Baylor St. Luke's Medical Group

Baylor College of Medicine

Registration Form

Date: _____ PCP's Name: _____ PCP's Ph#: _____

Patient Name: (Last)_____(First)_____(Middle)_____

DOB: _____ Marital Status: ___Single ___Married ___Divorced ___Separated ___Widower Social Security: _____-_____-_____

Race: _____ Ethnicity: _____ Religion Preferences: _____

Email: _____ Language: _____ Interpreter Needed? __Y or __N

Street Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Cell Ph#: _____ Work Ph#: _____ Home Ph#: _____

May We leave a detailed voice message? ___Y ___N Circle all that apply: ___Cell ___Work ___Home

Employment Status: ___Full Time ___Part Time ___Unemployed ___Student ___Other

Employer Name: _____

Pharmacy Name: _____ Pharmacy Ph#: _____

How did you hear about us? _____

Insurance Information (please give your insurance card and ID to the receptionist)

Person responsible for the bill: _____ DOB: _____ Address if different from patient: _____

Employer Name: _____ Cell Ph#: _____ Home Ph#: _____

Primary Insurance		Secondary Insurance	
Name of Insurance:		Name of Insurance:	
Subscriber Name:		Subscriber Name:	
Relationship to subscriber:		Relationship to subscriber:	
Subscriber SS#:	DOB:	Subscriber SS#:	DOB:
Policy #:	Group #:	Policy #:	Group #:

In Case of Emergency

Name of local friend or relative (not living with you): _____

Relationship: _____ Phone #: _____

The above information is true to the best of my knowledge, I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my insurance company to release and information required to process my claims. I acknowledge receipt for the notice of privacy policies and practices of this clinic.

Patient/Guardian signature: _____ Date: _____

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Informed Consent Form

The medical providers at Baylor St. Luke's Medical Group-Caritas Women's Care are pro-life healthcare providers. Dr.'s Hernandez, Jemelka and Karges are all Medical Consultants for the Creighton Model FertilityCare System. These Medical Consultants practice NaProTECHNOLOGY, an approach to women's reproductive health which uses hormones and treatments that cooperate with a woman's cycle and are not contraceptive in any way.

These providers recognize that there are other forms of Natural Family Planning that can be used both to achieve and/or to avoid pregnancy.

The medical providers at Baylor St. Luke's Medical Group-Caritas Women's Care do not prescribe or refer for any contraceptive agents for any reason. Such contraceptive agents include birth control pills, patches, rings, injections, intrauterine devices, barrier devices, and/or sterilization (i.e. "tubal ligation"). Additionally, our healthcare providers do not perform or refer for abortion procedures, including "medically indicated" abortions.

In addition to the above mentioned services and practices of our clinic, the medical providers do not practice and/or refer for any reproductive procedures such as in-vitro fertilization (IVF) or intrauterine insemination procedures (IUI).

By signing this consent, you are agreeing to receive medical care from Baylor St. Luke's Medical Group – Caritas Women's Care and understand that contraceptive services, abortive services and/or referrals, and in-vitro fertilization (IVF) and intrauterine insemination (IUI) procedures and/or referrals are not available from our healthcare providers.

_____ _____

Printed Name Date

_____

Signature

Baylor St. Luke's Medical Group

CommonSpirit
CARITAS WOMEN'S CARE

Sharing/Switching between Physicians

We understand choosing the right gynecologist/obstetrician is a difficult choice to make. It is with that understanding that we have this office policy in place: we do not allow switching or sharing of patients between our physicians.

The policy is set in place to keep the flow of continuity of care. Continuity of care is important in building the relationship between physician and patient. It builds trust, allows the physician to anticipate the needs of the patient, and enables the physician to effectively treat the patient since they know their history and have built rapport.

The only exception to the policy is if your physician is out of the office, you will be able to see one of their colleagues **in the event of an emergency** or **if you're pregnant** so it does not disrupt your prenatal care.

We appreciate your understanding.

Please indicate which physician in our practice you are choosing.

Physician of choice _____

By signing below, you are acknowledging you have read this document in its entirety.

Patient _____ DOB _____

Date _____

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Authorizations and Assignments

Thank you for choosing Baylor St. Luke's Medical Group Sugar Land. We realize you have a choice in selecting healthcare providers and we are honored you have chosen us. Our entire staff is committed to providing our patients with the highest quality of care possible. In doing so, we would like to provide you with information regarding our office policies. Please feel free to contact our office anytime Monday-Friday during our routine business hours if you have any questions, concerns or suggestions.

Office Policies

Our providers participate with many medical health plans and as a courtesy to our patients, we file claims with these companies. It is ultimately your responsibility for the full and timely payment of you account.

Check-In

Please be prepared to submit the following documents when check in for each visit. These documents will be scanned and saved as part of your patient record.

- ☐ Current Insurance Card
- ☐ Current Photo Identification
- ☐ Update contact information, such as home address, phone numbers, contact information, email address, employer, etc.

Verification of Benefits

We will attempt to verify coverage and benefits prior to your visit. If we are unable to obtain a verification of coverage, you may be asked to pay in full or reschedule your visit for a time the verification can be obtained. This verification will be used to estimate your financial responsibility; however, this verification is not a guarantee by your health plan to pay for services rendered.

_____Payment of Patient Responsibility

Payment of your estimated patient responsibility is expected at the time services are rendered. This payment will include know n deductibles, co pays, coinsurance and any past due amounts applicable for each visit and or procedure. While we may estimate your financial responsibility, it is your insurance company that makes the final determination regarding eligibility and benefits. For you convenience we accept: cash, checks, most major credit cards and debit cards.

Non-Covered Services

Please be aware certain office procedures or services may not be covered, or may be considered "not medically necessary," "experimental," "cosmetic," or simply "non-covered" by your health plan. You are responsible for payment of these services. In the event your care exceeds a plan limitation, you will be responsible for the balance. It is your responsibility to know your benefits and limitations or you current health care coverage. This clinic will provide medically necessary care based on patients' medical needs, not a patient's insurance coverage. This clinic is not responsible for knowing your plans specific benefits and coverage limitations.

NSF Checks/Denied Credit Card Payments

You will be charged a $25.00 fee should a payment be returned for insufficient funds. The fee applies to payments made at our front desk, mailed in the Business office, electronically via the Internet, or payments made by phone.

Past Due Amounts

In the event your account becomes past due, and all efforts to collect payment have failed, your account may be referred to a collection agency.

_____ Additional Services Rendered During a Preventative Screening

Please be aware if there are medical issues that you would like to discuss with the doctor that fall outside of a well woman exam, you will be rescheduled for a problem visit at another date/time. If your problem is emergent, we will address the problem today, but will be required to reschedule the annual well exam.

Third Party Insurances

We do not file insurance claims to non-contracted Third Parties involving automobile accidents, accidental injury, property insurance, etc. You will need to pay in full at the time of service and file the claim with your insurance company. An itemized statement may be obtained by calling our business office. This statement will assist you with reimbursement. It is your responsibility to file claims in these instances.

_____ Appointment Scheduling

Please be advised, as a courtesy, you will receive a call from our office to remind you of your appointment date and time. You must notify the office within 24 hours of your scheduled appointment if you are unable to keep your appointment. Failure to notify the office will result in a $25.00 fee assessed to your account. Repeated failure to call and cancel your scheduled appointment without the proper 24 hour notice, could result in your dismissal as a patient from the practice. As a courtesy to our scheduled appointments and doctor's schedule, if you are over 15 minutes late to your scheduled appointment we will need to reschedule and there will be a $25.00 fee assessed to your account.

_____ Forms/Medical Records

We are happy to assist you by completing forms and generating medical letters for you upon your request. The fee for this is $25.00 and varies depending on the form or letter, but most do not exceed $25.00 per form. Payment is collected when you pick up the documents or before they can be released.

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_____ Medical Records

Requests for your medical records must be in writing via a medical records release form. Release of records is managed via on outside vendor. The cost is $25.00 for the 1st-20 pages and $.50 for each additional page. You will pay the outside vendor for these copies.

Office Hours

While appointment times vary for each provider, our office staff is typically available by telephone Monday-Friday 8:00 am-4:00pm. Because our providers and nurses are most often tending to patients, it is typically necessary for you to leave a message so we may assist you in an adequate time and manner. Please leave pertinent information to include the reason for your call and the best number to contact you. We have an answering service to take you calls before and after our scheduled office hours.

- ☐ Emergency needs-always911
- ☐ Routine prescription refills-please contact your pharmacy first to initiate the refill request and the pharmacy will send authorization to the office for approval. Routine refills will be approved during regular office hours only. requests for controlled substances or narcotics must be requested through the clinic nursing staff.

Authorization to Release Information

I hereby authorize Baylor St. Luke's Medical Group-Caritas Women's Care to (1) Release any information necessary to insurance carriers regarding any illness and treatments; (2) Process insurance claims generated in the course of an examination or treatment: and (3) Allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked in writing.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct insurance carriers including Medicare, Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to Baylor St. Luke's Medical Group-Caritas Women's Care for medical services rendered to myself and/or my dependents regardless of my insurance benefits if any. I understand that I am responsible for any amount not covered by insurance.

Financial Responsibility

I acknowledge I have requested medical services from Baylor St. Luke's Medical Group-Caritas Women's Care, on behalf of myself and/or my dependents and understand that by making this request I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I agree to pay Baylor St. Luke's Medical Group-Caritas Women's Care for all services and products administered. I understand and acknowledge that any monies collected prior to the date services are rendered or products are administered, will be applied as a deposit towards total charges assessed for the services rendered. The deposit shall not be considered payment in full. If I participate in a managed care plan, such as a Mo or a PPO, I promise to pay for any services or products administered that are not covered under the plan, were not certified by the plan as medical necessary, or were denied by the plan as a result of inaccurate, incomplete or untimely patient information provided by me to the clinic and for any out-of-network charges. I further understand that fees are due and payable on the date the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Authorization and Assignment Acknowledgement

My Signature certifies I have read and understand the above content of this document

_____ _____

Print Patient Name **Patient Date of Birth**

_____ _____

Signature **Date**

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document.

_____ _____

Print Patient Name **Patient Date of Birth**

_____ _____

Signature **Date**

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Designation of Personal Representatives

Under the provisions of the Health Insurance Portability and Accountability Act (HIPPA) that became effective on April 14, 2003, health care providers and their staffs are limited in the information that they may share with individuals other than the patient or his/her parent or guardian. In may cases, patients would like to involve a member of their family or another person in the management of their health care. Such disclosures of information are permitted by HIPPA when the patient (or his/her parent or guardian) designates an individual(s) and his/her Personal Representative. therefore, if you would like to designate one or more individuals to serve as your personal representative, please complete the information below.

Name of Patient: _____ Date: _____

I, the patient/parent/guardian hereby designate the individual(s) or the Personal Representative of the named above. By designating this individual(s) as my Personal Representative, I am pertaining to my health care (including appointments, diagnoses, treatment plans, insurance information and other related topics) This designation will remain in effect until such time as I revoke in writing.

Name of Personal Representative	Relationship	Phone #	Address

_____ _____

Signature of Patient/Parent/Guardian Date

_____

Relationship to Patient

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Baylor St. Luke's Medical Group
Caritas Women's Care
Dr.'s Kathryn Karges, Brooke Jemelka, and Jamie Hernandez

Authorization to Release Healthcare Information

Patient Name: _____ Date of Birth: _____

Previous Name: _____ SSN#: _____

I request and authorize:

Doctor's/Clinic Name: _____

Phone #: _____ Fax #: _____

to release healthcare information of the patient named above to:

Name: Baylor St. Luke's Medical Group-Caritas Women's Care
Address: 1327 Lake Pointe Parkway #500
City: Sugar Land State: TX Zip: 77478
Phone: (281) 637-9095 Fax: (713)383-1502

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date: _____

This authorization expires ninety days after it is signed

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New Patient Intake Form

Patient Information

Patient Name: _____ Date: _____

Date of Birth: _____ Marital Status: _____

Address: _____

Phone:

		May we leave a message?	
Home:	_____	___Yes	___No
Work:	_____	___Yes	___No
Cell:	_____	___Yes	___No

Spouse/Partner: _____ Phone #: _____

Date of Birth: _____

Primary Care Physician: _____ Phone #: _____

Address: _____

Previous OB/GYN Physician: _____ Phone #: _____

Address: _____

Emergency Contact Name: _____ Relationship: _____

Phone: _____

Pharmacy Name: _____ Phone #: _____ Fax: _____

Address: _____

Who referred you to us/how did you hear about us? _____

Reason for initial visit? _____

Female History

Past Medical History-Have you had any of the following:

Yes		Details/Date of diagnosis if known
___	High Blood Pressure	_____
___	Heart Disease	_____
___	Diabetes	_____
___	Asthma or lung disease	_____
___	Stomach/Intestinal disease	_____

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___ Kidney Disease _____
___ Liver Disease _____
___ Anemia _____
___ Breast Disease _____
___ Lupus or autoimmune Disease _____
___ Thyroid disease _____
___ Seizure or epilepsy history _____
___ Neurologic problems _____
___ Cancer _____
___ History of trauma/car accident _____
___ Blood Clots _____
___ Depression/Anxiety _____
___ Schizophrenia/Bipolar Disorder _____
___ Chicken Pox _____
___ Other _____

Past Surgical History-Please list any surgeries you have had:

Year	Type of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Besides pregnancy and these surgeries, have you ever been hospitalized for any other reason?

_____
_____
_____
_____

Past Pregnancy Information: (Include miscarriages, abortions, ectopic pregnancies, etc.)

Date	How many weeks at birth?	Vaginal of C-Section	Weight of Baby	Sex of Baby	Time (months) to conceive	Fertility Treatment? if yes, describe	Other Comments
1.							
2.							

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3.							
4.							
5.							

Current Medications and Dose-Please list any medications you are taking

_____

_____

_____

_____

Do you take any supplements or herbal medicines? If yes, please list:

_____

Allergies-Please list any allergies to medication/latex/other:

_____

_____

_____

Family History-Does/Did anyone in your family have the following? Relationship?

Breast Cancer: _____

Ovarian Cancer: _____

Colon Cancer: _____

High Blood Pressure: _____

Diabetes: _____

Other: _____

Social History: (circle and describe)

Alcohol: ___Y ___N Drinks per week _____

Smoking: ___Y ___N Packs per day _____ # of Years smoking: _____

Recreational Drugs (circle): Heroin Cocaine Marijuana Methamphetamines Narcotics Sleeping Pills

Caffeine: ___Y ___N Cups per day _____

Occupation: _____

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Married for how long? _____

How long have you been trying to conceive? (i.e., intercourse with contraception) _____

Exercise type: _____ Frequency of exercise: _____

Have you ever had an eating disorder? ___Y ___N Describe: _____

Review of Symptoms: (Check any of the following symptoms if you are currently having them)

General:	___	weight loss	___	weight gain	___	fatigue	___	night sweats	
	___	fainting	___	swelling	___	dizziness			
Skin:	___	rash	___	hair loss	___	itching	___	dry skin	
	___	bothersome hair growth							
HEENT:	___	change in vision	___	change in hearing	___	difficulty swallowing			
	___	headaches	___	nosebleeds	___	neck pain			
Breast:	___	new lumps	___	nipple discharge					
Gastrointestinal:	___	nausea	___	vomiting	___	constipation	___	diarrhea	
	___	bloody stools	___	decreases appetite					
Chest:	___	shortness of breath	___	wheezing	___	cough			
Cardiovascular:	___	chest pain	___	heart palpitations					
Genitourinary:	___	pain with urination	___	frequent urination at night	___	blood in urine			
	___	irregular periods	___	vaginal discharge	___	vaginal itching			
	___	pain with intercourse	___	abnormal vaginal bleeding					
Extremities:	___	joint/muscle pain							
Neurological:	___	seizures	___	depression					

Gynecologic History

Menstrual History

Age when menstrual periods began: _____ Last menstrual period: _____

How many days of bleeding: _____

How long is the cycle in total (range of days) _____(shortest) to _____(longest)

Abnormal Bleeding

Do you have bleeding between your periods: ___Y ___N _____

Do you have very heavy periods: ___Y ___N _____

How many days of brown spotting, if any, do you have at the end of your blood flow: _____

How many days of very light bleeding do you have before the first heave day of your flow: _____

Have you ever charted your menstrual cycles: ___Y ___N what system: _____

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Pain

Do you have painful periods or cramps? (circle) ___None ___Mild ___Moderate ___Severe
Do you have pelvic pain at other times in your cycle? ___Yes ___No
Do you have bowel pain or problems during your period? ___Yes ___No
Do you have pain with intercourse? ___Yes ___No
Do you have low back pain with your periods: ___Yes ___No

Premenstrual Symptoms

How severe are you PMS symptoms? ___None ___Mild ___Moderate ___Severe

Please check any of the following symptoms if you notice them 3 days before your period:

___ Irritability ___ Breast Tenderness ___ Bloating ___ Weight gain
___ Salt/sweet cravings ___ Cry easily ___ Depression ___ Headache
___ Fatigue ___ Insomnia ___ Other: _____

Other symptoms

Do you have persistent low energy/fatigue? ___Yes ___No
Do you have difficult sleeping? ___Yes ___No
Do you have persistent low mood? ___Yes ___No
Do you have excessive anxiety? ___Yes ___No

Symptoms of Polycystic Ovaries

Do you have unwanted/excessive hair growth? ___Yes ___No
Do you have acne? ___Yes ___No
Are you overweight? ___Yes ___No
Do you have irregular/frequent menses? ___Yes ___No

Have you ever had a sexually transmitted infection? ___Yes ___No
Diagnosis (circle): ___HPV ___Chlamydia ___Gonorrhea ___Syphilis ___HIV ___Hepatitis
___Genital Warts ___Pelvic Inflammatory Disease (PID) ___Trichomonas
___ Other: _____

Family Planning History

1. None Since: _____(Date)
2. Abstinence Since: _____(Date)
3. Oral Contraceptive Pill Name: _____ Until: _____(Date)
   Total # of Months _____
4. Condoms Until: _____(Date) Total # of Months _____
5. NFP Until: _____(Date) Total # of Months _____
6. Depo Provera Until: _____(Date) Total # of Months _____

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7. IUD Until: _____(Date) Total # of Months _____
8. Other Until: _____(Date) Total # of Months _____

Are you currently sexually active? ___Yes ___No
If not, have you ever been sexually active? ___Yes ___No

Pap Test Information

Most recent pap smear test: _____ Result: _____

Ever had an abnormal result? ___Yes ___No Details: _____

Previous treatment for abnormal Pap: _____

Mammogram information

Most recent mammogram: _____ Result: _____

Ever had an abnormal result? ___Yes ___No Details: _____

Colon Screening Information

Have you ever had? (circle): ___Colonoscopy ___Sigmoidoscopy ___ Stool Blood testing
Date: _____

Bone Density: When was the last test? _____ Result: _____

Prior Investigations: (Check all that apply)

Tests		Details
___	Hormone lab tests	_____
___	Ultrasound	_____
___	HSG	_____
___	BBT	_____
___	Hysteroscopy	_____
___	Endometrial Biopsy	_____
___	MRI	_____
___	Urine LH Kit testing	_____
___	Other	_____

Prior Infertility Treatment

Cycles of IVF _____
Cycles of inseminations _____
Total cycles of ovulation induction: oral medicines _____ Inject able medicines _____

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Male History (If applicable-For patients trying to conceive)

Past Medical History-Have you had any of the following:

Yes		Details/Date of diagnosis if known
___	High Blood Pressure	_____
___	Heart Disease	_____
___	Diabetes	_____
___	Asthma or lung disease	_____
___	Stomach/Intestinal disease	_____
___	Kidney Disease	_____
___	Liver Disease	_____
___	Anemia	_____
___	Breast Disease	_____
___	Lupus or autoimmune Disease	_____
___	Thyroid disease	_____
___	Seizure or epilepsy history	_____
___	Neurologic problems	_____
___	Cancer	_____
___	History of trauma/car accident	_____
___	Blood Clots	_____
___	Depression/Anxiety	_____
___	Schizophrenia/Bipolar Disorder	_____
___	Chicken Pox	_____
___	Other	_____

Past Surgical History-Please list any surgeries you have had:

Year	Type of Surgery
_____	_____
_____	_____
_____	_____

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Male History (If applicable-For patients trying to conceive)

Besides these surgeries, have you ever been hospitalized for any other reason?

_____

_____

Have you ever had a sexually transmitted infection? ___Yes ___No

Diagnosis (circle): ___HPV ___Chlamydia ___Gonorrhea ___Syphilis ___HIV ___Hepatitis ___Genital Warts ___Trichomonas ___ Other: _____

Current Medications and Dose-Please list any medications you are taking

_____

_____

Do you take any supplements or herbal medicines? If yes, please list:

_____

Allergies-Please list any allergies to medication/latex/other:

_____

_____

_____

Family History-Does/Did anyone in your family have the following? Relationship?

Breast Cancer: _____

Ovarian Cancer: _____

Colon Cancer: _____

High Blood Pressure: _____

Diabetes: _____

Other: _____

Social History: (circle and describe)

Alcohol: ___Y ___N Drinks per week _____

Smoking: ___Y ___N Packs per day _____ # of Years smoking: _____

Recreational Drugs (circle): ___Heroin ___Cocaine ___Marijuana ___Methamphetamines ___Narcotics ___Sleeping Pills

Caffeine: ___Y ___N Cups per day _____

Occupation: _____

Exercise type: _____ Frequency of exercise: _____

Prior Investigations: (Check all that apply)

Tests	Details
___ Hormone lab tests	_____
___ Seminal Fluid Analysis	_____

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Women Abuse Screening Tool

1. In general, how would you describe you relationship?
   ___A lot of Tension ___Some Tension ___No Tension

2. Do you and your partner work out arguments with:
   ___Great Difficulty ___Some Difficulty ___No Difficulty

3. Do arguments ever result in you feeling down or bad about yourself?
   ___Often ___Sometimes ___Never

4. Do arguments ever result in hitting, kicking, or pushing?
   ___Often ___Sometimes ___Never

5. Do you ever feel frightened by what your partner says or does?
   ___Often ___Sometimes ___Never

6. Has you partner ever abused you physically?
   ___Often ___Sometimes ___Never

7. Has your partner ever abused you emotionally?
   ___Often ___Sometimes ___Never

8. Has your partner ever abused you sexually?
   ___Often ___Sometimes ___Never