is to keep your insurance or other financial arrangements as simple as possible as they are considered part of your treatment. In order to accomplish this, we ask that you adhere to the following guidelines. We require that you read and sign this prior to treatment.

Insurance - We are participating with most insurance companies. Please check with them prior to your appointment to confirm this. For those Insurance companies that we participate with, we will file all claims and accept assignment, however, *your insurance policy is a contract between you and your Insurance carrier.* We cannot guarantee payment, nor make excessive effort to collect payments from the insurance company. *The patient/guarantor is ultimately responsible for payment in full of charges for services rendered.* All co-pays and coinsurance amounts are due at the time of service. You will be asked for a valid insurance card at each visit. Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling future appointments. We realize that sometimes people have financial difficulty, and our business office will work with you to ensure you receive needed medical care. If you do not have insurance coverage, we will go over the estimated cost for your appointment. Payment in full is expected at the time of service.

Appointments and Scheduling – Patients are seen by appointment only. We understand that your time is as valuable as ours. We ask that you arrive on time for your appointments. Be assured that every effort is made to honor your appointment time. Due to the nature of our specialty, there may be delays when we have unexpected deliveries or surgeries. We will try to keep patients informed of delays, and will give the option of rescheduling. If you cannot keep your appointment for any reason, please call us 24 hours prior to your appointment time.

Fees: All patients will be required to put a card on file.

For No Show & Less than 24-hour cancelation fees are listed below. Charges apply if you do not provide us with the requested 24-hour cancelation notice. You will personally be responsible for this charge. It will not be billed to or paid by your insurance company. Future appointments will not be scheduled until this fee is paid. Please note: Missing more than three appointments without proper notification may result in dismissal from the practice.

- No Show or Cancellation within 24 hours will be charged for all patients unless extenuating circumstances.
  - $50 for any established patient scheduled visit.
  - $75 for New Patient only appointment
  - $50 for Ultrasound Only
  - $75 for Ultrasound and Appointment scheduled on the same day.
  - $100 for Procedures including in office procedures.
  - $100 to reschedule surgery following receipt of confirmation email.
  - $150 for No Show Surgery or Less than 24-hour cancelation of surgery.
  - $150 surgery deposit when a surgery is scheduled.

Payments - Payments may be made with cash, check, credit card or care credit. There will be a $35.00 charge added to your account for any checks that are returned by your bank. All co-pays are due at the time of service. There is also a $35.00 fee charged to any account over 90 days old that we send to an agency for collections.

Completion of Forms – There is a $10.00 per page charge up to a max of $50.00 for Disability, FMLA, Life Insurance or other letters. These may take up to 7 business days for completion.

Unified Premier Women's Care, LLC
Practice Policies

Patient Name_____ Date of Birth_____

Prescription Refills – You are encouraged to have prescriptions refilled at the time of your visit. We generally give you at least enough medication until your next visit. Should you need a refill between visits, ***please call your pharmacy.*** Prescription refills are only given during office hours (Mon-Fri 9am-5pm). We generally complete refill requests within 24 hours, however, some may take up to 48 hours. Please check with your pharmacy to make sure it is ready. Requests made after 4 pm may not be ready until the next day. Also, request that are received on Friday, may not be ready until Monday. ***Routine medication requests after hours will not be handled until the next business day.***

It is your responsibility to provide us with your current address, telephone numbers, and insurance information at each visit.

My signature below confirms that I have read, understand and will comply with the above listed Practice Policies of Unified Premier Women's Care, LLC.

_____ _____

Patient/Responsible Party Date

Updated 06.01.2022

Unified Premier Women's Care

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I have received a copy of the Notice of Privacy Practices for this office.

Signature _____ Date _____

Consent for Release of Information, for Treatment, Payment and Healthcare Operations
(For Insurance Purposes)

I consent to the use disclosure of my protected health information by Unified Premier Women's Care; Drs. Street, Robbins, Cauthen, Goh, and Epps, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Drs. Street, Robbins, Cauthen, Goh, and Epps.

I have the right to revoke this consent in writing at any time, except to the extent that Drs. Street, Robbins, Cauthen, Goh, and Epps, has taken action in reliance on this consent.

My "protected health information" is defined as any health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Signature _____ Date _____

Electronic Health Records

Our practice, Unified Premier Women's Care, utilizes electronic medical records to make sure we are in compliance with all federal laws. We utilize pharmacy interface which allows us to obtain your medication history from your pharmacy to keep us up to date on your current medications. We utilize a patient portal to have a more secure way to transfer and receive information with our patients. Lastly, we utilize an interface with the Georgia Department of Public Health to keep your vaccination record up to date.

Please sign that you understand and consent for treatment in our office.

Signature of Patient or Parent/Guardian _____ Date _____

Unified Premier Women's Care, LLC

Review of Health History: Please fill out form completely.

Medical Conditions / Problems / Illnesses: *(Please list date of diagnosis and type).*

Date	Type

Surgeries: *(Please list date of surgery, type of surgery, and reason)*

Date	Surgery/Reason

Current Medications/Supplements/Vitamins with Dose:

_____

_____

_____

_____

Date of Last Immunization:

Flu Vaccine: _____ Shingles Vaccine: _____

HPV Vaccine: _____ Tetanus Vaccine: _____

Pneumonia Vaccine: _____ Tuberculin Skin Test: _____

Allergies: *(Please list allergies and type of reaction)*

Medication	Reaction

SOCIAL HISTORY (*Please fill out completely. Mark N/A if it does not apply*)

Do you **currently** smoke:	Religion:
Have you ever smoked:	Marital Status:
If yes, how many years have you smoked:	Spouse/Partner's Name:
How many cigarettes/ packs per day:	Children's names and DOB:
Use of Illicit Drugs:	
Alcohol Intake:	
Country of Birth:	
Ethnic Background:	Domestic Violence:
Highest Level of Education:	Hobbies/Activities:
Occupation:	General Stress Level:

FAMILY HISTORY

Mark "X" in box	Father	Mother	Brother	Sister	MFG Mom's dad	MGM Mom's mom	PGF Dad's dad	PGM Dad's mom
Asthma								
Blood Clots								
Cancer: Breast								
Cancer: Colon								
Cancer: Ovarian								
Other Cancer: (*Please list type*)								
Cardiovascular (Heart) Disease								
Cystic Fibrosis								
Diabetes								
Down Syndrome								
High Blood Pressure								
High Cholesterol								
Lung Disease								
Osteoporosis								
Parkinson's Disease								
Stroke								
Thyroid Disease								

GYN HISTORY (*Please fill out completely. Mark N/A if it does not apply*)

Date of last Mammogram:	First day of last menstrual period:
Date of last Colonoscopy:	Are you **currently** sexually active?
Date of last Dexa Scan (*50 and older*):	Age at first sexual contact?
Date of last Pap Smear:	Total lifetime number of sexual partners:
Had HPV vaccine:	Sexual orientation:
Did you complete HPV vaccine (series of 3 shots):	History of Sexually Transmitted Infection?
History of Abnormal Pap:	Current Birth Control Method:
History of Cervical Dysplasia:	Age of Menopause:
History of Endometriosis:	Post-Menopausal Hormone use:
History of Fibroids:	Have you had a hysterectomy:
History of Infertility:	Have you had an ablation:
History of Ovarian Cyst:	Have you had a tubal ligation:
History of Polycystic Ovarian Syndrome:	

Other Providers you see:

PCP: _____

Other: _____

Other: _____

Pharmacy Info: (We will send most prescriptions to the pharmacy listed below).

Preferred: _____ Address/phone: _____

Patient History – (Please list any other history not otherwise noted on this form).

_____

_____

Prenatal History

Any problem with your pregnancies: _____

_____

Birth History

Any problems with the births: _____

_____

Past Pregnancies: (Please list all births/deliveries)

Date of Birth	*# of babies*	*Gestational age in weeks*	*Length of Labor*	*Birth Weight*	*Sex*	*Type of Delivery*	*Problems*	*Anesthesia*	*Hospital Delivered*

Obstetric History

Total number of times pregnant:

Number of full term births:

Number of premature births:

Number of miscarriages:

Number of abortions:

Number of living children:

Past Medical History: *(Mark if you have ever had any of these conditions. Please list dates if known).*

	√		√		√
Cancer- Breast		**GI**- Crohn's/ Ulcerative Colitis		**Orthopedic**- Fractures	
Cancer- Colon		**GI**- Hemorrhoids		**Psychiatric**- ADD/ ADHD	
Cancer- Gynecology		**GI**- Liver Disease/ Hepatitis		**Psychiatric**- Eating disorder	
Cancer- Skin		**GI**- Reflux/ Stomach Ulcers		**Psychiatric**- Anxiety Disorder	
Cancer- Lung		**GYN**- Abnormal Paps/ Dysplasia		**Psychiatric**- Bipolar Disorder	
Cancer- Genetic screening		**GYN**- Fibroids		**Psychiatric**- Depression	
Cardiac- High blood pressure/ hypertension		**GYN**- Infertility		**Psychiatric**- PMS/PMDD	
Cardiac- High Cholesterol		**GYN**- PCOS		**Pulmonary**- Asthma	
Cardiac- Heart Attack		**Hematology**- Anemia		**Pulmonary**- COPD	
Cardiac- Heart disease		**Hematology**- Bleeding disorder/clotting disorder/ Factor V Leiden		**Pulmonary**- Emphysema	
Cardiac- Mitral valve prolapse/ murmur/arrhythmia		**Hematology**- Blood Clots/ Pulmonary Embolism/ DVT		**Pulmonary**- Sleep Apnea	
Dermatology- Acne		**Infectious Disease**- Tuberculosis (TB)/ Positive PPD		**Rheumatology**- Autoimmune Disease	
Dermatology- Eczema/Psoriasis		**Infectious Disease**-Chicken Pox/ Shingles		**Rheumatology**- Fibromyalgia	
Ears/ Nose/Throat (ENT)- Hearing loss		**Infectious Disease**- HIV		**Rheumatology**- Chronic Pain	
Ears/Nose/Throat (ENT)- Seasonal allergies		**Infectious Disease**- MRSA		**Urology**- Frequent Urinary Tract Infections	
Endocrine- Diabetes/ History of GDM		**Nephrology**- Renal Disease		**Urology**- Urinary Incontinence/ Overactive Bladder	
Endocrine- Osteoporosis/ Osteopenia		**Neurology**- Migraines		**Urology**- Kidney Stones	
Endocrine- Thyroid Problems		**Neurology**- Dementia		**Urology**- Interstitial Cystitis	
Endocrine- Glucose intolerance/ Insulin resistance		**Neurology**- Multiple Sclerosis		**Urology**- Hematuria (Blood in urine)	
Eyes- Glaucoma/ Vision loss/ Macular Degeneration		**Neurology**- Seizures/ Epilepsy		**Vascular**- Aneurysm	
GI- Colon Polyps		**Neurology**- Stroke/ TIA		**Weight Management**- Obesity	
GI- Gallbladder Disease		**Orthopedic**- Arthritis		**Other Not Listed**-	
GI-IBS		**Orthopedic**- Chronic Back Pain			

Prenatal Genetic Screening Questionnaire

Patient's Name: _____ **Date of Birth:** _____

Doctor: _____ **Today's Date:** _____

The following questionnaire will help evaluate the health of your unborn baby. Your answers may indicate that certain test would be appropriate. Please answer all questions as completely as possible. All information will be kept confidential.

1. Will you be 35 or older at your due date?	Yes	No	Your due date is _____/_____/_____
2. Are you or the baby's father Southern Chinese, Asian, Indian, Taiwanese, Fillipino, Southeast Asian, Italian, Greek, Middle Eastern or Spanish?	Yes	No	If yes, have you or the baby's father been tested to see if you are a carrier or Thalassemia or other hemoglobin abnormality? If Yes, who was tested and what were the results? _____
3. Have you, the baby's father, or any relative had a neural tube defect (such as an open spine, Spina Bifida, or Anencephaly?	Yes	No	If yes, please write diagnosis or describe the defect_____. How is this person related to you or the baby's father?
4. Have you, the baby's father, or anyone in your families had a pregnancy or a child diagnosed with Down's Syndrome?	Yes	No	If yes, how is this person related to you or the baby's father? _____
5. Have you, the baby's father, or anyone in your families been born with a heart defect?	Yes	No	If yes, please write diagnosis or describe the defect _____. How is this person related to you or the baby's father?
6. Are you or the baby's father Jewish or French Canadian?	Yes	No	If yes, have you or the baby's father been tested to see if you are carriers of Tay-Sachs Disease, Cystic Fibrosis or Canavan disease? Yes or No If yes, who was tested and what were the results?_____
7. Are you or the baby's father African American or of African descent?	Yes	No	If yes, have either you or the baby's father been tested to see if you have sickle Cell Trait (are a carrier of Sickle Cell Anemia)? Yes or No. If yes, who was tested and what were the results?_____
8. Do you, the baby's father, or anyone in your families have Hemophilia or another bleeding disorder?	Yes	No	If yes, please write diagnosis or describe the defect _____. How is this person related to you or the baby's father?
9. Do you, the baby's father, or anyone in your families have a neuromuscular disease or Muscular Dystrophy?	Yes	No	If yes, please write diagnosis or describe the defect _____How is this person related to you or the baby's father?

10. Do you, the baby's father, or anyone in your families have Cystic Fibrosis?	Yes	No	If yes, how is this person related to you or the baby's father? _____
11. Do you, the baby's father, or anyone in your families have Autism or Mental Retardation?	Yes	No	If Yes, how is this person related to you? _____
12. Do you, the baby's father or anyone in your families have an inherited disorder or chromosome abnormality not listed above?	Yes	No	If yes, please write diagnosis or describe the defect _____ How is this person related to you or the baby's father?:_____
13. Do you have insulin Dependent Diabetes, PKU, Lupus, or other chronic condition?	Yes	No	If yes, please write diagnosis _____
14. Do you, the baby's father, or anyone in your families have a birth defect not listed above?	Yes	No	If yes how is this person related to you or the baby's father _____
15. Have you or the baby's father had a stillborn child or two or more pregnancy losses in this or any other relationship?	Yes	No	If yes, please describe: _____
16. Have you taken any medications, recreational drugs, or had any alcoholic drinks since your last menstrual period, or had any rashes or infectious diseases?	Yes	No	If yes, please describe: _____
17. Did you or the baby's father, or anyone in your families have any other serious medical condition in infancy or childhood?	Yes	No	If yes, please describe how this person is related to you or the baby's father_____.

I have answered these questions to the best of my knowledge.

Patient's signature: _____

For office use only:

Reviewed by: _____ Date: _____

Unified Premier Women's Care, LLC

OBSTETRICAL LABORATORY WORK

A very important part of our care for you as an obstetrical patient involves evaluating the results of certain lab tests, which includes, but is not limited to:

CBC, Blood typing, RH factor, Antibody screen, Screening for Hepatitis, Rubella, PPR (Syphilis), Gonorrhea, HIV, Herpes, Chlamydia, Urine culture, TSH, Group B Strep, Glucose, testing for Open Spine and Down's Syndrome, and Pap Smear.

Some of the testing must be done at specific times during your pregnancy. It is crucial you follow your physician's recommendations for the most accurate results. Your physician will review the different testing options available.

In addition to the above tests, we also offer Cystic Fibrosis carrier testing. Cystic Fibrosis (CF) is an inherited disease that affects more than 25,000 American children and young adults. Symptoms of CF vary, but include lung congestion, pneumonia, diarrhea, poor growth, and male infertility. Most people with CF have severe medical problems and some die at a young age. Others have so few symptoms that they are unaware they have CF. CF does not affect intelligence. Although there is no cure for CF at this time, scientists are making progress in improving treatment and in searching for a cure. The average person with CF lives to age 30. A baby born today with CF may live longer. There is a blood test that can be done to find out if you or your partner is a carrier. It is important to understand that carrier testing does not detect all CF carriers. If the test shows that you are both carriers, your unborn baby can be tested to find out if it has CF. If you have been tested for CF previously, you do not need to be tested again. See chart below for statistics.

Ethnicity	Carrier Frequency	Risk that a couple with no family history of CF will have a child with CF
Caucasian	1 in 25	~1 in 3,000
Ashkenazi Jewish	1 in 29	~1 in 3,000
Hispanic American	1 in 46	~1 in 8,000
African American	1 in 65	~1 in 15,000
Asian	1 in 90	~1 in 32,000

If you have any questions about any of the testing offered by this office, your physician can provide you with additional information.

Patient Name_____

Patient Signature _____

Reviewed by _____

Date_____