REGISTRATION

PLEASE PRINT -- **BLACK** INK ONLY

Northeast Texas Women's Health, P.A.

CHRISTOPHER N. MASON, MD
MELISSA S. SLOVAK-TUCKER, MD
MARTHA DEMING, RN, MSN, CNM
2001 N. JEFFERSON, SUITE 220
MT. PLEASANT, TX 75455
(903)572-4664

PATIENT INFORMATION

NAME _____ SOCIAL SECURITY _____
LAST NAME FIRST NAME INITIAL

BIRTHDATE _____ MARITAL STATUS S / M / D / W RACE: _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME ADDRESS (IF DIFFERENT) _____
STREET NUMBER CITY STATE ZIP

HOME PHONE ( ) _____ ALTERNATE PHONE ( ) _____

FAX ( ) _____ EMAIL _____

PATIENT EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

HOME PHONE ( ) ALTERNATE PHONE ( )

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT _____
LAST NAME FIRST NAME INITIAL

RELATIONSHIP TO PATIENT _____ BIRTHDATE _____

SOCIAL SECURITY _____ PHONE ( ) _____

ADDRESS (if different from patient's) _____

CITY _____ STATE _____ ZIP _____

PERSON RESPONSIBLE EMPLOYED BY _____ OCCUPATION _____

INSURANCE COMPANY _____

GROUP # POLICY # CO-PAY $

ADDITIONAL INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT _____
LAST NAME FIRST NAME INITIAL

RELATIONSHIP TO PATIENT _____ BIRTHDATE _____

SOCIAL SECURITY _____ PHONE ( ) _____

ADDRESS (if different from patient's) _____

CITY _____ STATE _____ ZIP _____

PERSON RESPONSIBLE EMPLOYED BY _____ OCCUPATION _____

INSURANCE COMPANY _____

GROUP # _____ POLICY # _____ CO-PAY $ _____

We check insurance eligibility and medication history electronically, as needed, on our patients. Please notify us in writing if you do not wish for this to be done.

_____
Patient Signature

_____
DATE

Informed Consent for Collaborative Care
at
Northeast Texas Women's Health, P.A.

This practice provides care for women for obstetrical and gynecological services. We currently have two board-certified OB/GYN physicians and a certified nurse midwife. To provide improved access and quality of care, you, as the patient, have the right to choose to establish care with either a physician or midwife.

A certified nurse midwife is a registered nurse that has received a master's degree and furthered their education in the fields of obstetrics and gynecology. They have been certified as an advanced practice nurse by the Texas Board of Nurse Examiners. They meet the requirements and are recognized by the American College of Nurse-Midwives. They are required to maintain a current license and to engage in required continuing medical education. They practice independently with the supervision of a qualified physician. They practice within certain guidelines based on experience and scope of practice.

If you choose a midwife for your care, you will receive the same level of care within the scope of midwifery practice as you would a physician in our clinic. This office has developed practice guidelines for the care of our patients. Both physicians and midwives practice by these guidelines. If you develop a problem outside the scope of the midwife's practice, you will be referred for consultation to one of the OB/GYN physicians in this office. In the event that your situation remains beyond the scope of the midwife's practice, your complete care will be transferred to a physician.

If you choose to establish care with a physician, your healthcare will be provided by that physician. However, there may be times that you will see another physician from this practice or the midwife. This may occur secondary to emergencies or scheduling problems. If your care is provided by this midwife, you are assured that the midwife is acting under guidelines approved by this clinic and accepted standards of care. However, it is your right to request to see a physician. This request may involve being rescheduled to a different time or day.

The availability of both physician and midwife providers in this clinic is intended to enhance the level of care for our patients. We look forward to serving your healthcare needs. Please sign below indicating that you understand your choices as explained above.

_____ _____

Signature of Patient Date

Patient Name _____ **Date of Birth** _____

NORTHEAST TEXAS WOMEN'S HEALTH, PA FINANCIAL POLICY

Thank you for choosing us as your women's health care provider. We are committed to providing you with the best possible medical care. Please understand payment of your bill is considered a part of your treatment. The following information is provided to avoid any misunderstanding or disagreement concerning payment for services provided by our office.

1. Our office participates with a variety of insurance plans. It is your responsibility to:
   - Bring your current insurance card to every visit and notify us of changes in coverage.
   - We will submit a claim to your insurance company for you. Balances not paid, per our contract by your primary insurance company may be billed to your secondary payer. A monthly statement will be sent to you. ***Ultimately*** you are responsible for payment of charges.
   - Be prepared to pay your co-pay at each visit. Payment can be made by cash, check, Mastercard, Visa, American Express, or Discover.
2. If you do not have insurance coverage or if you are insured by a company with which we are not contracted, payment in full is expected at time of service unless payment arrangements are made and kept.
3. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however should be directed to your insurance company member services department (number should be on your insurance card)
4. This office charges for all services that are significant and separately identifiable. Patients that are seen for physical exams and require other treatments for illnesses or problems may be charged separately for each service even when both services are provided on the same day.
5. This office can only code and file a claim for a patient's visit with a diagnosis that was encountered and documented in the medical record. To request a diagnosis change solely for the purpose of securing reimbursement from the insurance carrier is inappropriate and could be considered a fraudulent act.
6. All balances billed are due within 30 days of the statement date. Unpaid balances greater than 30 days are subject to our collection process. Accounts sent to our collection agency are subject to a collection charge of $50.00 for balances up to $150.00 and for balances of $150.01 and higher the fee is 35% of the outstanding balance.
7. Co-pays not paid at time of service may result in a processing fee.
8. There is a $25.00 fee on all returned checks.

Patient/Guardian's Initials _____

9. Yearly well woman exams may or may not be covered under your health insurance policy, however, they may be required by your physician. Some forms will not be filled out and/or signed if physicals are not up to date.
10. If you miss or no show for three (3) appointments you may be dismissed from the practice.
11. **MINORS** – For all services rendered to patients under 18 years old, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

By signing below, I certify that I will pay Northeast Texas Women's Health, PA, any co-payments, co-insurance, deductibles or non-covered services. I will immediately pay to Northeast Texas Women's Health, PA, any payments that I receive from my insurance company for services provided to me or my dependents. I will also be responsible for any amounts not paid by insurance because I have not provided the appropriate insurance information for billing.

I understand and agree that if my account is delinquent, Northeast Texas Women's Health, PA may deny me or my dependent, as named below, further supplies and services or may require that I pay for supplies and services at the time of the visit.

I certify that the information I have provided is a true and complete statement according to my best knowledge and belief, and that a full explanation of services and charges has been given to me. I understand that if given false information, withhold information or fail to report changes promptly, I will be breaking the law and can be prosecuted and/or have services discontinued.

_____ _____

PRINT PATIENT'S NAME DATE

_____

SIGNATURE OF PATIENT OR GUARDIAN

_____

WITNESS

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Northeast Texas Women's Health, PA for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Northeast Texas Women's Health to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Northeast Texas Women's Health on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Northeast Texas
Women's Health, P.A.

2001 N Jefferson, Suite 220
Mount Pleasant, TX 75455
903-572-4664

HIPAA ACCESS FORM FOR PROTECTED HEALTH INFORMATION

I understand that it is the policy of Northeast Texas Women's Health, PA to restrict access to my Protected Health Information. In addition to the caregiver(s) providing health services, and my insurance company(ies) for payment claim, I would like for the following person/people to have my Private Health Information:

NAMES (Please Print)	DOB	All or Restricted*
1. **Myself (Patient or Legal Guardian)**		
2.		
3.		
4.		
5.		

*Clinical Information Restricted – Please specify any clinical information you **DO NOT** wish to share with the person(s) listed above:

_____

_____

_____

_____

_____ _____ _____

Patient/Guardian Signature Date Witness Signature

NOTE: State law permits both parents to have access to PHI unless we are provided a court order restricting the right.

Northeast Texas Women's Health, P.A.

Northeast Texas Women's Health, P.A.
2001 N. Jefferson Suite 220
Mount Pleasant, Texas 75455
Phone (903) 572-4664 Fax (903) 572-4647

Patient Informed Consent for Use of Patient Portal

Northeast Texas Women's Health is now offering a patient portal as a secure, HIPPA compliant tool as a courtesy to our patients. It is an optional service and we reserve the right to suspend or terminate it at any time. We will you to any changes as promptly as possible. This form is intended to inform you of the facts and risks surrounding the use of the use of the web portal. By signing below, you confirm that you have read, understand, and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold the clinic or any of its staff liable for network infractions beyond their control.

Privacy and Security

The web portal has a secure connection with our clinic that uses encryption to keep unauthorized persons from being able to access and read your health information or your communications with us. To help us insure the tunnel remains secure, we need to have your current email address and be informed if it changes. Keep your portal user ID and password secure so that only you, or someone authorized by you, can gain access to patient information. If you think someone has learned your password, immediately go to the portal and change it.

Your email address is confidential and protected information. We will never share this information with any third party.

All access to our internal network and electronic medical record (EMR) is password protected. Our staff is instructed to logoff their workstations when not present. In addition, in compliance with HIPAA guidelines, our EMR automatically logs the user out after a period of inactivity.

The portal may be used for patient forms, medication management, appointment reminders and requests, communications with staff, and other features as needed. Similar to phone communications, messages may be read and addressed by different staff at different times throughout the day. These messages will be answered as quickly as possible. In an urgent or emergent situation, direct contact to the clinic is still the preferred option.

Confidential email, please print clearly:_____

Patient Name:_____ Date of Birth:_____

Responsible party if different than patient:_____

Signature:_____ Date:_____

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How to Use Our Patient Portal

Initial Set Up:

1. Request access from our office.
2. Review and sign the Portal Activation Consent Form
3. You will then receive a welcome email, from which you can log into the portal.
4. Once logged into the portal, click the "My Account" button on the top right. Here you can change your username and password to something only you will know. This is essential to ensure security and privacy!
5. You are now set up to use the portal!

Available Components:

1. *Messages:* This component allows you to send and receive secure email to/from our staff. When you receive a message from our office, you will receive an email asking you to log into the portal and retrieve it. You may also send messages to our staff:
   - **a.** Melissa Mason - Billing/Surgery Scheduling/Financial Issues
   - **b.** Teresa White, RN – Patient care issues/results for Dr. Mason and Martha's patients
   - **c.** Margaret Taylor, RN – Patient care issues/results for Dr. Slovak
   - **d.** Alyssa, Azeneth, or Azucena(Suzy) – Scheduling or Demographic questions
   - **e.** Christopher Mason, MD, FACOG – Specific medical questions or surgery
   - **f.** Melissa Slovak-Tucker, MD, FACOG – Specific medical questions or surgery
   - **g.** Martha Deming, RN, MSN, CNM – Specific medical questions

2. *Lab/test Results*: Here you can receive copies of labs/test ordered by our office.

3. *Health Summary*: This section allows you to view parts of your electronic medical record we have on file. The information in this section is information which has been provided by you, mostly based upon forms you filled out on your first visit. You can comment or request changes to the information, once approved by a staff member those changes will be reflected online.

4. *Medications*: Here you can see your current and past medications written by our office or entered by our staff. Medications which do not list a physician are ones not prescribed by our office, but are ones you told us you are taking. You can request refills of medications we prescribed by clicking on the medications and then clicking Request Refill on the left. Be sure to include your pharmacy information. We will review your request and notify you when approved.

5. *Appointments*: In this section, you can view upcoming appointments. You will receive a reminder message when an appointment is close. You may request a wait list appointment to try and get in sooner if desired.
   Our Patient Portal site is: **www.gotomyclinic.com/netwh**

NORTHEAST TEXAS WOMEN'S HEALTH, PA
2001 N. Jefferson, Suite 220
Mount Pleasant, TX 75455
903-572-4664

NAME: _____ DATE OF BIRTH: _____

FAMILY MEDICAL HISTORY

CONDITION	RELATION
Diabetes	_____
Heart problems	_____
High blood pressure	_____
Clotting disorders	_____
Birth Defects	_____
Cancer	_____
Other	_____

SOCIAL HISTORY

Marital status S / M / D / W / Other _____

Hobbies: _____

Do you exercise? Y / N

Type: _____

Frequency: _____

Are you currently dieting? Y / N

Have you ever used tobacco products? Y / N

Do you still use tobacco products? Y / N

Type: Cigarettes Cigars Smokeless

Frequency: _____

Do you drink alcohol? Y / N

Frequency: _____

Do you, or have you, ever used illicit drugs? Y / N

Frequency: _____

Are you taking any herbal supplements? Y / N

NORTHEAST TEXAS WOMEN'S HEALTH, PA
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903-572-4664

NAME: _____ DATE OF BIRTH: _____

MEDICATIONS

Please list any of the medications that you are currently taking:

_____

_____

Are you allergic to any medications? YES NO

If YES, please list medication(s) and reaction(s):

_____

_____

_____

PAST MEDICAL HISTORY

Please list any conditions or illnesses you have had in the past:

_____

_____

_____

Please list any procedures or surgeries you have had in the past:

_____

_____

_____

OB/GYN HISTORY

Date of last pap smear: _____

Age period started: _____

Date of last menstrual period: _____

Number of Pregnancies: _____

Number of children: _____

Number of miscarriages: _____

Number of Abortions: _____

Date of last mammogram: _____

Age at menopause: _____

Any menstrual problems? Y / N

Any pregnancy problems? Y / N

PRENATAL SCREENING

A wide range of test are now available to help plan and monitor your care/needs during pregnancy. Listed below are explanations of the screening tests that are usually performed on OB patients. There is no risk to you or your baby since they only require a blood sample be taken from your arm, urine collection, or pelvic (inside the vagina) examination.

CBC: Blood level to look for anemia or infection.
BLOOD TYPE/Rh: Some blood types can affect the baby and require special testing.
RUBELLA TITER: German measles a major cause of birth defects. This tells if you are protected against German measles.
SEXUALLY TRANSMITTED DISEASE (STD):

VDRL: Blood test for syphilis

HIV Screen: This test checks for a chemical in the body that appears if your body has been exposed to the AIDS virus. Rarely, this test may be positive if you have not been exposed to the AIDS virus (false positive). Further testing is done on all positive tests to tell if you have been exposed.

GC Culture: Test for Gonorrhea

Chlamydia Culture: Test for Chlamydia

GLUCOLA: This test for diabetes (blood sugar) is necessary because diabetes in pregnancy may be dangerous to the baby. This test is usually performed at 26-30 weeks, or about the 6th or 7th month.
URINE EVALUATION: A variety of tests are performed initially and throughout the pregnancy as indicated:

Urinalysis: Assess for excess protein or sugar in the urine

Culture & Sensitivity: Assess for possible urinary tract infection

Drug Screen: Assess for presence of drugs

PAP SMEAR: Test for cancer of the cervix (mouth of the womb)

OTHER PRENATAL TESTS/EVALUATIONS WHICH MAY BE USED

ULTRASOUND: Sound waves can be used to take a picture of the baby. This test is used to tell how far along in pregnancy you are. It is also used to find problems in the pregnancy such as twins, to understand vaginal bleeding, and to identify some birth defects. Ultrasounds are not done on all patients.
GENETIC COUNSELING: Genetic counseling and/or amniocentesis may be offered as specialized tests for you if you are found to have increased risk for certain problems. The doctor will discuss these with you. If you have any questions or concerns, discuss them with the doctor.
MATERNAL SERUM ALPHA FETOPROTEIN (MSAFP): Checks the level of a chemical in the mother's blood. High or low levels indicate an increased risk for the baby to have certain abnormalities such as spina bifida (hole in the spine) or Down Syndrome (mongoloid). This will be performed at 16 weeks from your last menstrual period.
Prenatal screening for neural tube defects such as spina bifida and Down Syndrome are available to women during the 15th to 19th weeks of pregnancy. Results of the mother's blood test can help identify women who should be offered additional special testing such as ultrasound and/or amniocentesis.
1: YOU MAY DECLINE ANY OF THESE TESTS.
2: THE REASON FOR THESE TESTS WILL BE FURTHER EXPLAINED.
3: HOW YOUR PREGNANCY WILL BE FOLLOWED AND MANAGED IF YOU DO NOT HAVE THESE TESTS WILL ALSO BE EXPLAINED

Patient's Signature _____ Date: _____

Reviewed By Ob Nurse _____ Date: _____

Reviewed by Physician _____ Date: _____

CYSTIC FIBROSIS CARRIER TESTING

What is cystic fibrosis (CF)?

Cystic fibrosis is a life-long illness that causes problems with breathing and digestion. A child with CF has normal intelligence and does not look different than other children.

Cystic fibrosis is a disorder that runs in families, but can occur in a child even if no other family members seem to have CF.

What are some of the health needs of children with CF?

Breathing (pulmonary) and digestion (gastrointestinal-GI) problems are the main complications of CF. All children with CF have some degree of breathing problems, although not all have major GI problems. The severity of the problems cannot be predicted by testing or by the severity in the other family members.

A variety of medications can be used at home to help a child with CF breath better and be able to digest food. Despite these treatments, complications such as lung infections can still develop. These infections are sometimes best treated in the hospital rather than at home. These treatments and occasional hospital stays obviously also affect other family members, not just the child with CF.

Eventually, some children with CF are best treated with lung and/or liver transplants.

Males, but not females, may also have infertility because of CF.

What is the purpose of CF carrier testing?

The purpose of CF carrier testing is to estimate the risk for giving birth to a child with CF. Testing must be done if you want to know about the risk for CF in your child before it is born.

Could I be a carrier for cystic fibrosis?

Cystic fibrosis develops in a child when it inherits abnormal CF genes from both parents. If a person inherits only one abnormal gene, he/she is a carrier for CF. A carrier does not get ill with CF but can give the abnormal CF gene to an unborn child.

The chance of being a carrier for CF is different in different groups of people. About 3% of Caucasians are carries for CF. If your ethnic background is not Caucasian, your chance of being a CF carrier is less. The chance of being a CF carrier is about 2% for African-Americans, and about 1.5% for Hispanic-Americans.

If neither parent, or only one parent is a CF carrier, it is still possible to have a child with CF, but the chance is very small.

What is the procedure for CF carrier testing?

Both parents must have blood drawn to find out if they are CF carriers. The blood should be drawn before 14 weeks of pregnancy to allow time for additional testing if it is needed.

If both parents are CF carriers, then each of their children has a 25% chance of having CF. Their unborn baby can be tested in the first half of pregnancy by an amniocentesis. At an amniocentesis, a needle is used to get some of the fluid from around the baby in the mother's uterus. Amniocentesis has a small risk of miscarriage (0.5%).

Things you may want to consider when deciding whether to have a CF carrier testing:

Do I have a family history of Cystic Fibrosis?	☐ YES	☐ NO
Am I a member of a higher risk ethnic group?	☐ YES	☐ NO
Would I want to have an amniocentesis if the carrier test is abnormal in me and my partner?	☐ YES	☐ NO
Knowing there is no cure, would I consider termination based on CF carrier results?	☐ YES	☐NO
Will my insurance pay for the testing?	☐ YES	☐ NO
I want CF carrier testing	☐YES	☐NO

Patient's Signature Date

Physician's Signature Date

Northeast Texas
Women's Health, P.A.

RELEASE OF PRENATAL RECORDS

In order to provide you with the utmost quality of prenatal care, we routinely send your prenatal records to facilities which will be treating you for this pregnancy. These facilities include TRMC Labor & Delivery and other physicians who may need to treat you during this time. Please consent to sending of your medical records, which include HIV/AIDS testing results.

I consent to the release of my medical records, which include results of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS.

_____ _____

Patient Signature Date

_____

Printed Name

Informed Consent for Collaborative Care
at
Northeast Texas Women's Health, PA

We currently have two board-certified OB/GYN physicians – Dr. Christopher Mason and Dr. Melissa Slovak-Tucker – and a Certified Nurse Midwife, Martha Deming. You may choose with which provider you would like to establish your prenatal care, and we will try our best to accommodate your choice. However, be aware that some providers have a limit on the number of monthly deliveries, and may not be available. Be assured that you will be provided with the same excellent healthcare with all of our providers.

Please be aware that due to emergencies or scheduling conflicts, there may be a possibility that the provider that you have chosen for your prenatal care may not be the provider that will deliver you.

Please do not hesitate to speak to the Office Manager regarding any issues that you may have.

By signing below, you acknowledge that you have read, understood, and agreed to our policy regarding provider coverage.

_____ _____

Signature of Patient Date

Acknowledgement of Receipt
Texas Department of Health
Postpartum Depression Resources

By signing this form, I hereby acknowledge that my physician has provided me with the resource information on postpartum depression that is required by the State of Texas. If I have any questions about these resources, I will feel free to ask my physician about them or contact the resources listed for more information.

Date:_____

Signature:_____

Printed Name:_____