Fresno Women's Medical Group

Welcome to Fresno Women's Medical Group

We would like to draw your attention to the enclosures in this packet and ask that you take the time to read and complete them prior to your visit.

- ✓ Please fill out the Patient Medical History form prior to coming to our office. This will facilitate your being seen in a timely fashion.
- ✓ Please read and sign the office policy.
- ✓ Please bring your insurance information to your visit. If you do not have health insurance, please be prepared to pay the full amount at the time of service.

It is important that you keep the appointment scheduled for you. As a courtesy to other patients, we request that cancellations be made 24 hours in advance. If you miss an appointment without cancellation, you will be charged the basic fee for the scheduled visit. This charge is not paid by your insurance company.

We are here to serve you. Your assistance in these matters greatly facilitates our ability to care for you and other patients in an effective and personal manner.

We are grateful that you have selected Fresno Women's Medical Group for your obstetrical and gynecologic care.

YOU MUST ARRIVE 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME

Fresno Women's Medical Group
Obstetrics and Gynecology
726 Medical Center Drive East, Suite 221 Clovis, CA 93611
(559) 322-2900 Fax (559) 322-2901
www.fwmg.org

Fresno Women's Medical Group

WHAT IS AN ANNUAL EXAM?

We are glad you have chosen Fresno Women's Medical Group to provide you with your annual gynecologic examination. Our goal, as always, is to provide you with quality women's health care. We want to work with you to achieve and maintain your health as a woman, and hope that this information will help us do that.

An annual gynecologic exam is a twenty minute visit. It consists of a review of your medical history and a physical examination including a breast and pelvis exam. Usually a Pap smear is collected. Other tests may be performed depending on your age, history, and other individual risk factors. Prescriptions for contraceptives or hormone replacement can be refilled at this visit. We may order additional testing and/or make recommendations based on your individual needs. The emphasis of this visit is on prevention and health care maintenance.

Your gynecologic annual exam is also known as a well-woman exam. If you are having gynecologic problems, or wish to discuss gynecologic concerns, you will need to make an additional appointment on another day to address these issues. If you are having an urgent or emergent gynecologic problem, please let our office staff know prior to your annual exam appointment so we can address these in a timely fashion.

Your annual exam in our office is a gynecologic exam. We are specialists, not primary care providers. We are not qualified to manage your non-gynecologic problems. For this reason, it is very important that you establish a working relationship with your primary care physician. She or he will need to manage all of your non-gynecologic care. The results of all laboratory and radiology studies we order, including your Pap smear, will be sent to your primary care doctor.

In our practice, annual exams are generally done by our nurse practitioners and certified nurse midwives. They are experts with special training in women's health care maintenance. A physician is always available to them for consultation should the need arise. This arrangement allows our physicians to be more available to you when you are having gynecologic problems. If you feel you are a high risk patient or otherwise need to see a physician for your annual exam, please let our staff know when you make your appointment.

Please note, not all insurance plans cover well-woman care. This means that your annual gynecologic exam and the lab fee for your Pap smear may not be covered benefits on your insurance plan. As always, unless your insurance is expected to cover your visit, payment is due at the time service is rendered. Please make every effort to keep your appointment, or call to cancel if you cannot. If you fail to keep your appointment, (or cancel or reschedule with less than twenty-four hours notice), you will be billed for the full amount of your visit. Your insurance company will not cover this charge.

Thank you for your understanding as we strive to provide you with the best in women's health care. We look forward to working with you to achieve and maintain your health as a woman.

Fresno Women's Medical Group

Patient Registration Sheet

Last Name: _____ **First Name:** _____ **Middle:** _____

Preferred Name: _____ **Maiden Name:** _____ **Pharmacy:** _____**Location:** _____

DOB: _____ **Sex:** _____ **SSN:** _____ **Marital Status:** _____ **Driver's License:** _____

Mailings Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____ **Preferred:** _____

Email: _____ **Employed By:** _____ **Phone:** _____

Employer Address: _____**Occupation:**_____**Primary Care Dr:**_____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____**DOB:** _____

Federal regulations now require that we collect the following demographic information.
Please check one of the options from each category.

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African America ☐ Decline to answer
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other Race

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to answer

Insurance Information (Please provide a current copy of your insurance card).

Primary Insurance Carrier: _____ Self/Spouse/Parent **through** Individual or Employer

Policy Holder Name: _____ **DOB:** _____ **SSN:** _____

Employer: _____ **Occupation:** _____ **Work Phone:** _____

Secondary Insurance Carrier: _____ Self/Spouse/Parent **through** Individual or Employer

Policy Holder Name: _____ **DOB:** _____ **SSN:** _____

Employer: _____ **Occupation:** _____ **Work Phone:** _____

I understand that I will be responsible for any co-insurance, deductible, or spend down not covered by my insurance. If any balance is not paid when due I Understand that I will be responsible for the balance. I also understand that if the unpaid account is referred to an outside agency, I am responsible to pay all costs of collection including attorney fees. I hereby authorize the release of information to my insurance carrier or its intermediaries for all covered services rendered by Fresno Women's Medical Group, A member of Community Foundation Medical Group (CFMG) a part of Santè Health Foundation, and you may receive a bill from CFMG for your services with FWMG.

_____	_____	_____	_____
Patient Signature	**Print name if other than patient**	**Relationship to patient**	**Today's Date**

Fresno Women's Medical Group

E-PRESCRIBING PBM CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Formulary and benefit transactions—** This gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions---** Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Fresno Women's Medical Group can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Patient Name (printed)_____ Date of Birth_____
Patient Signature/Representative_____
Date _____ Relationship to Patient _____

Consent Denied _____ Date _____

Fresno Women's Medical Group

OFFICE POLICY

Facilities: FWMG physicians provide obstetric and emergency services only at Clovis Community Hospital. If you present to any other facility with emergency needs, we will be unable to attend you. Our surgical patients are scheduled at Clovis Community Hospital.

On-Call Physician: A qualified physician is on-call for our group at all times. We cannot guarantee a specific physician for on-call services.

Healthy Choices: We want to work with you to help you make healthy choices. You have the right to decline any medical therapies or evaluations, which we might recommend. We want to help ensure that our pregnant patients will deliver healthy babies. Multiple cancellations or no-show appointments may mean dismissal from our practice, and you will need to seek medical care elsewhere. Toxicology studies are a part of our standard lab orders for our pregnant patients.

Phone Calls: We cannot provide adequate medical care over the telephone or fax. Our physicians and nurse practitioners do not provide telephone consultations. It is a priority of the staff and providers at FWMG to answer emergent phone calls in a timely manner. Our staff may be able to answer simple, routine questions for you, but in general non-emergency concerns should be addressed at a scheduled office visit. Non-emergent phone calls are not covered by your insurance company. Emergent calls will be directed to the on-call physician after triage by our staff or the telephone exchange service. If you have a life threatening emergency, call 911.

Privacy: We make every effort to protect your privacy and maintain your medical information in a confidential manner. FWMG has a Health Information Portability and Accountability Act (HIPAA) office policy in place which describes how your protected health information may be used and disclosed and how you can obtain access to this information. Please ask our staff for a copy of our Notice of Privacy Practices. With a few exceptions defined by federal law, we cannot release any of your medical information to anyone, including your spouse and/or other family members, without your specific written consent. Your request for release of information must be made in person; we do not accept phone, fax or mailed requests.

Chaperones: A staff member is always available to be in attendance as a chaperone during any part of your office visit. If you wish to have a chaperone present during all or part of your visit, simply indicate this to your provider or to her medical assistant. Under some circumstances a medical assistant or other chaperone may be present during your office visit at your provider's request.

Late Arrivals: If you are 15 minutes late to your appointment, your appointment will be rescheduled.
New Patient's must arrive 30 minutes early to their appointment or they will be rescheduled.

Labs/Radiology: Our providers recommend specific lab tests in order to determine treatment. Some insurance companies may not pay for these services. You need to be responsible for understanding your insurance benefits and limitations, when in doubt check with your insurance company **prior** to having labs/radiology done. We will notify you of your laboratory and radiology results by mail, or through MyChart. We ask that you please not call our office for these results unless you have not received the information in a timely manner. It is important to note that our office does not receive many test results for several days or even weeks.

Contracted Insurance Plans: It is your responsibility to supply us with the appropriate billing information. This includes current insurance identification. You will be required to pay any **Co-Payment**, **Deductible**, and/or **Non-Covered services** at the time of your visit. Please be aware that we do not bill **Tertiary Insurance.** If you consent to receive medical services that are not covered by your HMO or PPO insurance, then you will be held financially responsible for those charges.

Referrals/Prior Authorizations: If your insurance company requires a referral or prior authorization, you must contact your primary care physician. You must bring the referral/prior authorization to your scheduled appointment. It is the patient's responsibility to request and make sure that the referral/prior authorization is received prior to treatment. If your primary care physician does not authorize a referral/prior authorization and you agree to medical treatment anyway, you are responsible for the fees at the time of your visit. If your insurance plan does not pay your account, you will be responsible to pay for your medical services.

Co-Pays: Co-pays are due at the time of your visit. We do not bill for co-pays. If you cannot pay your co-pay at the time of your appointment, your appointment will be rescheduled. If you appointment is rescheduled and you think you are having an emergent medical problem, we suggest you go immediately to Clovis Community Hospital Emergency Room.

Out-of-Pocket Expenses. The following services are not covered by insurance:

- Missed appointment (cancelled in less than 24 hours) $50
- Returned check $25
- Medical records request (no charge to requesting physician) $45 per request
- Disability and other forms $45 per form

Cancellation Policy. As a courtesy to other patients, please notify us if you are unable to keep your surgical appointment.You will be charged a cancellation fee of $100.00 if you fail to cancel within 5 business days of a procedure related appointment, and $50.00 for an office appointment. Your insurance will not cover this fee.

Respect. We do our best to offer you excellence in medical care in an atmosphere of comfort and respect. In turn, we ask that you respect our staff and other patients by cooperating with our policies. If you have questions and/or concerns about FWMG' s policies, please ask to speak with our Practice Administrator. We value your input and appreciate your suggestions.

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov

Physician Assistants are licensed and regulated by the Physician Assistant Committee, (916) 561-8780, www.pac.ca.gov

Thank you for your trust and allowing us the privilege of caring for you.

I have read and agree to these policies, and have received a copy of FWMG's Office Policy document.

Print Name_____ Date of birth_____

Patient Signature_____ Date_____

FWMG Staff_____ Date_____

Family Practice

Fresno Women's Medical Group

PATIENT NAME:_____ **DOB:**_____

DATE:_____ **Patient #** _____

MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Allergies			Diabetes mellitus			Migraine Headache		
Anemia			Emphysema			Myocardial Infarction		
Anxiety			Fall			Nerve/muscle disease		
Arthritis			Fractures			Obesity		
Asthma			GERD			Osteoporosis		
Auto Accident			Glaucoma			Seizures		
Blood transfusion			Gun Shot Wound			Sickle cell anemia		
Burn Injury			Head Injury			Stroke		
Cancer			Heart murmur			Substance Abuse		
Cataracts			HIV/AIDS			Thyroid disease		
CHF			Hyperlipidemia			Trauma/Violence		
Chronic obstr pulm disease			Hypertension			Tuberculosis		
Clotting disorder			Kidney disease			Ulcers		
Depression			Meningitis			Varicella		

SURGICAL HISTORY

	Yes	No		Yes	No		Yes	No
Abdomen surgery			Cosmetic surgery			Prostate surgery		
Appendectomy			C-Section			Small Bowel Resection		
Back surgery			Eye surgery			Small intestine surgery		
Brain surgery			Fracture surgery			Spine surgery		
Breast surgery			Gastric Bypass			Take Down Colostomy		
CABG			Hernia repair			Tonsillectomy		
Cholecystectomy			Hysterectomy			Tubal ligation		
Closure Colostomy			Joint replacement			Valve replacement		
Colon surgery			Lung Cancer surgery			Vasectomy		

ALLERGIES	**REACTION**

MEDICATIONS	**MEDICATIONS**

726 Medical Center Drive East Ste 221 · Clovis, California 93611 · P (559)322-2900 · F (559)322-2901
A MEMBER OF COMMUNITY FOUNDATION MEDICAL GROUP AND A PART OF SANTÉ HEALTH FOUNDATION

FAMILY HISTORY

	Name			Cause	Age
Mother		Living	Deceased		
Father		Living	Deceased		
Brother		Living	Deceased		
Sister		Living	Deceased		
MGM (Mother's)		Living	Deceased		
MGF (Mother's)		Living	Deceased		
PGM (Father's)		Living	Deceased		
PGF (Father's)		Living	Deceased		
Daughter		Living	Deceased		
Daughter		Living	Deceased		
Son		Living	Deceased		
Son		Living	Deceased		
Son		Living	Deceased		

***Please include history for: Mother, Father, Brother, Sister, Daughter,Son,MAunt,MUnc,PAunt,PUnc,Cousin,Other Grand Parents- MGM** (mother's mom)**,MGF** (mother's father)**,PGM** (father's mom)**,PGF** (father's father)*

ILLNESS	WHICH RELATIVE(S) NAME & AGE OF ONSET		
Adopted			
Alcohol Abuse			
Arthritis			
Asthma			
Birth Defects			
Cancer			
COPD			
Depression			
Diabetes			
Drug Abuse			
Early Death			
Healthy			
Hearing Loss			
Heart Attack			
Heart Disease			
High Cholesterol			
History Unknown			
Hypertension			
Kidney Disease			
Learning Disability			
Mental Illness			
Mental Retardation			
Stroke			
Tobacco Use			
Vison Loss			
Other			
High Blood Pressure			
Leukemia/Lymphoma			

SOCIAL HISTORY

Current Alcohol Use	Yes	No						
	Drinks Per Week							
Glasses of Wine								
Cans of Beer								
Shots of Liquor								
Standard drinks								
Sexually Active:	Yes	No	Not Currently					
Birth Control/Protection:		Abstinence	Coitus Interruptus	Condom	Diaphragm	Implant	Injection	
Inserts	IUD	OCP	Patch	Post-Menopausal	Rhythm	Spermicide	Sponge	
Surgical	Other: See Comments		None					
Partners:	Female	Male						
Drug Use:	Yes	No						
Types:	Marijuana	Methamphetamines	Cocaine	IV				
Per Week:								
Tobacco Use:	Yes	No	Smokeless Tobacco				Yes	No
Quit Date:			Snuff	Chew	Quit Date			
Types:	Cigarettes		Pipe	Cigars				
Packs/day:	0.25	0.5	1	1.5	2			
Years	0.5	1	2	3	4	5	10	15
Ready to Quit?	Yes	No						
Military Service	Yes	No						

OBSTETRIC HISTORY

		Number		**Number**		**Number**	
Pregnancies			Abortions		Miscarriages		
Premature Births			Live Births		Living Children		
No.	**Birth Date**	**Wt.at Birth**	**Baby's Sex**	**Weeks Pregnant**	**Type of Delivery**		**Complications**
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

ACTIVITIES OF DAILY LIVING

Back Care	Yes	No	Gun Owner	Yes	No	Sleep Concer	Yes	No
Bike Helmet	Yes	No	Hobby Hazards	Yes	No	Smoke Dectectors	Yes	No
Blood Transfusions	Yes	No	Military Service	Yes	No	Special Diet	Yes	No
Body Piercings	Yes	No	Occupational Exposure	Yes	No	Stress Concern	Yes	No
Caffeine Concern	Yes	No	Seat Belt	Yes	No	Tattoos	Yes	No
Exercise	Yes	No	Self-Exams	Yes	No	Weight Concern	Yes	No

Patient Signature:_____

Date:_____