Amanda Hollingsworth D.O.
Board Certified Obstetrics & Gynecology

1700 N. Oregon Suite 530, El Paso, Texas 79902

(Please Print)

Today's date:	Primary physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
❑ Yes	❑ No			/ /		❑ M	❑ F

Street address:	Social Security #:	Home phone #:
		( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone #:
		( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.		❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	

Other family members seen here:	

Ethnic Background/race: ❑ white ❑ African American ❑ Native American ❑ Asian ❑ Pacific Islander ❑ Hispanic ❑Other_____

Preferred language:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone #:
	/ /		( )

Is this person a patient here?	❑ Yes	❑ No		

Occupation:	Employer:	Employer address:	Employer phone #:
			( )

Is this patient covered by insurance?	❑ Yes	❑ No	

Subscriber's name:	Subscriber's S.S. #:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			$

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #:	Work phone #:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

	Patient/Guardian signature		*Date*	

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PATIENT POLICY

We ACCEPT CASH, CREDIT OR DEBIT CARDS for all payments
Payment is expected at the time services are rendered.

- Please remember that payment is your responsibility regardless of insurance.
- If you have more than one insurance, we will need information regarding **every** single health insurance you are covered under. If you do not give us information on all of your health insurance carriers, we may not be paid and then you will be responsible for paying us for our services.
- If you are a Medicare beneficiary, Medicare will be billed for you. You will be responsible for deductibles, all non-covered services, etc. according to Medicare guidelines.
- Please note for certain insurance carriers, routine exams & preventative care visits are not covered services.
- All Co-Pays are due at the time of the office visit.
- In the event we are contracted with your insurance company, we will bill for you. If we receive notification that you are not eligible for coverage, you will be responsible for all charges incurred.
- All balances not paid within 30 days of statement date are subject to a $10.00 late fee.
- No Shows:
    - There will be a $25 fee applied to your balance in the event of failure to call and cancel appointment 24 hours in advance or fail to show for appointment.
    - You will be allowed one no show free of charge.
    - After 3 no shows without valid reason, you may be fired from our practice.

Authorization to Release Information for Insurance Purposes: I hereby authorize Dr. Amanda Hollingsworth DO, PA to release any information acquired in the course of my examination/treatment. I have read and understand the above statement. I agree to comply with the financial policies of this office and am financially responsible for my account.

SIGNATURE: _____ DATE: _____

I hereby authorize payment of benefits to be made directly Dr. Amanda Hollingsworth for services provided to me. I understand that I am financially responsible for charges and/or services not covered by this agreement. This authorization will remain in effect until revoked in writing by the undersigned.

SIGNATURE: _____ DATE: _____

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NOTICE OF PRIVACY PRACTICES

To Our Patients:
This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances
The following circumstances may require us to use or disclose your health information:
1. To public health authorities and health oversight agencies that are authorized by law to collect information
2. Lawsuits and similar proceedings in response to a court or administrative order
3. If required to do so by a law enforcement official
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, we will only made disclosures to a person or organization able to help prevent the threat
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities
6. To federal officials for intelligence and national security activities authorized by law
7. To correctional institutions or law enforcement, if you are and inmate or under the custody of a law enforcement official
8. For Workers Compensation and similar programs

Your rights regarding your health information
1. Communications: you can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information of only certain individuals involved in your care of the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your physician.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to your physician. You must provide us with a reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy the Notice at any time.
6. Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Region VI, Office of Civil Rights, U.S. Department of Health and Human Services by mail at 1301 Young St., Dallas, Texas, 75202, by telephone at (214) 767-4056, by TDD at (214) 767-8940, or by fax at (214) 767-0432 You will not be penalized for filing a complaint
7. Right to provide an authorization for other uses and disclosures: our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices.

Signature _____

Printed Name of Patient _____Date _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. With my consent, Amanda Hollingsworth DO, PA may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Notice of Privacy Practices for a more complete description of such uses and disclosures.
2. I have the right to review the Notice of Privacy Practices prior to signing this consent. Amanda Hollingsworth DO, PA, reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by making a written request to Region VI, Office of Civil Rights, U.S. Department of Health and Human Services by mail at 1301 Young St., Dallas, Texas, 75202, by telephone at (214) 767-4056, by TDD at (214) 767-8940, or by fax at (214) 767-0432.
3. With my consent, Amanda Hollingsworth DO, PA may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, necessary insurance information, etc.
4. With my consent, Amanda Hollingsworth DO, PA, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, etc.
5. I understand that if I choose to be accompanied by any persons during my office visit, private medical information may be disclosed.
6. By signing this form, I am consenting to Amanda Hollingsworth DO, PA use the disclosure of my PHI to carry out TPO.
7. 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, Amanda Hollingsworth DO, PA, may decline to provide treatment to me.
8. I give permission for Amanda Hollingsworth DO, PA, to disclose protected health information (PHI) to the following persons.

Name: Relationship:

_____ _____

_____ _____

_____ _____

Patient's or Legal Guardian's Signature Date

_____

Print Name of Patient and Legal Guardian

Consent for Treatment

1. I hereby do voluntarily consent to such care, including routine procedures and other treatment by professionals and their assigns, appointees or Consultants as is necessary in their judgment.
2. I am aware that the practices of medicine, surgery and other health disciples do not constitute exact sciences; I acknowledge that no guarantees have been made to me as the result of treatments or examinations.
3. I understand that for certain procedures deemed necessary by my physician, I will be required to sign a Special Consent Form. Furthermore, if I do not fully understand a procedure or its risks, consequences and alternate methods of treatment I have the right to question the appropriate professional.
4. I understand that Amanda Hollingsworth DO, PA, shall not be responsible or liable for the loss of/or damage to any personal property.
5. I authorize the release to any party for my care, such information from my records as is required in order for Amanda Hollingsworth DO,PA, and all entities providing services to obtain payment. This includes records of alcohol and drug abuse and/or treatment records of psychological services and social services, including communications made by the patient to the physician, social worker, or psychologist. This authorization shall be effective as long as necessary to obtain payment or reimbursement and will end when payment or reimbursement is received.
6. I have read the above statement. I certify that I understand its contents.

Print Patient Name _____ Date of Birth_____

Signature of Patient_____ Date _____

Signature of Parent/Legal Guardian_____Relationship_____

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With my consent, I agree to have emails sent to me.

My email address is: _____

Please print

Patient name: _____

Date of Birth: _____

Signature: _____ Date: _____

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NEW GYN PATIENT INTAKE QUESTIONNAIRE ***Patient Name*_____**

Please fill in the blanks as much as possible or as they pertain to you.

GYN/MENSTRUAL HISTORY

First day of last period: _____ Certain(Y/N)?____ Periods regular (Y/ N)?_____ Age at first menses?_____
How many days do you bleed?_____ Are they heavy (Y/N)?_____ Are they painful(scale 0-5)?_____
Age first intercourse?_____ Have you had STD's?_____ Any abnormal PAPs/treatment?_____
Do you have bladder trouble(Y/N)?_____ Do you feel a bulge below(Y/N)?_____ Hot flashes?_____
Last PAP date_____ Last Mammogram date_____ Last Dexa Scan date_____

OB HISTORY

Number of pregnancies_____Number of deliveries_____Number of miscarriages_____Number of abortions_____
Number of living children_____ Number of c-sections_____ Weight of largest child at birth_____
Did you breastfeed?_____Any pregnancy complications?_____ If yes, describe:_____

SUBSTANCE USE

Drink alcohol?_____ How many drinks per day?_____ Do you use tobacco?_____ How many per day?_____
Drug use ever?_____History of IV drug use?_____ Are you currently using?___ Caffeinated beverages per day(#):_____
If pregnant, list any drug exposure (including medication) since conception below:

SOCIAL HISTORY

Are you married?_____ Are you employed?_____ Any concern for STD's?_____ Risk for HIV/AIDS?_____
Do you feel safe at home?_____ History of rape or sexual abuse?_____ Number of sexual partners in last 5 yrs:____
Do you exercise (type and amount)?_____

MEDICAL HISTORY Circle medical conditions which you have or have had in the past (pregnant or not)

High blood pressure	Depression	Preterm labor or delivery
Diabetes	Clotting/bleeding disorder	Fetal growth abnormality
Thyroid disorder	Clot of legs or lungs	Anemia
Asthma	Seizures	Migraines
Kidney or bladder disease	Cancer	Herpes (genital or oral)
Heart disease	Lupus or autoimmune disease	Pneumonia
Other (please specify):_____	_____	Last Colonoscopy date _____

MEDICATIONS (name, dose, and times per day)

1._____
2._____
3._____

ALLERGIES

PAST SURGICAL HISTORY List type and date of surgeries.

_____
_____
_____

FAMILY HISTORY Circle positive answers. Write-in blood relation (ex: mom, sister) next to the circled item.

High blood pressure Stroke Anesthesia reaction

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Diabetes	Heart Attack	Breast or Ovarian cancer
Birth defects/Genetic disorder	Other_____	Other cancer

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REVIEW OF SYSTEMS Please circle symptoms that are currently present.

CONSTITUTIONAL
Weight Loss
Weight gain
Fever
Chills
Fatigue

EYES
Glasses/contacts
Eye pain
Double vision
Cataracts

EAR/NOSE/THROAT
Hearing loss
Sinus trouble
Sore throat
Congestion
Vertigo

CARDIOVASCULAR
Murmur
Chest pain
Dizziness
Shortness of breath
Intolerance of exertion

ENDOCRINE
Loss of hair
Heat/Cold intolerance
Facial hair growth

RESPIRATORY
Cough
Wheezing
Chest tightness

GASTROINTESTINAL
Abdominal pain
Diarrhea
Constipation
Blood in stool
Heartburn
Nausea/Vomiting

GENITO-URINARY
Genital sores
Abnormal discharge
Frequent voiding
Incontinence
Genital bulge/prolapse
Abnormal bleeding

ALLERGIC
Hives/Eczema
Hayfever

PSYCHIATRIC
Anxiety
Depression
Difficulty sleeping
Mood swings

HEMATOLOGIC/LYMPH
Easy bruising
Prolonged bleeding
Enlarged glands

MUSCULOSKELETAL
Joint pain
Stiffness
Swelling
Limited motion
Back pain
Muscle pain

SKIN
Rash
Acne
Moles or sores
Itching/burning

NEUROLOGIC
Weakness
Tingling/burning
Numbness
Tremors
Memory loss

DATE REVIEWED:
(For Physician Use Only)
1.
2.
3.

MORE ABOUT YOU

Who is your primary provider/physician? _____

Your preferred pharmacy: _____

Topics/Concerns you would like to address today?_____

_____

_____

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Pregnancy Supplemental Questionnaire

1. Please write the name of the father of the baby or significant other's name.

   _____

2. Please list all pregnancies and their outcomes below (including miscarriages and abortions),

Month/Year	Sex of Baby	Baby's weight	Type of Delivery	Complications with pregnancy or Delivery

3. Is there a history of any of the following birth defects or genetic diseases in your family or the father of the baby's family : (Please Circle the disorder and write the affected person's relation to you)

Cystic Fibrosis	Down's Syndrome	Huntington's Disease	Hemophilia
Muscular dystrophy	Sickle Cell Anemia	Tay Sach's Disease	Thalassemia
Spina Bifida	Anencephaly	Cleft Lip/Cleft Palate	Heart defects
Mental Retardation	Other Birth Defects/Genetic Diseases:_____		

4. Have you had any of the following infections? (please circle)

Chlamydia	Hepatitis B/Hepatitis C	Chicken pox (Varicella)	Genital Herpes
Gonorrhea	Syphilis	Rubella	Measles

5. Do you have cats or reptiles? Yes No
6. Any recent fevers (more than 100.4 F) or rashes? Yes No
7. Was this a planned pregnancy? Yes No
8. Were you using some form of birth control at time of conception? Yes No
   What type of birth control were you using?
   _____
9. If you are over 21, are you considering this pregnancy to be your last pregnancy and are you interested in permanent and nonreversible birth control (ie tubal sterilization)? Yes No
10. Are you interested in starting some form of birth control after delivery? Yes No
11. Do you want to breastfeed after delivery? Yes No
12. With labor and delivery, which options are you considering for pain control? (please circle options)

Walking/Moving Around	Breathing Techniques	Massage	Showers
Birthing Ball	IV pain medication (narcotics)	Epidural	

13. How important is it to you to have a vaginal delivery?

Want C/S without trial of labor	willing to try to have vaginal delivery	vaginal delivery very important

14. Do you have a preference for which hospital you deliver at? Options are:

Sierra Medical Center	Providence Memorial	Las Palmas