



Consent to Treatment and Other Acknowledgments

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following: While routinely performed without incident, there may be material risks associated with any procedure. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.

I hereby expressly authorize and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to Modern OB/GYN of North Atlanta and all professionals (including independent contractors) providing for such care and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to Modern OB/GYN of North Atlanta and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits).

A copy of this document may be utilized the same as the original.

Name: _____

DOB: ____/____/____

Today's Date: ____/____/____



Patient Consent & Acknowledge of Receipt of Privacy Notice

I, _____ understand that as a part of the provision of healthcare services, Modern Obstetrics & Gynecology of North Atlanta, P.C. creates and maintains health records describing my health information. This includes but is not limited to my health history, symptoms, diagnoses, examination and test results, treatment, and any plans for future treatment, personal information and insurance data.

I have read and/or have been provided with a copy of the Notice of Privacy Practices that provides a complete description of the uses and disclosures of certain health care information.

By signing this form, I consent to the use and disclosure of the protected health information about me for the purpose of treatment, payment and health care operations. I understand that I have the right to revoke this consent in writing except where disclosures have already been made in reliance on my prior consent.

Patient Printed Name: _____

Signature: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

I, hereby authorize and give permission to Modern Obstetrics & Gynecology of North Atlanta, P.C., to disclose and discuss any information related to my medical condition(s) to/with the following persons:

Name	Relationship
_____	_____
Name	Relationship

OR: Do not share my information with anyone outside of my PCP, Referring MD and Insurance Company.

I wish to be contacted in the following manner:

Home/Work/Cell Number; _____

OR: Written Communication:

OK To Leave a Detailed Message

OK To Mail To My Home Address

Leave A Simple Message With A Call Back Number

OK To Fax To This Number: _____

By my signature below, I authorize the release of any medical or other information deemed necessary by Modern Ob Gyn of North Atlanta, P.C., including transferring of medical records to support medically necessary referrals to other health providers.

Signature of Patient: _____ Date: ____/____/____



John C. Reyes, M.D., F.A.C.O.G.
Ingrid V. Reyes M.D., F.A.C.O.G.
Natu N. Mmbaga, M.D., F.A.C.O.G.
Annie Kim, M.D., F.A.C.O.G.
Stacey Pereira, M.D.

Medical Records Release Request

Patient Information:

Patient Name: _____
DOB: ____/____/_____
Home Address: _____
City, State and Zip: _____

Contact Number: _____
Social Security ID: _____

I, _____ authorize the above listed person/s, firm, or entity (or its agents, representatives or employee) to release for inspection and copying and use, any and all of the Personal Health Information (PHI) listed below that pertains to my treatment, hospitalization or care from date/s of: ____/____/____ to ____/____/____

To/From:

Modern Ob/Gyn of North Atlanta
10692 Medlock Bridge Road, Suite 100-A
Johns Creek Ga 30097
Fax: 404-446-2497
Office: 404-446-2480

To/From:

Name: _____
Address: _____
City, State, Zip: _____
Fax: _____

Note: All records requests that come *into* our office either written or verbal will initially be processed by our Medical Records Coordinator. From that point, requested information will be forwarded to the provider for approval and signature. No records are to be released without the provider's approval, and Administrative Certification. Please note, there will be a Fee of \$35.00 if the records are released **to you** directly.

What Records Do You Need:

- Entire Record
- Radiology/X-ray Reports
- Operative Reports
- Pathology Reports
- Laboratory Results
- Labor & Delivery Records
- ER/Hospital Reports
- Other: _____

Which Provider Do You See:

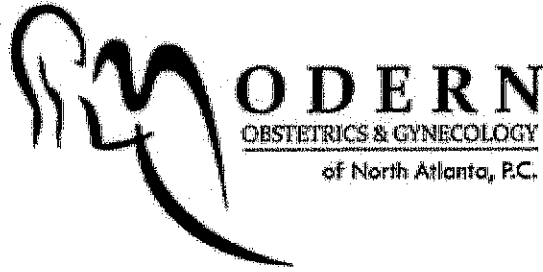
- Dr. John Reyes
- Dr. Ingrid Reyes
- Dr. Natu Mmbaga
- Dr. Annie Kim
- Dr. Stacey Pereira

Reason For Records Request: Relocation Insurance Change Patient Discontent
 Second Opinion Employment Request Other: _____

Patient Signature Of Release: _____ Date: ____/____/_____

Initials of Certifier

Date Completed/Sent/Mailed



Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to you and your healthcare needs. Please understand payment of your bills is considered part of your care. The following is a statement of our financial policy. We require all of our patients to read and sign prior to treatment or consultation.

All patients must complete our Information and provide insurance information before seeing the doctor.

FULL PAYMENT IS DUE (UPON REQUEST) AT THE TIME OF SERVICE.

For your convenience, we accept Cash, Checks, and Credit or Debit cards.

(Please initial after each number.)

1. ____ It is the responsibility of the patient to confirm the physician is on the insurance plan and that your benefits are active. Our office will file claims to your insurance company for professional services rendered. We cannot bill your insurance carrier unless you give us your current insurance information. Please remember, **INSURANCE COVERAGE IS A LEGAL CONTRACT BETWEEN THE PATIENT AND THE INSURANCE COMPANY.** Benefits may differ depending upon what type of contract you have with the carrier on your behalf. If your insurance company has not paid your account in full at the end of 90 days, the balance will automatically be transferred to your responsibility for payment in full. Please be aware that some or perhaps all of the services provided may be non-covered services and not be considered necessary under the Medicare Program or other medical insurances.
2. ____ All co-pays and deductibles are due at the time of treatment. We require payment in full for your portion (coinsurance, deductible or out-of-pocket fees) at the time of service. Our office accepts Visa, MasterCard, Discover, American Express, checks, cash and money orders. If a check is returned from your bank, there will be a \$40 returned check fee added to your total amount due. Ultimately, you are responsible for all charges incurred in our office. The law does not allow us to write off co-pays or deductible amounts.
3. ____ If the patient cannot keep the scheduled appointment, it is the patient's responsibility to give our office at least 24 hours cancellation notice. We reserve the right to charge an **\$85.00** fee for missed or cancelled appointments with less than 24 hours notice. Surgeries and In-office procedures that are cancelled with less than 1 week notice will be subject to a **\$300.00** non-refundable service fee. Please help us serve you and other patients better by keeping scheduled appointments.
4. ____ If you are turned over to a collections agency, there will be a **\$50.00** processing/filing fee, as well as a fee of **40%** of your balance added to your account that you will be responsible for.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT FINANCIAL RESPONSIBILITY AS DESCRIBED ABOVE.

Patient, Legal Guardian or Responsible Party Signature

DOB: ____/____/____

Today's Date: ____/____/____

Modern Ob/Gyn of North Atlanta, P.C.

Patient Medical History

Please complete the following information as accurately as possible. Your answers on this form will help your provider understand your medical concerns and conditions better. If you cannot remember specific details, please give best estimates. We realize this a very lengthy form, but we are asking you to provide a comprehensive history for our Electronic Medical Record which results in improved care for you.

Name: _____ DOB: _____ Date: _____

Marital Status: Single Married Widowed Divorced Domestic Partner SS#: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Email: _____

Preferred Method of Communication: Phone Mail E-mail Text

How did you hear about us? _____ Referred by: _____

Spouse's Name: _____ Spouse's Contact Phone: _____

Spouse's Occupation: _____ Spouse's DOB: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Pharmacy Name: _____ Phone: _____ Location: _____

Reason for Visit:

What is the reason for your visit: Annual exam Obstetric first visit Gyn Problem

If you are here for a problem what are your concerns? _____

Health Maintenance Screening Tests:

Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Dexa Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Mammogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

Pap Smear History:

Pap smear	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
LEEP	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Colposcopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date / /	Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
History of HPV?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date / /			
Received HPV vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date ____/____/____	<input type="checkbox"/> Inj.1	<input type="checkbox"/> Inj.2	<input type="checkbox"/> Inj.3

Personal Medical History: Check if you had any of these medical problems in the past.

Major illness	Yes	Major Illness	Yes
Anemia		Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
Anxiety		High blood Pressure	
Arthritis/Joint Pain		High Cholesterol	
Asthma		Hypothyroid	
Blood clot/DVT		Hyperthyroid	
Blood Transfusions		Interstitial Cystitis	
Breast Cancer		IBS (irritable bowel syndrome)	
Cancer- list type:		Jaundice	
Chronic Lung Disease		Migraines	
Depression		Osteopenia	
Diabetes Type1		Osteoporosis	
Diabetes Type 2		Ovarian Cancer	
Fibroids		Seizures	
Fracture		Sexually Transmitted Disease	
GERD		Stroke	
Heart Disease		Tuberculosis-TB	

Other: _____

Past Surgical History: No past surgical history

Year	Surgery	Complications?

Current Medications: None If there is not sufficient space please attach copy of medications list to this form.
 Prescription and non-prescription medicine, vitamins, home remedies, birth control pills, herbs:

Medication	Dosage (mg)	Frequency	Prescribing Physician

Allergies: (Food, Drugs, Environmental) None Latex Iodine

Allergy	Interaction	Allergy	Interaction

Family Medical History: Please indicate below significant medical problems of family members. Indicate which family member by checking the appropriate column and the AGE OF ONSET: No Family History Adopted

	None	Mother	Father	Brother	Sister	Grand Mother (Maternal)	Grand Mother (Paternal)	Grand Father (Maternal)	Grand Father (Paternal)	Aunt	Uncle
Blood Clots/DVT											
Breast Cancer											
Cervical Cancer											
Colon Cancer											
Diabetes											
Ovarian Cancer											
Hypertension											
Stroke											
Uterine Cancer											
Other Cancers not mentioned											
Other disease's not mentioned											

Genetic Screening: None Includes patient, baby's father, or anyone in either family

Indicate Yes or No	Yes	No		Yes	No
Tay-Sachs			Sickle Cell Disease or Trait		
Neural Tube Defect			Maternal Metabolic Disorder		
Other inherited Genetic or chromosomal Disorder			Mental Retardation/Autism		
Thalassemia			Medication/Street Drugs/Alcohol		
Hemophilia			Muscular Dystrophy		
Cystic Fibrosis			Huntington Chorea		
Down Syndrome			Congenital Heart defect		
Patient or father of the baby had/has a child with birth defects not listed			Recurrent pregnancy loss or a still birth		

Gynecology:

Age at first period:	1 st day (date) of last period:
Frequency of period:	Describe Period: <input type="checkbox"/> Light <input type="checkbox"/> Normal <input type="checkbox"/> Heavy
Length of period:	Current Contraceptive Method:
Do you have concerns regarding your period? describe:	Are you in menopause? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Date of last period: Are you on hormone replacement therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No

Obstetrics:

	Number			Number			
Total number of pregnancies			Abortions Induced				
Full Term Births			Miscarriages				
Pre-Term Births			Living Children				
No.	Birth Date	#weeks at delivery	Sex	Birth Weight	Delivery Type	Complications	Location of Delivery
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

Social History

Are you currently sexually active? Yes No _____ If yes, what age did you become sexually active? _____

Current sexual partner (s) is/are: Male Female Male and Female _____

Have you had more than 5 sexual partners in a lifetime? Yes No If yes, how many? _____

Have you ever has any sexually transmitted diseases?(STDs): Yes No

If yes, what kind? _____

Are you interested in STD screening? Yes No

Do you drink alcohol? Yes No If yes, Social Drinker Daily if yes, how many drinks per week? _____

Do you use recreational drugs? Yes No If yes, what kind? _____

Do you use tobacco? Yes No If yes, Current every day _____ Current some days _____
Former _____ Never _____

If current, how many cigarettes a day? _____ if an occasional smoker – please describe: _____

Life Style: Please check off answer and give detail if it applies:

Have you been a victim of abuse or domestic violence? Yes No

Do you feel safe at home? Yes No

Do you live alone? Yes No

Do you perform self-breast exam? Yes No

Do you drink milk or consume dairy products daily? Yes No

Do you take calcium tablets? Yes No

Do you exercise? Yes No If yes, frequency - how many times a week? _____

BLOOD TRANSFUSION/PRODUCTS:	YES	NO	IF NO, PLEASE BRIEFLY EXPLAIN WHY.
WOULD YOU ACCEPT A BLOOD TRANSFUSION OR BLOOD PRODUCTS IN THE EVENT OF A LIFE THREATENING SITUATION?			

Please add any additional information:

AUTHORIZATION AND RELEASE:

I hereby certify that I have completed the above information to the best of my knowledge. I authorize, consent, request, and agree to actively participate in such services as routine assessments, the performance of diagnostic tests and procedures, care and treatment as self-referred or as ordered by my physician, his/her assistant or designees.

Signature

Date

Please mail or fax your completed form to our office prior to your appointment. If you cannot return your form prior to your appointment, you must arrive 30 minutes early so we can enter your information into the computer. Thank you for your attention and cooperation.

Revised 4/2016