



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



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.

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**



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** _____



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 your 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 _____



PATIENT NAME: _____

DOB: _____

DATE: _____

Patient # _____

MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Abnormal Pap			Headaches			Osteoporosis		
Allergies			Heart Problems			Ovarian Cancer		
Anemia			Hepatitis			Rh Incompatibility		
Arthritis			HIV/AIDS			Seizures		
Asthma			Hypercoagulable State			STD		
Autoimmune Disorder			Hyperlipidemia			Thyroid Disease		
Breast Cancer			Hypertension			Tuberculosis		
Cholelithiasis			Kidney Disease			Ulcerative Colitis		
Depression			Liver Disease			Uterine Cancer		
DES Exposure			Mental Disorder			Vaginal Infection		
Diabetes Mellitus			Migraine Headache			Vision Problems		
GERD			Nerve/Muscle Disease					

SURGICAL HISTORY

	Yes	No		Yes	No		Yes	No
Abdomen Surgery			Colon Surgery			Joint Replacement		
Appendectomy			Cosmetic Surgery			Lung Cancer Surgery		
Brain Surgery			C-Section			Ovary Removal		
Breast Surgery			Endometrial Ablation			Tubal Reversal		
Cardiac Surgery			Hernia Repair			Spine Surgery		
Cholecystectomy			Hysterectomy			Tubal Ligation		

ALLERGIES

REACTION

MEDICATIONS

DOSAGE

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	
Cousin		Living	Deceased	
FOB		Living	Deceased	
MUncle		Living	Deceased	
Other		Living	Deceased	

Please include history for: Mother, Father, Brother, Sister, Children, Cousin, Father of Baby, 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		
Allergies			
Anemia			
Birth Defects			
Bleeding Problems			
BRCA 1/2			
Breast Cancer			
Cancer			
Cervical Cancer			
Colon Cancer			
Depression			
Diabetes			
Genetic Problems			
Genitourinary (Gu)			
Heart Attack			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Immunodeficiency			
Mental Illness			
Ovarian Cancer			
Preterm Labor			
Substance Abuse			
Stroke			
Uterine Cancer			
Other:			

OBGYN

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						
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	3			
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						

OBGYN

GYN HISTORY

Age at First Menstrual Cycle:				
Menstrual Cycles:	Regular	Irregular	Spotting	
Menstrual Flow:	Heavy	Normal	Light	
Menstrual Control:	Panty Liner	Thin pad	Maxi pad	Hospital pad Tampon Other:
Menstrual Control Change Frequency:				
Number of Pads/Tampon on Heaviest Day:				
Period Duration:				
Painful Intercourse?	Yes	No		
Painful Periods?	Yes	No		
Last Pap:				
Colposcopy?	Yes	No		
Abnormal Pap Procedures:	Laser	Leep	Cold Knife Conization	Cryotherapy
Abnormal Vaginal Discharge?	Yes	No		
Characteristics of Vaginal Discharge				
Vaginal discharge amount				
Last Mammogram:				
History of Abnormal Mammogram?	Yes	No		
History of Breast Biopsy?	Yes	No		
Breast Complaints?	Yes	No		
History IV Drug Use?	Yes	No		
Partner, History IV Drug Use?	Yes	No		
History Transfusion?	Yes	No		
Number of Transfusions:				
Vomiting?	Yes	No		
Exercise?	Yes	No		
Urinary Problems ?	Yes	No		
Eating Problems?	Yes	No		
Taking Iron?	Yes	No		
Calcium Intake?	Yes	No		
History of STDs or HIV?	Yes	No		
Partner, History of STDs or HIV?	Yes	No		
History of Genital Herpes?	Yes	No		
Lifetime Partner?	Yes	No		
New Sex Partner?	Yes	No		
Number of Sex Partners (6 mos):				
Partner: Multiple Partners?	Yes	No		
Satisfied Sex Life?	Yes	No		



Fresno Women's Medical Group

Breast Cancer before age 50 ?	Yes	No
Multiple breast cancers on the same side of the family ?	Yes	No
If 2 breast cancers one must be before age 50 .	Yes	No
If 3 or more breast cancers they can be at any age.	Yes	No
Ashkenazi Jewish ancestry with a breast cancer in any family member at any age ?	Yes	No
Male breast cancer at any age ?	Yes	No
Ovarian cancer at any age ?	Yes	No
Endometrial (Uterine) cancer before age 50 ?	Yes	No
Colon cancer before age 50 ?	Yes	No
Colon and/or endometrial cancer at any age AGE 2 or more of the following cancers in the same person or on the same side of the family at any age ? (ovarian, stomach, kidney/renal, small bowel, pancreas, brain)		
	Yes	No
Other cancers ?	Yes	No

Patient Signature: _____

Date: _____