OB⚜GYN

ALBERT I. TYDINGS, M.D. CHEVIES W. NEWMAN, M.D.

Patient Name: _____ **Date of Birth:** _____

Marital Status: S / M / D / Other **AGE:** _____ **Social Security Number:** _____

Mailing Address: _____
Street Address/Post Office Box City State Zip Code

Home Phone Number: _____ **Cell** _____ **Email** _____

EMERGENCY CONTACT: _____
NAME PHONE RELATION TO PATIENT

Who is your Primary Care Physician? _____ **Phone** _____

Are you a student? Yes No Full Time Part Time **Other:** _____

Patient Employment Information: **Are you employed?** YES NO **Employment Status:** Full Time Part Time Other

Who is your employer? _____ **Phone** _____

ONLY COMPLETE THIS SECTION IF THE PATIENT IS UNDER THE AGE OF 18

Parent/Guardian Name: _____ **Phone** _____

Is the person listed above the custodial parent? YES NO **If not, who has custody?** _____

Custodial Parent Address: _____

Custodial Parent Phone Number: _____ **Employer:** _____

INSURANCE INFORMATION

Primary Insurance: _____ **Are you the policy holder?** YES NO

Policy Holder Name: _____ **DOB** _____ **SS#** _____
Relationship to Patient: _____

Secondary Insurance: _____ **Are you the policy holder?** YES NO

Policy Holder Name: _____ **DOB** _____ **SS#** _____
Relationship to Patient: _____

PATIENT SIGNATURE: _____ **DATE** _____

ASSIGNEMNT OF BENEFITS: I hereby assign all medical and/or surgical benefits to which I am entitles, including Medicare and other government sponsored programs, private insurance and any other health plans to Albert I. Tydings,MD and Chevies Newman, MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that if any Action in getting my account settles is taken, that I am responsible for ALL attorney fees. I hereby authorize said assignee to release all information necessary to secure payment.

OFFICE POLICY

Appointment Policy

You will receive an automated call to confirm your appointment. Please respond to the call. We will receive a report daily from our company stating if your phone line was busy, a message was left on voicemail, confirmed, phone was answered and no response was given, or if your line was busy. You will still be charged accordingly ($25) for NO SHOW appointments, and appointments that are cancelled with less than a 24 hour notice.

Reminders are a courtesy. All patients are responsible to keep up with their own appointments. If you need to cancel your appointment, please call us as soon as possible. If you have any problems that concern you throughout the day please make every effort to contact us during office hours.

Patient Information

You are responsible for keeping us informed of **new telephone numbers; address changes and insurance changes.** If you do not notify us of new insurance coverage at the time of your visit and we file a claim to your insurance company and it is denied, we will not refile the claim to the new insurance company. The bill will then become your responsibility to pay, and you may file a claim to your insurance to be reimbursed. If you have a primary care doctor assigned to you by Medicaid you need to make sure your referral is up to date when you come in for your visit. You will be expected to call and obtain the referral. You will not be seen without a referral.

Emergencies

If you have an emergency at night or during the weekend please contact Dr. Tydings before going to the ER. Please call the answering service at (985) 796-6174.

Cash Patients/Circumcision Fee

If you are not approved for Medicaid yet, and you are paying cash for a visit we will give you a receipt. You will then be able to file for Medicaid to reimburse you. For all patients regardless of insurance type, there is a fee for circumcision that is due before delivery. The fee MUST be paid in our office during regular business hours. The fee is $225.00. You can make a payment arrangement with our office to make small payments throughout your pregnancy. By the request of Lakeview and St. Tammany hospital, please choose a pediatrician by your 7th month of pregnancy, and pre-register for your delivery.

Medical Leave/FMLA Paperwork

If you will need paperwork completed for time off during or after your pregnancy or surgery, there is a $25 fee for each set of paperwork that must be completed. We require the fee to be paid before the paperwork is completed, and we ask for 7 days for completion.

Transferring Patients

In the event that you should transfer to another physician you are responsible for completing a Medical Release of Health Information form. We will need a 7 day notice to have your records transferred to another healthcare facility. There will be a fee for medical records requested by the patient, insurance company, attorney etc.

Test Results

We encourage patients to call Quest at the number that is provided to you on your clinical summary upon checkout to obtain results. If you results are abnormal we will attempt to call you. We will mail a notice if our attempt to contact you is unsuccessful.

Phone Calls and Prescriptions

Please understand that the nurses and our physicians are seeing patients all day. Please be courteous when we ask you to leave a message. It is in your best interest to give to give us the most information possible so that when the nurse or physician returns your call, we can have an answer or solution to your problem or concern.

_____ _____

Patient Signature **Date**

OB GYN

ALBERT I. TYDINGS, M.D. CHEVIES W. NEWMAN, M.D.

121 Lakeview Circle, Suite C
Covington, LA 70433
Phone (985) 892-1111
Fax (985) 892-1116

ACKNOWLEDGMENT FORM

I have been provided a copy of the Notice of Privacy Practices and I am aware of how my medical information will be used and/or disclosed.

Print Name: _____

Signature: _____

Date: _____

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PATIENT AUTHORIZATION

As required by the Health Information Portability and Accountability Act of 1996, Albert I. Tydings, MD, APMC and Chevies W. Newman, MD may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the disclosure and/or use described herein. You may revoke this authorization at any time.

The privacy of your medical information is important to us. We understand that your medical information is person, and we are committed to protecting it. We create a record of the care and services that you receive at our organization. We need this record to provide you with quality care and to comply with all legal requirements.

We may use or disclose your medical information to:

- Staff members, other doctors, nurses, technicians, laboratory corporations or other health care providers via mail, telephone and electronic systems.
- For payment purposes to collection agencies and insurance companies via mail, telephone and electronic systems.
- Family members and/or care givers.
- Funeral directors, coroner, medical examiner and/or clergy.
- Government agencies.
- Court orders, judicial administrative proceedings.
- Public health, legal authorities, and/or abuse agencies.
- Workers Compensation.
- Law Enforcement officials required by law.
- Health plan organization.
- Pharmacies and/or pharmaceutical companies.

I, _____, (**print name**) hereby authorize the use and/or disclosure of the health information that pertains to me. I understand that information disclosed pursuant to the authorization may be re-disclosed to additional parties. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of m y health information. I have been provided a copy of the Notice of Privacy Practices and I am aware of how my medical information will be use and/or disclosed.

Patient Signature: _____ **Date:** _____

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APPOINTMENT CANCELLATION POLICY

To better accommodate our patients, we ask that you give our office a minimum of a 24 hour notice for all appointment cancellations. Cancellations that do not meet this criteria are subject to a $25 fee. Thank you in advance for your cooperation in this matter.

By signing this form, I am acknowledging that I have read and understand the office *No Show* policy.

Patient Signature: _____

Print Name: _____ **Date:** _____

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Authorization To Disclose Medical Information

Patient Name: _____

Birth Date: _____ Social Security Number: _____

Medical Information From: Release to:

I request and authorize the above named healthcare provider to disclose the medical information specified below to the organization, agency, or individual name on this request.

INFORMATION REQUESTED:

Date of service: _____

Information to be disclosed: _____

Purpose of disclosure : _____

I understand that the information to be disclosed may include information regarding the following conditions:

( ) Drug and/or alcohol abuse (Protected by State/Federal Law)
( ) AIDS (Protected by State Law)
( ) Psychological or psychiatric conditions (Protected by State Law)

Authorization: I certify that this request is made voluntarily and that the information given is accurate and to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on it. This authorization will expire in _____ days unless revoked at an earlier time.
Re-disclosure of my medical information by those I hereby authorize to receive the above specifications information should not be made without my further written consent. I agree that the healthcare provider is not responsible for the misuse, and cannot guarantee the confidentiality of medical information once it is released to another party. I hereby release the healthcare provider from any liability, which may results from furnishing the information requested as authorized. A copy or fax of this authorization will be as valid as the original.

SIGNATURE: _____ DATE: _____
(Patient, Parent/Guardian if patient is a minor)

RELATIONSHIP (if other than patient) _____

WITNESS: _____ DATE: _____

FEDERAL PROHIBITION ON RE-DISCLOSURE: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization of the release of medical or other information is NOT SUFFICIENT FOR THIS PURPOSE. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HEALTH HISTORY UPDATE

PATIENT NAME: _____ **DOB:**_____

Please list any and all ongoing, chronic medical problems you are being treated for.

(please be as thorough as possible)

1. _____ 2._____

3. _____ 4._____

Past Medical History *(Have you ever had?)*

__Abnormal PAP Smear
__Asthma or other lung disease
__Breast lumps / nipple discharge
__Chronic Urinary tract infections
__Depression, anorexia or bulimia
__Diabetes
__DVT or phlebitis
__Elevated cholesterol
__Genital warts / HPV
__Chlamydia / Trichomonas
__Heart disease
__Hepatitis A, B or C
__High blood pressure
__Liver or gallbladder disease
__Migraines or other type of headaches
__Mitral Valve Prolapse
__Pathologic ovarian cysts
__Psychiatric disorder
__Seizures or other neurologic disorders
__Sicle cell, thalassemia
__Stroke
__Condyloma, Herpes, PID, Gonorrhea
__Thyroid Disorder
__Uterine fibroids
__Vision or hearing problems
__OTHER:
_____

Gynecologic/Obstetric History

WHAT FORM OF BIRTH CONTROL ARE YOU CURRENTLY USING? _____

Age when periods began: _____
Period comes every ____ days and lasts ____ days
Date of your last PAP exam: _____
Where: _____
Date of your last Colonoscopy: _____

Has there been a change in your periods recently? Y N
Are you sexually active? Yes No
Date of your last Mammogram: _____
Date of your last DEXA scan: _____

Have you ever been pregnant? Yes No

<u>Total</u> number of Pregnancies: _____

How many were full term? _____ Premature _____ Miscarriages ____ Stillbirths _____ Ectopic Preg. _____ Abortions _____

Date of Delivery	Weeks	Length of Labor	Birth Weight	Sex	Delivery Type	Anesthesia: (Epidural Or Spinal etc.)	Hospital	Complications (If any)

Please list the pharmacy in which you would like us to ELECTRONICALLY send your prescriptions to:

Pharmacy Name : _____ Pharmacy #: _____

Pharmacy Address/Location: _____

Family History

Please list any past or present health issues with your family members listed below

Mother Alive/Deceased _____ Father Alive/Deceased _____

Maternal Grandmother Alive/Deceased _____ Paternal Grandmother Alive/Deceased _____

Maternal Grandfather Alive/Deceased _____ Paternal Grandfather Alive/Deceased _____

Social History

Do you smoke? YES / NO / FORMER
Do you drink Caffeine? Yes No
Do you drink alcohol? Yes No
Do you use Marijuana or other recreational drugs? Yes No

How many cigarettes per day? ____ For how long? _____
How many caffeinated drinks per day? ____ Week? _____
How many alcoholic drinks per day? ___ Week? _____
If so, please specify: _____

Surgeries

Please list ALL surgeries you have had with dates (month/year)

_____ _____

_____ _____

_____ _____

Allergies

Please list all allergies you have to MEDICATIONS with reactions. **Are you allergic to LATEX? Allergic Sensitive**

_____ _____

_____ _____

_____ _____

Medications

Please list all medications (prescriptions, over the counter & supplements) that you are currently taking, including dosages and frequency.

1. _____ Dose:_____ Frequency: _____
2. _____ Dose: _____ Frequency: _____
3. _____ Dose: _____ Frequency: _____
4. _____ Dose: _____ Frequency: _____
5. _____ Dose: _____ Frequency: _____
6. _____ Dose: _____ Frequency: _____

PATIENT'S SIGNATURE: _____ **DATE:** _____