GALLERIA WOMEN'S HEALTH

PATIENT INFORMATION

Patient Name: Last: ______________________________First: _____________________________ Middle: _________________

Date of Birth: __________________Social Security#: ________________________ Cell Phone: __________________________

Address: ____ Home Phone: ______________________

City: ___________________________________ State: _______ Zip: ______________Email: ____________________________

Check one: ____Single ____Married ____Divorced ____Widowed ____Separated

Preferred Method of Contact: ___Home ____Cell ____Work Phone ____Email

Patient's Employer: ____Occupation: ___________________________________

Employer Address: ____Work Phone: ___________________________

City: _______________________________________State: ___________________ Zip: _______________________________

Worked-related Injury: ___Yes ___No Automobile Accident: ___Yes ___No Date of Injury/Accident: __________________

Emergency Contact: _____________________________Relationship: ________________Phone: ________________________

Advanced Directive: __Yes __No Copy on File: __Yes __No Retired: __Yes __No

Referred by:____

Primary Insurance: ____Phone: ___________________________

Policy#: ____ Group#: ____

Subscriber Name: ____

To be HIPPA compliant we need you to tell us how to contact you with your health information. You need to be very specific regarding how you prefer to be contacted and where we can leave clinical messages and tests or lab results. Are we able to leave personal clinical, medical or lab results messages? _______Yes _______No

(YES) I hereby give Deepali Kashyap, M.D. PLLC (d/b/a Galleria Women's Health) permission to leave clinical/medical messages, which may include personal and sensitive information on the media source(s) that I have indicated above. I understand that it is my responsibility to keep my contact information updated.

(NO) I only consent for Deepali Kashyap, M.D. PLLC (d/b/a Galleria Women's Health) to leave a general call back message for me. **I understand that it is fully my responsibility to return all calls in a timely manner**. I understand that it is my responsibility to keep my contact information updated.

Pharmacy Name: ___________________________________ Pharmacy Phone: ____________________________________

Pharmacy Address: ____

Signature: ____ Date: ____________________________

MEDICAL HISTORY FORM

Patient Name: ____ **Date of Birth:** ______________________

Reason for Visit (Check One): ______ Annual ______Problem: ____

Obstetrical History: Total pregnancies:______ Vaginal:_______ Cesarean:_______ Abortions:_______ Miscarriages:________

Gynecology History

When was your last Pap Smear? ____________________ History of Abnormal Pap: __Yes __No

When was your last mammogram? ____________________ History of Abnormal Mammogram: __Yes __No

When was your last Dexa Scan? ____________________ History of Abnormal Dexa: __Yes __No

When was your last colonoscopy? ____________________ History of Abnormal Colonoscopy: __Yes __No

When was your last menstrual period? ____________________

Are you sexually active? ____________________

What do you use for birth control? ____________________

Have you been exposed to HIV, Hep C, or any autoimmune compromised diseases? ____Yes ____No

If yes, explain: ____

Interested in getting your prescriptions out of pocket cost covered with Rosemont Pharmacy medication program? _____Yes _____No

Past Medical History:____

____

____

Past Surgical History: List **ALL** operations:

Year: Type of Operations:

________ ____

________ ____

________ ____

________ ____

Medications: Include dosages and any over the counter medications.

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

Medication Allergies: ____

Social History:

Marital Status: ____________________Occupation: _________________________ # in household: __________________

Tobacco: ________________ Alcohol: ________________ Drug Abuse: ________________ Exercise: ________________

Family History: Do you have any close relatives with the following problems?

Cancer: _____ Yes. Type:______________ Who?____________________________________

Heart Disease: _____ Yes. Who? ____

Other: _____ Yes. Type:______________ Who?____________________________________

Patient Signature:____ Date: ________________________

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www.galleriawomenshealth.com

GALLERIA WOMEN'S HEALTH

SERVICE & FINANCIAL AGREEMENT

Consent to Treat:

I, ____, I hereby give permission to Deepali Kashyap, M.D. PLLC (d/b/a Galleria Women's Health) to evaluate and treat me/my child, who is a minor. I also give my permission to evaluate and treat in the event that a medical emergency arises and I am unable to personally consent to the treatment. I also agree to be responsible to Galleria Women's Health, PLLC for the charges of medical services rendered.

______ • I understand that my insurance policy is a contract between me, my employer, and my insurance company. Galleria Women's Health is not a party in that contract.

______ • I authorize Deepali Kashyap, M.D. PLLC to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company, and thereby authorize insurance payment directly to Deepali Kashyap, M.D. PLLC for any services rendered that are not paid by me.

______ • **All copayments and deductibles are due at the time of service**. Payments can be made with cash, debit or credit cards. **Personal checks are not accepted**.

______ • I understand that not all services are covered by my insurance. **Fees for NON-COVERED care; such as the cosmetic vulvo-vaginal surgeries, Botox®, Fillers, etc., are due in full at or before the time of service unless prior arrangements have been made**.

______ • **I understand that if I do not inform my doctor of ALL of my insurances (ex. primary and secondary insurances), I will be responsible for all refunded payments requested from my doctor by my insurances**.

______ • I understand that my doctor will bill my insurance company if they are contracted providers. If payment is not received from my insurance company 90 days from the date of billing, I am financially responsible for any and all services rendered.

______ • I understand that there is a **$40.00** fee to have each of my **Disability or FMLA form(s)** completed.

______ • I understand that **if I do not cancel my appointment at least 24 hours prior to the scheduled time, I will be charged a $25 fee for office visits, $75 fee for ultrasound and a $150 fee for procedures, including surgeries**. I understand that these charges are not billed to my insurance and will be charged to my credit card/debit card on file.

______ • I understand that **all labs and radiology services will be charged separately from Galleria Women's Health.**

______ • I hereby assign to Galleria Women's Health any insurance benefits available for health care services provided to me. If these benefits are not assigned to the doctors, I agree to forward all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

______ • **If this account is turned over to a collection agency**, I agree to pay the collection and legal fees necessary to collect the balance, including **a fifty percent (50%) charge** for collection services added to the unpaid balance.

____ ______________________

Patient or Legal Guardian Signature Date

NO SHOW / LATE CANCELLATION POLICY AND FEE

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment in a timely manner, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Ultrasounds: For our patient's convenience, we are able to schedule ultrasounds in our office. However, scheduling your ultrasound requires us to book an ultrasound technician to come to our office and be available for the scheduled times. A late cancellation or no show results in direct costs of the ultrasound technician.

Surgeries: Scheduling your surgery requires significant coordination between the hospital or surgery center, your insurance company, anesthesiologist and first assist, if applicable. A late cancellation or no show creates significant disruption.

Therefore, in order to continue to better utilize available appointments for our patients in need of medical care, we strictly enforce the following No Show / Late Cancellation Policy. **Please read the following agreement carefully, fill in the required information, and then sign and date below**.

______ • I understand that if I do not cancel my scheduled appointment (as detailed below), I will be charged a late fee (also detailed below), which is not billed to my insurance:

- **$25.00** for an **office appointment**, if I do not cancel at least **24 hours** prior to my scheduled appointment.
- **$75.00** for an **ultrasound appointment**, if I do not cancel at least **48 hours** prior to my scheduled appointment.
- **$50.00** for a **health coaching appointment**, if I do not cancel at least **48 hours** prior to my scheduled appointment.
- **$150.00** for a **scheduled surgery**, if I do not cancel at least **72 hours** prior to my scheduled appointment.

______ • I understand this policy, agree to its terms and authorize Galleria Women's Health to assess no show and late cancellation fee according to the policy outlined to the Credit Card /Debit Card that has been provided to Galleria Women's Health.

______ • For Ultrasound/Surgery Appointments, in case of a cash deposit instead of credit card information, I understand that the $75.00/$150.00 deposit will be refunded to me on my first visit after the procedure.

______________________________ ______________________ ______________________

Patient's Printed Name | Patient's Signature | Date

______________________________ ______________________ ______________________

Legal Guardian | Relationship | Date

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS IN ACCORDANCE TO HIPAA

I, ____, understand that as a part of my health care, Deepali Kashyap M.D., PLLC (d/b/a Galleria Women's Health) originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer (s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent/disclosure
- The right to request restrictions as to bow my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that Deepali Kashyap MD, PLLC is not required to agree with the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization 's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity (Insurance company, referring physician, consulting physician, hospital, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to Deepali Kashyap MD PLLC to disclose my protected healthcare information to the following person and/or people:

Name: ____ Relationship: ______________________

Name:____ Relationship: ______________________

Name: ____ Relationship: ______________________

I fully understand and accept the terms of this consent.

____ ________________________

Patient or Legal Guardian Signature Date