J. Leonard Tadvick. MD PLLC

1904 Pine St. Suite 4A Abilene, TX 79601 Phone 325-437-4020 Fax 325-437-4029

Patient Registration Form

Patient Information (please print)

Last Name: _____ First:_____ Initial:_____ Date of Birth: _____/_____/_____

Address: _____City:_____ State:_____ Zip:_____ County:_____

Cell Number_____ Home Phone:_____ Work Phone:_____

SSN#:_____ Sex: ❑ Male ❑Female

I am:

- ❑ Asian
- ❑ Black/African American
- ❑ White (including Whites of Hispanic Descent)
- ❑ American Indian /Alaska Native
- ❑ Pacific Islander
- ❑ Multi-racial
- ❑ No Response

Are you Hispanic? ❑Yes ❑No

Marital Status:

❑ Single ❑ Married ❑Divorced ❑Widow ❑Other

Occupation:_____ email address:_____

Employer's Name_____

Preferred Language:_____ Primary Language: _____

Primary Care Doctor: _____ Preferred Pharmacy: _____

Responsible Party

Last Name: _____ First:_____ Initial:_____ Date of Birth: _____/_____/_____

Address: _____City:_____ State:_____ Zip:_____ County:_____

Home Phone:_____ WorkPhone:_____SSN#:_____

Race: ___ Sex: ___ Marital Status:_____ Occupation:_____Relationship:_____

Insurance Company

1. Primary Insurance:_____

Policy Holder: _____ Insured's Date of Birth: _____/_____/_____ SSN: _____

Employer's Name: _____ Policy#: _____ Group#:_____

2. Secondary Insurance: _____

Policy Holder: _____ Insured's Date of Birth: _____/_____/_____ SSN: _____

Employer's Name: _____ Policy#: _____ Group#:_____

If you are over 65 and Medicare is secondary, please list reason: _____

Emergency Contact

First Contact Name:_____ Phone:_____ Relationship:_____

Second Contact Name:_____ Phone:_____ Relationship:_____

CONSENT TO TREAT: ***I hereby give permission to the providers of J. Leonard Tadvick, MD PLLC and/or their designee, to provide medical care, including the prescribing of medication, to me or my dependant.***

Signature: _____ Date: _____

Name: **Date:**

REVIEW OF SYSTEMS

Please check any of the following symptoms that apply to you.

Constitutional

☐ Fatigue	☐ Fever	
☐ Night sweats	☐ Weight gain	☐ Weight loss
☐ Other: _____		

Eyes

☐ Blurred vision	☐ Double vision	☐ Glasses/ contacts
☐ Vision changes		

Ear, Nose & Throat

☐ Congestion	☐ Dental problems	☐ Difficulty swallowing
☐ Earaches	☐ Hearing problems	☐ Neck stiffness/ pain
☐ Runny nose	☐ Seasonal Allergies	☐ Sinus problems
☐ Sore throat	☐ Other: _____	

Cardiovascular

☐ Chest pain or pressure	☐ Leg swelling	☐ Palpitations
☐ Rapid or irregular heart beat	☐ Varicose veins	
☐ Difficulty breathing w/ exertion	☐ Difficulty breathing when lying flat	
☐ Other: _____		

Respiratory

☐ Chronic cough	☐ Painful breathing	☐ Shortness of breath
☐ Snoring	☐ Wheezing	
☐ Other: _____		

Gastrointestinal

☐ Abdominal mass	☐ Abdominal pain	☐ Black stools
☐ Bloody stools	☐ Constipation	☐ Diarrhea
☐ Hemorrhoids	☐ Incontinence of stool or gas	☐ Indigestion
☐ Nausea/ vomiting	☐ Rectal pain	
☐ Other: _____		

Name: **Date:**

Genitourinary

☐ Abnormal bleeding	☐ Absence of periods	☐ Blood in urine
☐ Frequent bladder infections	☐ Frequent urination	☐ Incomplete emptying
☐ Incontinence of urine	☐ Infertility	☐ Pain with urination
☐ Painful intercourse	☐ Painful periods	☐ Pelvic pain
☐ Vaginal discharge	☐ Vaginal dryness	☐ Vaginal itching

☐ Other: _____

Musculoskeletal

☐ Back pain	☐ Joint pain/ stiffness	☐ Joint swelling
☐ Muscle pain	☐ Muscle weakness	☐ Weight loss

☐ Other: _____

Skin

☐ Acne	☐ Dry skin	☐ Easy bruising
☐ Enlarged lymph nodes	☐ Itching	
☐ Rash	☐ Sores	

☐ Other: _____

Breasts

☐ Breast mass	☐ Breast pain	☐ Nipple discharge/ blood

☐ Other: _____

Neurologic

☐ Dizziness	☐ Headaches	☐ Memory problems
☐ Numbness	☐ Seizures	☐ Tremor

☐ Other: _____

Psychiatric

☐ Anxiety	☐ Depression	☐ Frequent crying

☐ Other: _____

Endocrine

☐ Abnormal hair growth	☐ Abnormal thirst	☐ Deepening of voice
☐ Hair loss	☐ Heat/ cold intolerance	☐ Hot flashes

☐ Other: _____

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Thank you for choosing Dr. Tadvick for your Obstetrics and Gynecology care. The following are some key points of information we would like to go over.

- It is necessary to go over all paperwork and make sure it is filled out completely and accurately. Example, it is imperative we have at least one working telephone number that we can use to get in touch with you or were we can leave a message that you will receive.
- Copayments are due at the time of your visit.
- We will need to be notified of all insurance coverage. If you are not sure, please ask the front office staff for assistance. If you have two (2) insurances, for example one under your employment and one under your spouse- your insurance will always be primary. If you have Medicaid in addition to commercial insurance-Medicaid is secondary. If correct information is not given to the office, bills will be the patient's responsibility.
- Please let our office know of any changes in address, insurance or demographic information that changes in between visits.
- We need a copy of your Drivers License and insurance at each yearly visit. For Medicaid patients we need a monthly copy of your Medicaid card.
- On occasion, Dr. Tadvick will be called away from the office for emergency purposes. When this happens it could result in one of the following; your appointment having to be rescheduled or a lengthy wait. Feel free to call us prior to your appointment to see if we are running on schedule. Please remember this can happen at any time-we appreciate your patience.
- Once the patient is in an exam room visitors will not be able to enter and leave the room. This is necessary for the privacy of our patients. As space is limited, please limit your visitors to no more than 2 persons.

We would like to thank you in advance for your cooperation. We look forward to having you as a patient.

I have read and received a copy of this form.

_____ _____

Signature Date

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BORDERLINE ABNORMAL PAP SMEAR TEST RESULTS

Patient Name:_____

When test indicate borderline abnormal pap results, Dr. Tadvick will routinely check an HPV (Human Papillomarvirus) test. **Some insurance companies do not cover this test.** It is patient responsibility to check on coverage.

- ❑ **Yes, I agree to HPV testing**
  I understand I will be responsible for any charges not covered by my insurance.

- ❑ **No, I decline HPV testing.**

Signature: _____

Date: _____

Witness: _____

J. Leonard Tadvick, MD PLLC

PATIENT AGREEMENT, ACKNOWLEDGMENT, & CONSENT

RELEASE OF INFORMATION TO FAMILY/FRIEND

Please list your friends or family members that you want to have access to your information. Please note that you may change this list at anytime. _____***(initials)***

1. _____ **3.** _____

2. _____ **4.** _____

AGREEMENT TO PAYMENT POLICY

I acknowledge that I received a copy of the J. Leonard Tadvick, MD PLLC financial policy and agree to the terms of payment due. _____*(initials)*

AUTHORIZATION TO RELEASE INFORMATION

I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. _____***(initials)***

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to J. Leonard Tadvick, MD PLLC for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services. _____***(initials)***

CONSENT TO LEAVE A MESSAGE WHEN YOU ARE NOT AVAILABLE

I give my consent for any staff member or representative of J. Leonard Tadvick, MD PLLC to contact me, and if necessary, leave a message at the following numbers: □Home □Cell □Work. The message may include: □Appointment reminders □Clinical information (lab values, radiology, etc…) _____***(initials)***

GUARANTEE OF PAYMENT

I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to coinsurance, deductibles or non-covered services, are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default. _____***(initials)***

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES

*I hereby acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practice of J. Leonard Tadvick, MD PLLC*_____***(initials)***

_____ _____

Signature of Patient **Date**

_____ _____

Responsible Party **Relationship to party**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 12/01/2010, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, to make requests regarding your protected health information, or for additional copies of this Notice, please contact us in writing: **1904 Pine Street, Suite 4A Abilene, TX 79601.**

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescription, medical supplies, x-ray, other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (voicemail messages, postcards, or letter).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. (You must make a request in writing to obtain access to your health information

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Advance Practice Nurse
Consent for Treatment

This facility has on staff, an advance practice nurse to assist in the delivery of medical OB/GYN cares.

An advance practice nurse is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, an advance practice nurse may treat minor lacerations and other minor injuries.

I have read the above and herby consent to the services of an advance practice nurse for my health care needs.

I understand that at any time I can refuse to see the advance practice nurse and request to see a physician.

Signature: _____

Date: _____

Witness: _____