Rachel Petersen, MD
Obstetrics & Gynecology

1 Hospital Drive, SW Suite 201
Huntsville, AL 35801
(256) 489-2442

PATIENT INFORMATION

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

Cell Number: _____ **Cell Phone Provider:** _____

Home Number: _____ **Work Number:** _____

Home Address: _____

City/State: _____ **Zip:** _____

Employer: _____ **Occupation:** _____

E-Mail: _____ **Relationship Status: S M W D**

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

Pharmacy with Location: _____

INSURANCE INFORMATION

Primary Insurance: _____ **Policy Holder:** _____

Date of Birth: _____ **Relation:** _____

Secondary Insurance: _____ **Policy Holder:** _____

Date of Birth: _____ **Relation:** _____

Insurance Preferred Lab *(Please call insurance for this information)* _____

I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE ABOVE NAMED PATEINT. I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY RACHEL PETERSEN, M.D. I AGREE TO PAY ALL REASONABLE ATTORNEY FEES AND COLLECTION COSTS IN THE EVENT OF DEFAULT OF PAYMENT. I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR GTREATMENT AND FINANCIAL RESPONSIBILITY.

DATE _____ **SIGNATURE** _____

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CONSENT FOR THE RELEASE OF MEDICAL INFORMATION TO SPECIFIED INDIVIDUALS

Rachel Petersen, M.D. is committed to the protection of our patient's personal health information. However, we recognize that individuals other than themselves attend to many of our patient's healthcare needs. In accordance with new HIPPA regulations, we ask that you take a moment to give us the names of individuals with whom we are able to discuss your medical appointments, condition, treatment options, insurance payment information, or other information necessary to our responsibility in your treatment. Please list the names (and phone numbers, if readily available) of any individuals with whom we may have communication, which may include all, or part of your personal health information. If you fail to list any names, we will not discuss your medical information with anyone other than yourself.

Contact/Relationship to Patient: **Telephone Number:**

1) _____ _____

2) _____ _____

3) _____ _____

Please check all approved methods that our office may contact you:

( ) Home phone/voicemail

( ) Cell phone/voicemail

( ) Reminders through text message – Cell Phone Provider _____

DATE _____ **SIGNATURE** _____

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MEDICARE EXTENDED PATIENT SIGNATAURE AUTHORIZATION (Medicare Patients Only)

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE PHYSICIAN RACHEL PETERSEN, M.D. FOR ANY HOLDER OF MEDICAL INFORMATION ABOUT TO RELEASE TO EHALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NECESSARY TO DETERMINE THESE BENEFITS FOR RELATED SERVICES.

_____ _____
PATIENT SIGNATURE DATE

NOTICE OF PRIVACY PRACTICES RECEIPT

I HAVE RECEIVED AND REVIEDWED THE NOTICE OF PRIVACY PRACTICES PROVIDED BY RACHEL PETERSEN M.D.

_____ _____
PATIENT SIGNATURE DATE

FINANCIAL RESPONSIBILITY AND MEDICAL RECORDS

I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT. I AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO RACHEL PETERSEN, M.D. I UNDERSTAND RACHEL PETERSEN, M.D., WILL ATTEMPT TO COLLECT ASSIGNED INSURANCE BENEFITS FOR A PERIOD OF 45-DAYS AFTER DATE OF SERVICE AT WHICH TIME PAYMENT OF THE FULL AMOUNT WILL BE MY RESPONSIBILITY. I REALIZE THAT RACHEL PETERSEN, M.D. MAY SEEK ASSISTANCE OUTSIDE THIS OFFICE TO EXPEDITE COLLECTION OF THE BALANCE DUE.

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO THE REFERRING AND FAMILY PHYSICIANS AND TO MY INSURANCE COMPANY, IF APPLICABLE. I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS IF NECESSARY.

_____ _____
PATIENT SIGNATURE DATE

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OFFICE POLICIES

1. Please notify our office as soon as possible if you are unable to make your scheduled appointment. There will be a $25.00 “No Show” fee charged if we are not notified before your appointment time.

2. You may be asked to reschedule your appointment if you are more than 15-minutes late.

3. There will be a $50.00 “No Show” fee charged for surgeries that are not cancelled or rescheduled within 36-hours of the schedule date.

4. Due to cross coverage with other physicians, you may see another physician if services are needed.

5. There will be a $25.00 processing fee for standard FMLA, disability, and any other paperwork that needs to be completed by our office. Additional $10.00 fee may apply for extra FMLA paperwork. Please **allow 7-10 business days for completion**.

6. A $35.00 charge will be assessed on all returned checks.

7. If you call to leave a message with your doctor or nurse please allow up to **24-hours** for a return call. Your call will be returned in a timely manner by a nurse after discussion with the physician.

8. Prescriptions requested on Friday after 10am, will not be filled until the next business day.

9. Any non-emergency messages left with the answering service may be subject to a $25 fee.

10. All unpaid balances over 30-days after insurance has made its final determination will be subject to a $35.00 late fee if no arrangement is made with the billing office. All balances over 60-days will be subject to an additional $28.00 collection fee and further legal action.

11. We will not release any medical records or perform any other services, i.e. refills on prescription, or filling out forms until your **OLD BALANCE IS PAID IN FULL.**

12. **Our office primarily uses LabCorp for all labs. If this lab is not within your network, it is your responsibility to inform our staff in order to send your labs to a different lab.**

_____ _____

Signature Date

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Rachel Petersen, M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (RACHEL PETERSEN, M.D. Notice of Privacy Practice provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practice prior to signing the consent. RACHEL PETERSEN, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Retina Clemons, Privacy Office at Rachel Petersen, M.D. – 1 Hospital Dr SW, Suite 201, Huntsville, Alabama 35801.

With this consent, RACHEL PETERSEN, M.D. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, RACHEL PETERSEN, M.D. may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that RACHEL PETERSEN, M.D. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to RACHEL PETERSEN, M.D. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, RACHEL PETERSEN, M.D. may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian | Date

_____ _____

Patient's Name | Print Name of Patient or Legal Guardian

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PATIENT'S NAME:_____ DOB: _____ DATE: _____

If a doctor referred you today, please provide us with the doctor's name.

Name of Referring Doctor: _____ **Phone:** _____

If you were not referred by a doctor, how did you hear about Dr. Petersen?

( ) Friend **( ) Facebook** **( ) Huntsville Times Ad** **( ) Health Ins./Website** **( ) Just for Women Magazine**

( ) Family **( ) Internet Search** **( ) Yellow Pages Ad** **( ) Hospital Referral** **( ) Other:** _____

What is your reason for coming in today?

_____

_____

Name of Family Doctor:

_____

Pharmacy (please list name, street and city)

_____

Insurance Preferred Lab:

_____

OB/GYN History

Please check all that apply:

( ) Menopausal

If yes, state year: _____

( ) Hysterectomy

If yes, state year: _____

Ovaries removed? (Y / N)

Date of last menstrual period: _____

How often each month: _____

Average length: _____

Average Flow (Heavy / Light / Moderate)

Do you pass clots? (Y / N)

Cramps? (Mild / Moderate / Severe)

Any Recent changes in periods? Please list

_____

_____

Present method of birth control (including tubal ligation or vasectomy):

_____

_____

Date of last Pap smear? _____

Result: _____

Ever have abnormal Pap smear? (Y / N)

# of pregnancies: _____

# of living children: _____

# of miscarriages: _____

# of ectopic pregnancies: _____

# of abortions: _____

# of vaginal deliveries: _____

# of C-Sections: _____

Date of last mammogram: _____

Result: _____

Date of last colonoscopy: _____

Results: _____

Date of last bone density: _____

Result: _____

SURGERIES

Please include date:

_____

_____

_____

_____

_____

_____

_____

CURRENT MEDICATIONS

Please list all current medications you are taking:

_____

_____

_____

_____

MEDICATION ALLERGIES

Please list any medication allergies and the response the medication causes:

_____

_____

SOCAIL HISTORY

Please check all that apply:

( ) I have smoked in the past

For how long? _____

Date stopped? _____

( ) I smoke currently

Packs per day? _____

For how long? _____

( ) I drink alcohol

Drinks per week? _____

Type of alcohol? _____

( ) I have a history of illicit drug use

Please list substance _____

_____

_____

FAMILY MEDICAL HISTORY

Please specify which relative:

Diabetes: _____

Heart Disease: _____

Blood Clots: _____

High Blood Pressure: _____

High Cholesterol: _____

Osteoporosis: _____

Alcohol/Drug Issues: _____

Breast Cancer: _____

Colon Cancer: _____

Ovarian Cancer: _____

Cervical Cancer: _____

Uterine Cancer: _____

Other Cancer: _____

Mental Illness: _____

Other: _____

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NAME: _____

PAST MEDICAL HISTORY

Please check all that apply:

( ) Asthma
( ) Kidney Infections
( ) Kidney Stones
( ) Tuberculosis
( ) Infertility
( ) HIV / AIDS
( ) Heart Attack
( ) Heart Disease
( ) Diabetes
( ) High Blood Pressure
( ) Blood Clots
( ) Stroke
( ) Eating Disorders
( ) Breast Cancer
( ) Colon Cancer
( ) Ovarian Cancer
( ) Cervical Cancer
( ) Uterine Cancer
( ) Other Cancer
Please specify: _____
( ) Reflux
( ) Hiatal Hernia
( ) Gastric Ulcers
( ) Mental Illness
Please specify: _____
( ) Anemia
( ) Blood Transfusion
( ) Seizures / Convulsions
( ) Bowel Problems
Please specify: _____
_____
( ) Arthritis
Please specify: _____
_____
( ) Back Problems
Please specify: _____
_____
_____
( ) Hepatitis
( ) Liver Disease
( ) Thyroid Disease
( ) Bleeding Disorders
( ) Other: _____
_____
_____

CURRENT MEDICAL PROBLEMS

Please check all that PRESNTLY apply:

Constitutional:
( ) Unexplained Weight Loss
( ) Fever
( ) Extreme Fatigue
( ) Change in Height

Eyes:
( ) Recent Vision Changes
( ) Glasses
( ) Contacts

Ears, Nose and Throat:
( ) Earaches
( ) Ringing in Ears
( ) Hearing Problems
( ) Sinus Problems
( ) Sore Throat
( ) Mouth Sores
( ) Dental Problems

Cardiovascular:
( ) Chest Pain/Pressure
( ) Difficulty Breathing on Exertion
( ) Swelling of legs
( ) Rapid/Irregular Heartbeat

Respiratory:
( ) Shortness of Breath
( ) Chronic Cough

Gastrointestinal:
( ) Frequent Diarrhea
( ) Bloody Stool
( ) Frequent Nausea
( ) Frequent Vomiting
( ) Heartburn
( ) Chronic Constipation
( ) Involuntary Loss of Gas/Stool

Genitourinary:
( ) Blood in Urine
( ) Pain with Urination
( ) Strong Urgency to Urine
( ) Frequent Urination

Genitourinary (Continued):
( ) Incomplete Bladder Emptying
( ) Involuntary Urine Loss
( ) Urine Loss Due to Coughing/Lifting
( ) Premenstrual Syndrome (PMS)

Musculoskeletal:
( ) Joint Pain

Skin:
( ) Rash
( ) Moles (Growth/Changes)

Breast:
( ) Tenderness
( ) Nipple Discharge
( ) Lump/Mass in Breast

Neurologic:
( ) Dizziness
( ) Numbness
( ) Frequent Headaches

Psychiatric:
( ) Depression
( ) Anxiety

Endocrine:
( ) Hair Loss
( ) Hot Flashes
( ) Night Sweats

Hematologic/Lymphatic:
( ) Difficulty Stopping Bleeding
( ) Enlarged Lymph Nodes (Glands)

Please list any other current symptoms not listed:

_____
_____
_____
_____
_____
_____

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NOTICE TO NEW PATIENTS

Please be advised, that at this time, Dr. Petersen is not accepting any new Medicaid patients. This includes patients who have another primary insurance. Should you decide to get Medicaid, we will not be able to continue your care. Upon notification, we will transfer all records to the physician of your choice.

_____
Patient Name Printed & DOB

_____ _____
Patient Signature Date