KATY WOMEN'S CARE

Dear _____

This is a reminder that you have an appointment with us on _____ at _____.

Please complete the attached documentation before your appointment or plan to arrive 15 minutes before your appointment to fill out. This is to help kept your wait to a minimum. **Failure to complete or allow appropriate time might result in rescheduling your appointment.** Please be certain to bring your insurance card and driver's license or other form of identification with you.

Your appointment is scheduled with: □Dr. Lin □Dr. Cleveland □Dr. Sanders □Dr. Liu □Laura Bankhead FNP

For: □Well Women Exam □Annual Physical □Ob Follow up □Gyn problem □Problem visit □Sick visit □Education/Counseling

The location for your appointment is: 23920 Katy Freeway, Suite #330 Building # 1 Third floor

Our physicians might be called away to labor and delivery with little to no notice. We do try to accommodate for this the best that we can. You might have an unexpected wait time or we try to get you seen by one of our other providers. We apologize in advance if this happens at your visit.

If for some reason you realize that you will be late for your appointment, please notify us as soon as possible. Potentially, your appointment may need to be rescheduled due to the number of patients being seen that day.

To avoid an additional charge or $25, please contact our office 24 hours in advance if you might cancel or reschedule your appointment.

The new parking garage has been completed and is in use. However, due to ongoing construction we urge you to arrive 30 minutes before you appointment time. Recently, appointments have needed to be rescheduled due to this situation.

Golf cart shuttles are provided to transfer patients from the parking lot next to Dick's Sporting Good/Golf Galaxy to the office building (Ask for Building #1).

If you have any questions or concerns, please feel free to call us at (281)392-2266.

Sincerely,

Katy Women's Care

Katy Women's Care

Printed Patient Name: _____

Patient Intake

Reason for Appointment

_____

Please list any allergies to medication, foods, dyes, latex AND type of reaction.

MEDICATION	REACTION

Please list any medication or supplements you are currently taking. Please note if medication is injection or infusion.

Medication	Dosage	How often are you taking

Pharmacy:_____ Pharmacy Phone:_____

Pharmacy Address:_____

(Street) (City) (Zip code)

Printed Patient Name: _____

Medical History

Have you ever had any of the following?

Anemia	□ Yes □No	Hyperlipidemia (elevated cholesterol)	□ Yes □No
Anxiety	□ Yes □No	High Blood pressure	□ Yes □No
Arthritis	□ Yes □No	Hepatitis	□ Yes □No
Asthma	□ Yes □No	Hypothyroidism	□ Yes □No
Abnormal Heart Rhythms Please list :_____	□ Yes □No	Irritable Bowel Disease Crohns_____ Ulcerative colitis_____	□ Yes □No
Bleeding disorders Please list:_____	□ Yes □No	Irritable Bowel Syndrome	□ Yes □No
Benign Prostatic Hyperplasia	□ Yes □No	Kidney disease Please list: _____	□ Yes □No
Coronary Artery Disease	□ Yes □No	Menopause	□ Yes □No
Congestive Heart Failure	□ Yes □No	Migraines/Headaches	□ Yes □No
Cancer Please list:_____	□ Yes □No	Myocardial Infarction (Heart attack)	□ Yes □No
COPD Chronic Bronchitis _____ Emphysema _____	□ Yes □No	Neuropathy	□ Yes □No
Cardiac Arrest	□ Yes □No	Osteoporosis	□ Yes □No
Celiac Disease	□ Yes □No	Osteopenia	□ Yes □No
Constipation (chronic)	□ Yes □No	Pulmonary Embolism	□ Yes □No
Depression	□ Yes □No	Psychiatric disorders Please list: _____	□ Yes □No
Diabetes Type 1 _____ Type 2 _____ Pre-diabetes_____	□ Yes □No	Non-alcoholic fatty liver disease Seizure disorder	□ Yes □No □ Yes □No
Diverticulitis/ Diverticulosis	□ Yes □No	Stomach ulcers	□ Yes □No
Drug abuse	□ Yes □No	Stroke	□ Yes □No
Alcohol abuse	□ Yes □No	TIA (mini stroke)	□ Yes □No
Fibromyalgia	□ Yes □No	Tuberculosis	□ Yes □No
GERD	□ Yes □No	Tremors	□ Yes □No
HIV/AIDS	□ Yes □No		

Please list any procedures or surgeries with year:

_____

_____

_____

_____

_____

Please list any other medical conditions that were not previously listed:

Printed Patient Name: _____

Family History

Problem	Yes	No	Relationship (please indicate maternal/paternal)
Breast Cancer			
Cervical Cancer			
Ovarian Cancer			
Uterine Cancer			
Lung Cancer			
Colon Cancer			
Other Cancer			
High blood pressure			
High cholesterol			
Heart disease			
Diabetes			
Kidney disease			
Psychiatric disease			
Other			

Printed Patient Name: _____

Immunization

Immunization	Date(s)
Flu	
Gardisil	
Covid	
Shingles	
Pneumonia	
Tdap	

Preventative Screenings

Screening	Never	Normal	Abnormal (please explain)	Year
PAP smear				
Mammogram				
Colonoscopy				
Cologuard				
PSA				
Bone Density				
Low dose CT Chest				

Social History

Do you exercise? □Yes □No
How often? □Daily □4-5 times a week □3-2 times week □Once a week

Do you drink caffeine? □Yes □No
How many cups per day?_____

Do you smoke cigarettes?
□ Yes How many a day?_____
□ Never smoked □ Former smoker □ Occasional smoker

What is your highest level of education you have completed?
□Some school □High School □GED □College □Graduate School

How would you rate your diet?
□Healthy □Average □Poor

Do you currently consume alcohol? □ Yes □No
How many drinks a week? _____

Do you currently use any recreational or street drugs?
□Marijuana □Cocaine □Crack □Fentanyl □Heroin □PCP □Opium □Methamphetamine □Ecstasy □Benzodiazepines □Norco/Vicodin

Occupation:_____

Printed Patient Name: _____

Obstetric History

Total number of pregnancies	
Full term deliveries	
Pre-term deliveries	
Miscarriages	
Abortions	
Vaginal Births	
Caesarian sections	
Living Children	
List any pregnancy complications _____ _____ _____ _____	

Any additional information you like your provider to know?

_____
_____
_____
_____
_____
_____

Gynecological History

Last Menstrual Period	
Age of First Menses	
Interval (days) between menses	
Date of last PAP	
Any abnormal PAP	
Are you sexually active	Yes No
Current type of contraception/protection	

Have you ever had?	Yes	No	Year
Painful periods			
Irregular bleeding			
Breakthrough bleeding between periods			
Abnormal mammogram			
Abnormal pap			
Surgery of cervix			
Infertility			
Abnormal shape of uterus			
Exposure to DES prior to your birth			
Tubal (ectopic) pregnancy			
Endometriosis			
Chlamydia			
Gonorrhea			
Genital Warts			
Infection in tubes			
Syphilis			
Are you in a sexual relationship now?			
Have you experienced a change in sex drive?			
Have you had a new sex partner(s) in last year?			
Have you had exposure to bisexual partner?			
Have you ever been HIV positive?			

Printed Patient Name: _____

MyRisk

Hereditary Cancer Test

Patient Name: _____

Check the boxes below based on your personal and family history of cancer. Leave blank what you do not know.

Do you have a personal history of:	
Breast, ovarian, colon, rectal, or pancreatic cancer at any age?	□ Yes □No
Uterine cancer at age 64 or younger	□Yes □No
Has any blood relative (parent, sibling, half-sibling, child, grandparent, grandchild, aunt/uncle, niece/nephew) been diagnosed with:	
Breast cancer at the age of 50 or younger?	□Yes □No
Ovarian cancer at any age?	□Yes □No
Ashkenazi Jewish ancestry with breast cancer in one relative at any age?	□Yes □No
Has a parent, sibling, or child been diagnosed with:	
Pancreatic cancer at any age?	□Yes □No
Colon or rectal cancer at age 49 or younger?	□Yes □No
Endometrial cancer at age 49 or younger?	□Yes □No
If you answered "Yes" to any of the questions above, show this card to your healthcare provider today and ask to discuss hereditary cancer testing.	

Printed Patient Name: _____

Katy Women's Care

Katy Women's Care, P.A.
23920 Katy Freeway, Suite #330
Katy, Texas 77494
281-392-2266
www.katywomens.com

Patient Registration

TODAY'S DATE: _____

FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____ AGE: _____ ETHNICITY/RACE: _____ WEIGHT:_____ HEIGHT:_____

Home Address_____

City: _____ State:_____ Zip:_____

Email: _____

Sex: □Male □Female Phone Number: _____ (Home) _____ (Cell)

PRIMARY LANGUAGE: □ENGLISH □SPANISH □MANDARIN □HINDI □VIETNAMESE

MARITAL STATUS: □Single □Married □Divorced □Separated □Widowed

ETHNICITY: □White □Black/African American □Hispanic/Latino □Asian □American Indian/Alaska Native

How did you hear about us? □Personal reference □Internet □Referred by another physician

Referred by:_____

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship: _____Home Phone: _____ Mobile Phone: _____

INSURANCE INORMATION

Insurance Company: _____Insurance phone number: _____

Cardholder's name/Insured: _____ Cardholder date of birth: _____

Relationship: _____ Policy#: _____ Group#: _____

Printed Patient Name: _____

Release of Information

List the name of up to two people with whom your provider may discuss your health information. This person will need to know your date of birth to access your information.

□ None

1. _____ 2. _____

Name of your Primary care Provider: _____ Phone: _____

Address: _____

Authorization to pay benefits to provider: I hereby authorize payment directly to the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.	_____ Signature (Patient or Parent if Minor) Date
Authorization to release information: I hereby authorize the provider to release any information acquired in the course of my treatment necessary to process insurance claims	_____ Signature (Patient or Parent if Minor) Date

Printed Patient Name: _____

Welcome to your Well Woman Appointment

We would like to welcome you to Katy Women's Care for your well woman appointment. Since the passage of the healthcare legislation, most insurance companies will cover preventative care (annual well woman visits) at 100%. However, insurance companies will not cover all gynecologic issues (problems) at 100%. If during your well woman visit you end up being treated for something other than preventative care, you will be charged for an additional visit and your co-pay/coinsurance may apply.

Since ASCCP has routinely changed guidelines about how often a pap smear is needed, some insurance companies will not pay for the Pap smear lab every year. The provider will discuss with you how often a pap smear is needed in your individual case. You may choose to still have a pap smear performed outside of the guidelines, but paying for the Pap smear lab may be your responsibility. The cost for that lab varies with the type of Pap smear ordered.

Medicare Advantage Patients:

Your insurance will follow the regular Medicare guidelines for your Well Woman Exam. Currently, the guidelines will only cover a Well Woman Exam every other year. If you choose to be seen in the off year, you will be responsible for the charges.

By signing below, I acknowledge that I have read and understand the above.

_____ _____

Patient Signature Date

Printed Patient Name: _____

Katy Women's Care

Patient Financial Responsibilities

Thank you for choosing **Katy Women's Care, P.A. (Tax ID 76-0341804)** as your healthcare provider. We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment of your bill is considered part of your overall treatment. In order to keep your cost of healthcare to an absolute minimum, we have adopted the following policies.

Fees and Payments: Fees are standardized and are based on the complexity of your visit. Payment in full is required at the time of service and can be made with cash, check or credit card. We reserve the right to refuse methods of payment at our discretion. No cancellations or refunds are available once services are provided.

Required at Check-In: Each time you check in for your appointment you will be required to verify your personal contact information, present a current copy of your insurance card, a valid photo I.D. and pay any outstanding balance as well as today's visit.

Insurance Plans: Your insurance is a contract between you, your employer, and the insurance company. We must emphasize that as healthcare providers, our relationship is with you, not with your insurance company. Before your visit, please contact your insurance company to verify we are participants in your plan and the services you intend to receive are covered. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. In order for us to file your claim, you must present a current copy of your primary insurance card, and communicate any changes in your personal contact information.

Most insurance policies specify that some of the cost of the patient's care is the patient's responsibility. This can be accomplished through any combination of co-payments, coinsurance or deductibles. The patient's responsibility is due when you check in for your appointment. The amount of patient responsibility determined by your insurance policy is not negotiable. We do not waive the patient responsibility or bill for it later. Once all claims have been paid, any over-collected amounts will be refunded to the patient in the form of a check sent in the mail.

Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your policy. Some insurance companies arbitrarily select certain services they will not cover and so we cannot guarantee payment of all claims by your insurance company. If your insurance company pays only a portion of your claim or rejects your claim, they will notify you through an explanation of benefits (EOB). Reduction or rejection of your claim by your insurance company does not relieve you of your financial responsibility. Please be advised that we cannot and will not change records after your visit. The diagnosis established at the time of your visit is what will be billed to your insurance.

Obstetrical Payment Plans – At the beginning of your obstetrical care, we will contact your insurance company and compile an estimate of your portion of responsibility for the pregnancy ("global"). This amount will be shared with you and is due by the 20th week of your pregnancy. This amount does not include any ultrasounds, laboratory fees or fees for the hospital. Because this cost can be significant, we offer the option of payments leading up to your 20th week. In limited circumstances, we will grant an extension to your 24th week, but you must have prior approval from our billing department and be making payments. Please ask to speak to our billing department if you have questions.

Surgical Payment Plans – Prior to scheduling an office or hospital procedure, we may contact your insurance company and compile an estimate of your portion of responsibility. This amount will be shared with you and is due prior to your procedure. Because this cost may be significant, we offer the option of monthly payments leading up to your procedure. Please ask to speak to our billing department if you have questions.

Self-pay: Patients without insurance are considered self-pay patients. When possible, a fee range will be given upon check-in or when you make your appointment, along with any anticipated additional charges. Lab fees are billed separately by the providing lab. The full cost due to Katy Women's Care for the visit is due at the time of service. We do not see self-pay obstetrical patients.

Minors: The parent(s) or guardian(s) of a minor are responsible for providing current insurance information for the minor and/or payment in full at the time services are provided. There are limited medical situations we can see an unaccompanied minor, but they must have authorization for medical treatment signed by a parent or guardian, and the same insurance and payment requirements apply.

Miscellaneous Fees: I understand and agree the following fees will be charged when applicable.

Laboratory Charges - Laboratory charges are not included in the cost of your care at Katy Women's Care. You may get a separate bill from the lab. It is your responsibility to know your laboratory benefits and their requirements. Please contact the laboratory facility directly to discuss any questions with your bill.

Returned Check - Checks returned non-paid will be subject to a 35.00 returned check fee. This charge is in addition to any bank charges.

Credit Card Dispute - Disputed credit card charges will be subject to a $50.00 fee. This charge is in addition to any bank charges.

Missed Appointments - If you miss an appointment, and have not cancelled that appointment 24 hours in advance, a $25 "no show" fee will be charged.

Medical Records Charge - The fee to release medical information to any entity is $25 for the first 25 pages and $0.17 per additional page plus postage.

Forms Completion - The fee for this office to complete forms is $20.00 per set of forms. Please allow 72 hour turnaround time.

Collections Charges - Accounts that are not paid will be sent to an external collections agency and reported to the credit bureau. In addition to the outstanding balance, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts. You may also be dismissed from the practice.

I have read and understand the above terms and conditions agree to the **Patient's Financial Responsibilities.** I have been offered a copy of Katy Women's Care's **Notice of Privacy Practices**. I hereby attest, that I do not have additional healthcare coverage other than the insurance supplied by myself or legal guardian at the time of my visit.

_____ _____

Patient Signature Date

Printed Patient Name: _____

Telemedicine Consent Form

I understand that my health care provider may recommend a telemedicine consultation. This means that I or my healthcare designee will be able to consult with my healthcare provider about my condition through an audio and/or video connection. My healthcare provider has explained to me how the telemedicine technology will be used to do such a consultation.

I understand there is potential risk with this technology:

1. The audio/video connection may not work, may not be available due to external factors, or may stop working during the consultation.
2. The audio, video, or information transmitted may not be clear enough to be useful for the consultation.
3. I may be required to go to the location of the consulting provider if it is felt that the information obtained via telemedicine was not sufficient to make a diagnosis, or additional elements must be performed in person.

The benefits of a telemedicine consultation are:

1. The potential to avoid travel to the consultation location.
2. Access to a specialist through this consultation.

I give my consent to be interviewed remotely. I also understand other individuals may be involved to complete the telemedicine visit and that they will take reasonable steps to maintain confidentiality of the information obtained.

In the state of Texas there are some limitations to telemedicine visits. Providers are not allowed to perform telemedicine visit to patients that are out of the state of Texas. If the patient is out of state the appointment will be terminated.

I understand that I have the right to ask my healthcare provider to discontinue a telemedicine conference at any time.

I authorize the release of any relevant medical information about me to my primary health care provider, consultant(s), any other healthcare providers who may need this information for continuity of care, any staff supervised by my health care provider, and third-party payers.

I hereby release Katy Women's Care, its personnel and any other person participating in my care from any and all liability which may arise from the authorized use and transmission of video and audio from a telemedicine visit. I have read this document and understand the risk and benefits of telemedicine, and I have had my questions regarding the procedure explained.

I hereby consent to participate in a telemedicine visit under the conditions described in this document.

By signing below, I acknowledge that I have read and understand the above.

_____ _____

Patient Signature Date

Printed Patient Name: _____

Electronic Communication Consent Form

To better serve you, this office has established a **patient portal** for secure messaging. This is a wonderful new tool that opens another avenue for you to communicate with us and for us to communicate with you. Once you establish your portal account with us, you can use our website to request appointments, request prescription refills, send questions to the doctor, send questions to the billing and insurance department and more. In limited instances, we communicate with you through email. We avoid this method of communication since it is not as secure as our patient portal.

Should you require urgent or immediate attention, these electronic means of communication are not appropriate. These types of communication are for **non-urgent issues only**. The turn around time for the patient portal is within two business days.

Communications through the patient portal are retained as a part of your medical record. Emails relating to diagnosis and treatment will be retained as a part of your medical record as well.

When we send you a message, you will receive an email indicating that you have a message from us and the click the attached link. The link will take you to our website where you will sign in with your username and password. The secure message screen looks and works much like email. Please note the subject line of the secure message is the only thing transmitted through email and will always be of a general nature.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of electronic communications, third parties may have access to messages. When communicating from work, you should be aware that some companies consider electronic communications corporate property and your messages may be monitored. Even when communicating from home, you may feel that access to your electronic communication is not well controlled, so you should take that into consideration. In addition, you should be aware that although addressed to a particular staff member, other staff members would have access to this information.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control. I understand and agree to the above electronic communications policy.

By signing below, you are agreeing that we may send medical related correspondence to you via electronic communication, and that we may respond to your electronic communications to us via electronic communication.

Patient Signature _____ Date _____

Printed Patient Name: _____

Katy Women's Care

Dear Patients,

Thank you for choosing Katy Women's Care and Katy Wellness to take care of your women's health and primary care concerns. Our providers are dedicated to delivering evidence based care with kindness and compassion. We understand that healthcare can be complicated and often stressful. In order to cut down on some of the stress of "going to the doctor's office" we would like to give you some reminders to make your experience go well.

ALWAYS bring your photo identification and your insurance card to EVERY appointment.

Please complete the necessary paperwork prior to your appointment or plan to come early to your appointment to complete.

Please arrive 15 minutes early to your appointment.

In order to avoid a $25 late fee or no show fee, please call if you are running late or not able to make your appointment. If you are running late we will try to get you in that day however, we may have to reschedule or cancel your appointment.

We have dedicated staff to answer all types of calls during normal business hours. They are available Monday through Thursday from 8 am -12pm and 1:30-5pm and Friday 8 am- 2 pm. We do have an afterhour's emergent call line. Please see below on what constitute a reason to call this number. We respect our providers and we hope you will too if you call the afterhour's number for a non-emergent reason (example schedule an appointment or medication refill) you will be charged a $25 fee each time.

Print Name (printed) Signature Date

Revised 4/5/2024

There are limitations to calling after hours. This is to help guide you to the proper next steps.

IF YOU ARE HAVING A MEDICAL EMERGENCY PLEASE DO NOT WAIT TO HEAR BACK FROM YOUR PROVIDER AND PROCEED TO THE NEAREST EMERGENCY DEPARTMENT.

Reasons to go straight to the emergency room

EMERGENCIES (APPLIES TO ALL PATIENTS)→Chest pain, persistent high or low heart rate (over 120 under 50) or blood pressure over 180/110, palpitations, persistent shortness of breath or difficulty breathing, abnormal headache, vision disturbances or vision loss, passing out, slurred speech, difficulty moving one side of the body, glucose reading over 350 or under 60, suicidal thoughts or hurting yourself, not able to tolerate fluids, abdominal pain that is getting worse or accompanied with fever greater than 102, vaginal bleeding that is soaking a pad every hour for a total of 2 hours (in a row), if you have an issue that feels like it needs immediate attention

OBSTETRIC (PREGNANCY) SPECIFIC EMERGENCIES →ALL car accidents, falls, regular or painful contractions that are coming every 10 minutes, blood pressure greater than 160/110, leaking of vaginal fluids, vaginal bleeding, passing out, decreased fetal movement

Appropriate uses of afterhours call line:

Leaking of vaginal fluids/bleeding

Decreased fetal movement

Regular contractions

Elevated blood pressure

Persistent fever greater than 100.4

Inappropriate uses of afterhours call line:

Lab results

Schedule or reschedule appointment

Medication refills or Antibiotics

Questions about medication

Minor complaints (ex cough, congestion, normal type of headache, vaginal discharge/itching, urinary complaints)

Pay or discuss bill

*Any inappropriate calls will result in a $25 fee and will **NOT** be handled after hours.

Print Name (printed) Signature Date

Revised 4/5/2024