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

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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______________________________________

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

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Dr Miesch as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

•The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for her treatment and care. *After filing your insurance if they do not pay for any reason you will be responsible for your bill*. **We do not file secondary insurance.**

•We are pleased to assist you by billing for your contracted primary insurer. We will not file secondary insurance. You are required to provide us with the most correct and updated information about your insurance and will be responsible for any charges incurred if the information provided is not correct or updated at the time of billing.

•Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their primary insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.

•Patients may incur and are responsible for the payment of additional charges at our discretion. These charges may include (but are not limited to):

- ♣Charge for returned checks.
- ♣Charge for missed appointments without 24 hours advance notice
- ♣Charge for extensive phone consultations and/or after-hours phone calls
- ♣Charge for the copying and distribution of patient medical records.
- ♣Charge for extensive forms completion.
- ♣Any costs associated with collection of patient balances.

Patient Authorizations

•By my signature below, I hereby authorize Dr Miesch, staff, and hospitals associated with Dr Miesch to release medical and other information acquired in the course of my examination and/or treatment (with the exceptions stipulated below) to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

•By my signature below, I hereby authorize assignment of financial benefits directly to Dr Miesch and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

•By my signature below, I authorize Dr Miesch's personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

•By my signature below. I understand that I am responsible for all charges for services that I receive from Dr Miesch, and that if the patient responsibility portion of my charges (including charges applied to my deductible and/or coinsurance) is not paid in full within thirty (30) days following the receipt of the patient statement mailed from the office of Dr Miesch, Dr Miesch will send 2nd statement and if not paid within 30 days the outstanding balance will be referred to collections.

I have read, understand and agree to provisions of this Patient Financial Responsibility Form.

Signature of Patient or Guardian Date

____

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion

Signature of Patient or Guardian Date

____