MARY GAIL MIESCH, M.D., F.A.C.O.G.
945 SOUTH COLLEGIATE DRIVE
PARIS, TEXAS 75460

THIS PATIENT PACKET IS REQUIRED EVERY YEAR FOR PRIVATE/COMMERCIAL INSURANCE AND EVERY TWO YEARS FOR MEDICARE. DUE TO RECENT CHANGES WITH HIPPA, (HEALTH INSURANCE PORTABILITY ACT), YOU CAN NO LONGER PUT, "UNCHANGED, SAME, OR NO YOU MUST FILL THE PACKET OUT COMPLETELEY, LEAVING NO BLANK SPACES, OR YOUR PATIENT PACKET WILL BE REJECTED.

PATIENT INFORMATION (PLEASE PRINT) **TODAY'S DATE**_____

Name_____
Last **First** **Middle Initial**

Address_____
Number & Street **City & State** **Zip**

Phone
(Home)_____**(Cell)**_____

Work Phone _____

Social Security #_____

How would you like to be contacted? Email_____**Phone**_____ **Mail**_____

Date of Birth_____**Marital Status**_____**Age**_____

Race:_____ **Ethnicity : Hispanic**_____ **Non Hispanic**_____

Occupation:_____

Employer:_____

Name of Preferred Pharmacy
_____

SPOUSE: DATE OF BIRTH:_____

NAME _____

Social Security _____

Occupation _____

Telephone _____

Responsible party or insured:

NAME_____
Last **First** **date of birth**

ADDRESS_____
Number & Street **City & State** **Zip**

PHONE_____**SOCIAL SECURITY**_____**RELATIONSHIP**_____

AUTHORIZATION TO RELEASE INFORMATION
I authorize the release of medical information necessary to process insurance.

SIGNATURE_____
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN
I authorize payment of medical and surgical benefits to include major medical to Mary Gail Miesch, M.D. for services rendered. I understand I am financially responsible to the physician for charges not covered by insurance.

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Name_____**Date**_____

What is the purpose of your visit?_____

Who is your primary care physician?_____

MEDICAL HISTORY

GYNECOLOGY REVIEW

Date last period began_____

Birth Control Method_____

Do you smoke cigarettes? ___No ____Yes ____How many packs per day?
Do you exercise regularly ____No ____Yes
Have you ever had an abnormal pap smear? ____No ____Yes

Date of last: Pap smear_____
DEXA _____
Mammogram_____
Colonoscopy_____

Periods
How often do you have your period?_____
How many days do you flow?_____
How many pads/tampons do you use on heaviest days?_____

Obstetrical History
Please list all pregnancies, miscarriages, terminations:
Date Length of Pregnancy D&C Vaginal Caesarean Sex Weight
_____
_____
_____
_____

Past Medical History
Have you ever been treated for any of the following?
If yes, indicate date and treatment beside each:

Mitral valve prolapse	___Yes	___No
Heart disease	___Yes	___No
Kidney disease	___Yes	___No
Anemia	___Yes	___No
Hepatitis	___Yes	___No
Thyroid disease	___Yes	___No
Migraine headaches	___Yes	___No
Asthma	___Yes	___No
Blood clots (Legs)	___Yes	___No
Blood Clots (Lungs)	___Yes	___No
High blood pressure	___Yes	___No
Diabetes	___Yes	___No
Stroke	___Yes	___No
Personal history of cancer	___Yes	___No

Surgeries

Date	Hospital	Operation	Transfusion	Duration of Stay

Family History

	Age	Specific Ailments	If deceased cause of death and age
Mother			
Father			
Brother			
Sister			
Children			

Are you ALLERGIC to any drugs or medication? Yes____No____
If yes please list name of drug and reaction:_____

Please list medications including strength and how often you take them. Please include over the counter medications.

Review of systems: Please check yes, no or unchanged.

	Yes	No
Constitutional		
Weight loss	___	___
Weight gain	___	___
Fever	___	___
Fatigue	___	___
Genitourinary		
Blood in urine	___	___
Pain with urination	___	___
Urgency	___	___
Incomplete emptying	___	___
Stress incontinence	___	___
Abnormal periods	___	___
Painful intercourse	___	___
Fecal incontinence	___	___
Skin/Breast		
Pain in breast	___	___
Discharge	___	___
Masses	___	___
Rash	___	___
Ulcers	___	___

History reviewed with patient.
PHYSICIAN'S SIGNATURE:_____
Date_____

APPOINTMENT CANCELLATION POLICY

Your appointment is reserved especially for you. Should you need to cancel or change the date of your appointment, we require a notice of at least two business days as a courtesy to other patients seeking appointments. If less than two business days notice is given or if you miss an appointment, **then a late cancellation fee or missed appointment fee of $50 will be applied to your account**. This amount must be paid before you will be given another appointment.

How to cancel your appointment:
To cancel appointments, please call 903-784-1141. If you do not reach the receptionist, you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

No-show Policy

A "no-show" is someone who misses an appointment without canceling it in an adequate manner. A failure to present at the time of a scheduled appointment will be recorded as a "no-show" and a fee of $50 will be billed to your account. This amount must be paid before you will be given another appointment.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Mary Gail Miesch, MD, FACOG.

_____ _____

Printed Name Signature

Date

MARY GAIL MIESCH, M.D., F.A.C.O.G.
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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INORMATION

With my consent Dr. Mary Gail Miesch may use and disclose protected health information (PIH) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Mary Gail Miesch's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Mary Gail Miesch reserves the right to revise her Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Mary Gail Miesch Privacy Officer at 945 S. Collegiate Paris, Texas 75460.

With my consent, Dr. Mary Gail Miesch may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assists the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent Dr. Mary Gail Miesch, MD, FACOG may mail to my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statement. I have the right to request that Dr. Mary Gail Miesch, MD, FACOG restrict how she uses or discloses my PHI to carry out TPO; however, the practice is not required to agree to my requested restrictions, but, if it does, it is bound by this agreement.

By signing this form I am consenting to Dr. Mary Gail Miesch, MD's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Mary Gail Miesch, MD, FACOG may decline to provide treatment to me,.

Signature of Patient or Legal Guardian

Patient's Name Date

Print Name of Patient or Legal Guardian

MARY GAIL MIESCH, M.D., F.A.C.O.G.
945 SOUTH COLLEGIATE
PARIS, TEXAS 75460
903-784-1141

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED INFORMATION

This authorization permits Mary Gail Miesch, MD, FACOG to use and/or disclose the following individually identifiable health information about me up to and including appointment dates and times, lab results, physical exam results, treatment options, procedures performed, any information that was disclosed on my medical history form, and financial obligations. This means any name you place on this disclosure form will be entitled to all of your health care record information whether personal or financial. Please carefully consider each and every name you place on this form. By signing this authorization I authorize Dr. Mary Gail Miesch to use and/or disclose certain protected health information (PHI) about me to:

1. _____Relationship_____
(telephone number)
2. _____Relationship_____
(telephone number)
3. _____Relationship_____
(telephone number)
4. _____Relationship_____
(telephone number)
5. _____Relationship_____
(telephone number)

This authorization will expire 365 days from date signed unless otherwise stated.

_____ _____
Signature of Patient/Legal Guardian Relationship to Patient

_____ _____
Patient's DOB Patient's Social Security Number

_____ _____
Print Name of Patient Date (expiration date is one year after signature Unless otherwise indicated.)

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What is an annual exam?

An annual exam is a once a year visit to your gynecologist for a general health check, including a breast exam and pap smear. **A gynecologist is a specialist/surgeon who does not take care of your primary health care.** An annual exam visit does not include discussion of new problems or detailed review of chronic conditions. The purpose of the personal/medical history form is to help Dr. Miesch completely accomplish the requirements of your annual exam.

Examples of problems not covered at a routine annual include:

1. A list of concerns or questions
2. New health care concerns or problems found at the time of your annual exam
3. Ongoing health problems that need more attention or any health problem not related to gynecology.

What should I expect during my annual exam?

1. General physical exam (including breast exam)
2. Pelvic exam (Pap smear)
3. Update of family health history (any new serious illnesses in your family?)
4. Review of your health history
5. Update of current medications, herbs, and supplements (Bring list)
6. Need for medication refills
7. Evaluation of need for health screening tests based on age and personal and family history (such as mammogram, test for sexually transmitted diseases, and bone density screening)

Problems addressed at the time of the well woman/annual exam are not services covered by well woman copays alone and require a second copay according to the individual insurance carrier.

Your signature below indicates you have read the above and understand.

Date_____Signature_____

Due to requirements of the Texas State Department of Health, I will fill Schedule 3 and Schedule 4 drugs for a period of thirty days with five refills which will equal six months. If you need one of these drugs for a longer period of time, you will need to be seen in my office for refill authorization. Please call and make that appointment before this refill runs out. An example of these drugs is:

Ambien (Zolpidem)
Fiorinal (Butalbital)
Lunesta

Testosterone – injectable, topical, or oral (This includes Estratest and generic equivalents such as Syntest)

Clonopin or Klonopin (Clonazepam)
Xanax (Alprazolam)
Ultram (Tramadol)
Restoril (Temazepam)
Valium (diazepam)
Phentermine

Your signature below indicates you have read the above and understand.

Signature Date

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ATTENTION: AETNA, CIGNA, AND UNITED HEALTHCARE POLICY HOLDERS!

Annal/Well Woman Exam:
If you are having your "annual" or "Well Woman Exam" today, the visit by definition may include the following if indicated:

Breast Exam
Pelvic Exam
Pap Smear
Rectal Exam if Requested By Patient
Review of Health History
Refills for Current Medication Prescribed to You by Dr. Miesch

If you want to discuss any other medical or social issues not related to a Well Woman Exam/Pap Smear, want/need NEW prescriptions, a separate appointment will need to be made. Due to the policy guidelines set forth by Aetna, Cigna, and United Healthcare, an annual or well woman exam will not be covered on the same date as a problem orientated visit. The issues mentioned below are examples of problems/issues that ARE NOT included in the Annual/Well Woman Exam:

Hormone Issues	Bladder Issues
Depression	Fatigue & Malaise (Consult PCP)
Anxiety	Pelvic Pain
Insomnia	Low Sex Drive
Thyroid Issues	Painful Intercourse
Irregular Bleeding/irregular cycles	Infertility

We apologize for any inconvenience this may cause.
Please indicate below by checking the appropriate visit that applies to you:

_____Annual/Well Woman Exam _____ Problem Oriented Visit

Please inform us if a separate appointment needs to be made, as scheduled appointment times do not allow for both. Thank you for your cooperation.

_____ _____
Patient Signature Date