McDaniel & Durrett, PC

This form must be filled out completely in order for us to file your insurance

Date: ____________ Referred by: ____________________________ Chart: ________________

Status: S M D W DOB: ________________ Age: _____ SS#: ________________________

Name: ______________________________________ Pref. Name: ______________________
Last First M.

Address: ____
City State Zip

Hm.#: ____________________ Wrk#: ____________________ Cell#: ____________________

E-mail: ____ Religion: ____________________

Patient Employer: ______________________________ Occupation: ____________________

Spouse/Sig.Other: _____________________________________ DOB: ____________________

Spouse/Sig.Other SS#: ____________________________ Wrk.#: ________________________

Emergency Contact: ______________________ Emergency Contact: ______________________

Relationship: ___________________________ Relationship: ___________________________

Phone #: ______________________________ Phone #: ______________________________

Primary Insurance: ______________________________ Cust.Service #: ________________

Policy Holder Name: _____________________________ DOB: ________________________

Member/Subscriber ID#: ___________________________ Group#: ______________________

Secondary Insurance: _____________________________ Cust.Service#: ________________

Policy Holder Name: _____________________________ DOB: ________________________

Member/Subscriber ID#: ___________________________ Group#: ______________________

I understand that it is my responsibility to provide a valid insurance card at the time of my exam. Should my insurance deny coverage on any service(s) rendered, I realize I am responsible for payment. I understand that if I do not have insurance, I am responsible for payment at the time of service. I understand that if I am seventeen years of age or younger, I must be accompanied by a parent or legal guardian.

________________________________ ________________________________
Patient Signature Parent or legal Guardian Signature

McDaniel & Durrett, PC
Patient Information Update

Patient Name________________________ DOB________Age___ Today'sDate___________

Please describe what brings you in today and what you would like to discuss with your provider:

____

____

Who is your Primary Care Provider: ________________________ Phone Number:____________

Last Menstrual Period ________ N/A Patient email address ____________________________

Please list any changes in each category since your last visit:

Medical History: ____

Surgical History: ____

Family History: ____

Recent Hospitalizations: ____

What Medications are you currently taking (including over-the-counter supplements):

Medication Name **Dosage/# Times Per Day**

____

____

____

____

____

____

____

Allergies to Medications/Chemical Irritants

____

Preferred LOCAL Pharmacy Name, Address & Phone Number

____

Preferred COMPOUNDING Pharmacy Name & Phone Number

____

McDaniel & Durrett, PC
Patient Information Update

Review of Systems: Please check the symptoms that most describe you and if a symptom is not listed, write it in the "other" section.

Name____________________ **Birth Date ______________**

General:

- ☐ Fatigue
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Other:___________

Head, Ears, Eyes, Nose, Throat:

- ☐ Headaches
- ☐ Change in vision
- ☐ Decreased Hearing
- ☐ Other:___________

Cardiovascular:

- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Rapid Heart Rate
- ☐ Fainting
- ☐ Other: ____________

Respiratory:

- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough
- ☐ Other: ____________

Gastrointestinal:

- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stool
- ☐ Abdominal Pain
- ☐ Other: ____________

Neurologic:

- ☐ Seizures
- ☐ Tingling or Numbness
- ☐ Loss of Consciousness
- ☐ Loss of Balance
- ☐ Other:__________

Musculoskeletal:

- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Back Pain
- ☐ Leg Cramps
- ☐ Other:__________

Endocrine:

- ☐ Hot flashes
- ☐ Night Sweats
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Acne
- ☐ Abnormal Hair Growth
- ☐ Decreased Libido
- ☐ Other:__________

Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty Sleeping
- ☐ Suicidal Thoughts
- ☐ Other:____________

Breast:

- ☐ Breast Lumps
- ☐ Nipple Discharge
- ☐ Skin Change
- ☐ Breast Tenderness
- ☐ Other:___________

Gynecologic:

- ☐ Heavy Menses
- ☐ Irregular Menses
- ☐ Painful Menses
- ☐ Absence of Menses
- ☐ Post-Menopausal Bleeding
- ☐ PMS Symptoms
- ☐ Possible Pregnancy
- ☐ Pain with Intercourse
- ☐ Vaginal Dryness
- ☐ Vaginal Discharge
- ☐ Vaginal Itching
- ☐ Bleeding after Intercourse
- ☐ Bulging from Vagina
- ☐ Other:__________

Urologic:

- ☐ Urinary Urgency
- ☐ Urinary Frequency
- ☐ Painful Urination
- ☐ Frequent Nighttime Urination
- ☐ Blood in Urine
- ☐ Urinary Retention
- ☐ Urinary Incontinence
- ☐ Other:__________

KNOWING YOUR INSURANCE & YOUR PAYMENT RESPONSIBILITIES

As the patient, it is your responsibility to provide us with accurate and up to date insurance information. As a courtesy, we will gladly file claims to your insurance company on your behalf, based upon the information you have provided. If for some reason your insurance company does not pay for all of your visits, a portion of your visit , and/or does not pay in a timely fashion; you, as the patient, are ultimately responsible for the services rendered.

Cancellation Policy

A CERTAIN AMOUNT OF TIME IS HELD SPECIFICALLY FOR YOU WHEN YOU SCHEDULE AN APPOINMENT. AS A COURTESY TO OUR PROVIDERS & OTHER PATIENTS; WE REQUIRE A 24 HOUR NOTICE IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINMENT FOR ANY REASON. A $25 FEE WILL BE ASSESSED TO YOUR ACCOUNT FOR A LESS THAN 24 HOUR CANCELLATION OR ANY MISSED APPOINMENTS.

_______ I have read, understand and agree to the above guidelines. I understand that I am responsible for
(Initial) knowing my insurance company's guidelines & informing McDaniel & Durrett, P.C. of those guidelines. I understand that if I cancel my appointment less that 24 hours in advance; for any Reason, I will be charged a $25 fee.

Email Blast form McDaniel & Durrett, PC

______ I agree to receive quarterly Email Blast from McDaniel & Durrett, PC

If so please list your email address below:

____

PREFFERED METHOD(S) OF CONTACT

Primary Contact Phone Number ____

Secondary Contact Phone Number ____

____ I give my consent to leave messages with DETAILED information.

____ I DO NOT give my consent to leave messages with DETAILED information.

I authorize McDaniel & Durrett, PC to discuss my Private Healthcare Information with the following person(s)

____

____

____ ________________________

Patient Signature **Date**

McDaniel & Durrett, P.C.

105 Collier Road, N.W. Suite 1080

Atlanta, GA 30309

Cervical Cancer Screening

There has been an exciting development in cervical cancer screening, which McDaniel & Durrett, P.C. are pleased to offer our patients. If you are 30 years or older, adding the test for Human Papilloma Virus (HPV) greatly improves the accuracy of cervical cancer screening, allows your provider to better determine your risk of cervical cancer or it's precursors, and provides guidance on how often you should be screened.

Most insurance companies cover the HPV test when used with a Pap test for cervical cancer screening of women 30 years of age and older. However, the elected health benefit plan you or your employer chose, may not cover the test. If the test is not paid for by your insurance company, you could receive a bill from the laboratory.

Cervical cancer screening guidelines recommend that every women 30 years of age and older receive the HPV test along with her Pap test. McDaniel & Durrett, P.C. recommend this as well.

_______ I would like to add the HPV test to my pap smear

_______ I would not like to add the HPV test to my pap smear

_______________________________________ _________________________

Patient Signature Date

MCDANIEL & DURRETT, P.C.

E-PRESCRIBING PBM CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

- Ø **Formulary and benefit transactions**-- Gives the prescriber information about which drugs are covered by the drug benefit plan.

- Ø **Medication history transactions**--Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that McDaniel and Durrett P.C Gynecology can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

I also acknowledge that I have received a copy of the McDaniel & Durrett, P.C.'s **Notice of Privacy Practices.**

<u>Acknowledgement of Receipt of Privacy Notice and E-Prescribing PBM Consent Form</u>

Patient Name (printed) ____ Date of Birth ___ /___ /_____
Signature of patient (or representative)____
Date ____ /____ /______ Relationship if other than patient_____________________________________
Consent Denied _________________________________ Date ____ /____ /______