☐Kristen N. Innes, M.D., P.A. ☐ Christine V. Ku., M.D., P.L.L.C. ☐ Jennifer R. Gulick , M.D., P.L.L.C.
3880 Parkwood Blvd. Suite 403 • Frisco, Texas 75034 • Phone 214-618-2802 • Fax 214-618-3208

PATIENT NAME:_____ **DOB:**_____

NAME: _____
LAST FIRST DATE OF BIRTH

ADDRESS: _____
STREET CITY STATE ZIP

PHONE (PLACE CHECK WHERE WE MAY LEAVE A MESSAGE, YOU CAN PICK MORE THAN ONE)

HOME☐ _____ WORK☐ _____ CELL☐ _____ EMAIL: _____

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐LEGALLY SEPARATED

SOCIAL SECURITY NUMBER: _____-___-_____ PHARMACY: _____ PHARMACY PHONE:_____

RACE (PLEASE CIRCLE ONE): CAUCASIAN AFRICAN AMERICAN NATIVE AMERICAN CHINESE ASIAN FILIPINO HISPANIC S. AMERICAN JAPANESE PACIFIC ISLANDER RUSSIAN MULTIRACIAL OTHER: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

EMPLOYER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

_____
EMERGENCY CONTACT #1 PHONE # RELATIONSHIP

_____
EMERGENCY CONTACT #2 PHONE # RELATIONSHIP

INSURANCE POLICYHOLDER NAME: _____
(If same as patient may leave following blank)

DOB: _____ SSN #: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PRIMARY INSURANCE CARRIER: _____

PLAN TYPE: ☐HMO ☐EPO ☐PPO ☐POS _____

BILLING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____

POLICY NUMBER: _____ GROUP # : _____

COPAY/COINSURANCE AMOUNT: _____

SECONDARY INSURANCE?☐Y ☐N (IF SO, PLEASE PROVIDE A COPY OF ABOVEINFORMATION TO RECEPTIONIST) _____

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PATIENT NAME:_____ **DOB:**_____

Please complete entire form.* ***If something does not apply, please mark N/A**. Thank you!**

REASON FOR VISIT: _____

FIRST DAY OF LAST MENSTRUAL CYCLE: _____ AGE OF FIRST MENSTRUATION: _____

ANY PROBLEMS WITH MENSTRUAL CYCLE? _____ AGE OF MENOPAUSE: _____

ARE YOUR CYCLES REGULAR? ☐Y ☐N HOW MANY PADS/TAMPONS ON HEAVIEST DAY: _____

ARE YOU CURRENTLY SEXUALLY ACTIVE?: ☐Y ☐N WITH ☐ Male ☐Female ☐Both BIRTH CONTROL METHOD USED: _____

PREGNANCIES: _____ DELIVERIES: _____ MISCARRIAGES: _____ ABORTIONS: _____ LIVING :_____

YEAR	SEX	WEIGHT	VAGINAL OR CESAREAN DELIVERY	COMPLICATIONS

Operations	Year	Other Hospitalizations	Year

***LIST ALL MEDICATIONS AND DOSAGES (INCLUDING OVER THE COUNTER MEDICATION):**

MEDICATION NAME	DOSAGE	DIRECTIONS

***DRUG ALLERGIES:** _____

_____

Please check if you have had any of the following:

☐Heart disease	☐Hypertension	Cancer (Type)_____
☐Diabetes	☐Hypothyroid	☐Hyperthyroid
☐Migraine Headaches	☐Blood Clotting Disorder	☐Asthma or ☐ lung disease
☐High cholesterol	☐Heart murmur	☐Abnormal Pap
☐Abnormal Mammogram	☐Seizure disorder	☐Liver disease
☐Infertility	☐Herpes	☐Frequent Urinary Infections
☐HIV	☐Other STD	☐Endometriosis

Other: _____

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PATIENT NAME:_____ **DOB:**_____

ARE YOU *CURRENTLY EXPERIENCING* ANY OF THE FOLLOWING*?*

☐ Urinary incontinence (leakage)	☐ Abnormal vaginal discharge
☐ Genital warts or lesions	☐ Hot flashes
☐ Abnormal vaginal bleeding	☐ Pain with intercourse
☐ Breast discharge or lumps	☐ Vaginal dryness
☐ Pelvic or abdominal pain	☐ Fever

***OTHER SYMPTOMS YOU WOULD LIKE ADDRESSED AT YOUR VISIT TODAY** _____

_____

LAST PAP SMEAR DATE: _____ NORMAL? ☐Y ☐ N

LAST MAMMOGRAM DATE: _____ NORMAL? ☐Y ☐ N

LAST ANNUAL LABS DATE: _____ NORMAL? ☐Y ☐ N

IF YOU ARE OVER THE AGE OF 50:

COLONOSCOPY DATE: _____ NORMAL? ☐Y ☐N

BONE DENSITY SCAN DATE: _____ NORMAL? ☐Y ☐ N

FAMILY HISTORY:

MOTHER: LIVING? ☐Y ☐N AGE: ILLNESS: _____

FATHER: LIVING? ☐Y ☐N AGE: ILLNESS: _____

OF BROTHERS: ILLNESS _____ # OF SISTERS: ILLNESS: _____

OTHER FAMILY ILLNESS: _____

SOCIAL HISTORY:

OCCUPATION: _____ ARE YOU: ☐SINGLE ☐LIVING WITH PARTNER ☐MARRIED ☐DIVORCED ☐WIDOWED

TOBACCO USE?☐Y ☐N CIGARETTES PER DAY: _____ HOW LONG? _____

ILLICITDRUGUSE?☐Y ☐N _____

ALCOHOL USE?☐Y ☐N DRINKS/WEEK: _____

EXERCISE REGULARLY? ☐Y ☐N TYPE: _____ DAYS/WEEK: _____

SPECIAL DIET?: _____

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PATIENT NAME:_____ **DOB:**_____

Appointment Policy

We value our patients and the time we spend with each of you and we would like to set aside appointments that work well for your schedule. If there is a conflict with your scheduled appointment time, we ask that you call the office 24 hours in advance to cancel or reschedule your appointment. ***Appointments cancelled without a 24 hours advance notice will be charged $25. If you miss more than 3 scheduled appointments, you may be dismissed from the practice.***

_____ _____
Signature of Patient/Guardian Date

_____
Printed Name of Patient/Guardian

Clarification of Medical Visits

In our office, we want to put the patient first by providing outstanding medical care. In order for us to do this, we want to make sure our patients understand our policy for billing your medical visits. If you are scheduled to come in for your annual well woman exam, the doctors will only discuss details or perform services regarding that visit. If there are other medical issues that you would like to discuss that is not considered part of an annual well woman exam, we ask that you schedule another appointment.

If you have an emergent problem, we will address that problem and you will need to reschedule your annual well woman exam. If the problem visit and annual well woman exam is done on the same day, you will be billed for each service separately. Depending on your insurance benefits, you may be held responsible for any out of pocket expenses associated with both services.

If you have any questions or concerns regarding these policies, please ask our staff.

Thank you.

_____ _____
Signature of Patient/Guardian Date

_____
Printed Name of Patient/Guardian

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PATIENT NAME:_____ **DOB:**_____

Policy on Insurance Coverage

We are enrolled in numerous insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of each plan. Each one has different stipulations and restrictions. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated. Your medical insurance is a benefit that your employer provides for you or you purchase for yourself.

During the course of treatment, charges will be accumulated and routinely filed with your insurance company. Charges not covered by your insurance, such as, copays, deductibles and co-insurance will be your responsibility and are due at the time of service.

Understanding your benefits can be confusing and we will do our best to assist you in this area, but keep in mind we have limited access to your medical benefits. Your employer or you have chosen this plan and benefits, not your physician. If YOU do not inform us of any special requirements in your contract, and we subsequently order services, such as labs, pathology or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill YOU directly for those charges.

Your insurance company will never guarantee your benefits to you or to this office. That is why we can only estimate your portion. Regardless of what we calculate as your medical plan benefit, ultimately ***YOU are responsible for the TOTAL cost of your medical treatment.*** If you are unable to pay the estimated portion for your appointment today we will be happy to reschedule it to a later date.

If your insurance company requires a "referral" from your primary care physician, you will be responsible for contacting your primary care physician for the referral (this is the patient's responsibility NOT the responsibility of this office).Treatment rendered by this office without the required referral will serve as your consent for treatment not covered by insurance, and will be payable by you. If we are contracted with your insurance company, your appointment will be rescheduled until a referral can be obtained.

Please check the appropriate boxes:

- ☐ I certify that I have **no insurance** and will be solely responsible for payment in full. (Payment is expected at the time of service)
- ☐ I certify that the insurance reported to this office is a complete and current listing. I understand the office will not submit a claim for any insurance not reported at the time of service.
- ☐ I **DO NOT** have any other insurance coverage other than that which has been provided upon submission of this authorization.

***** You are responsible for providing the correct information regarding which insurance is PRIMARY and SECONDARY. *****

I have read and understood the office policy stated above and agree to accept responsibility as described.

_____ _____

Signature of Patient/Guardian Date

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PATIENT NAME:_____ **DOB:**_____

_____
Printed Name of Guardian if under 18

Consent to Treat Patient

I, _____ (name of patient) have an appointment for an examination and treatment and I give permission to be examined and treated by the following physician.

☐**Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku., M.D., P.L.L.C.** ☐ **Jennifer R. Gulick , M.D., P.L.L.C.**

Consent to Treat a Minor

_____ (name of minor) has an appointment for examination and treatment. I, _____ (parent/legal guardian) give permission for _____ (name of minor) to be examined & treated by the following physician.

☐**Kristen N. Innes, M.D., P.A.** ☐ **Christine V. Ku., M.D., P.L.L.C.** ☐ **Jennifer R. Gulick , M.D., P.L.L.C.**

PLEASE INITIAL EACH OF THE FOLLOWING SECTIONS TO ACKNOWLDEGE YOU HAVE READ THE INFORMATION AND SIGN BELOW:

_____ **Assignment of Benefits:**
By signing this form, you authorize payment of medical benefits, including private insurance benefits, directly to Kristen N. Innes, M.D., P.A., Christine V. Ku, M.D., P.L.L.C., and Jennifer Gulick, M.D., P.L.L.C. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete your insurance claim. The duration of this consent is definite and continues until revoked in writing

_____ **Acknowledgement of Receipt of Notice of Health Information Practices**
The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. Kristen N. Innes, M.D., P.A., Christine V. Ku, M.D., P.L.L.C.,and Jennifer Gulick, M.D., P.L.L.C. are furnishing you with the attached notice, which provides information about how our office may use and/or disclose protected health information about your for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of this office's notice of Health Information Practices.

_____ **Acknowledgement of Receipt of Notice of Office Policies and Procedures**
Kristen N. Innes, M.D., P.A., Christine V. Ku, P.L.L.C., and Jennifer Gulick, M.D., P.L.L.C. are furnishing you with the attached notice, which provides information regarding our office protocols and policies which we have developed in order to optimize our ability to deliver you care. By signing this form, you acknowledge that you have received a copy of our office policies.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE: _____ Date: _____

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PATIENT NAME:_____ **DOB:**_____

PHYSICIAN OWNERSHIP DISCLOSURE FORM

During the course of your physician/patient relationship with Dr. Kristen Innes and/or Dr. Jennifer Gulick, either of these two physicians may refer you to Baylor Medical Center in Frisco. The address of the hospital is 5601 Warren Parkway, Frisco TX 75034.

In connection with any referral the hospital, you are hereby advised that Dr. Kristen Innes and Dr. Jennifer Gulick have an investment interest in the Hospital.

This information is being provided to you to help your make an informed decision about your health care. You have the right to choose your healthcare provider. You have the option of obtaining healthcare ordered by your physician at a different facility other than Baylor Medical Center in Frisco. You will not be treated differently by your physician or Baylor Medical Center in Frisco if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

By signing below, you acknowledge that should you be referred to the Hospital, your signature below evidences your informed decision to decline the option to have your health care provided at another health care facility.

Date_____

Patient Signature_____

Patient Printed Name_____

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PATIENT NAME:_____ **DOB:**_____

FAMILY HISTORY QUESTIONNAIRE

GENESCREEN
GENETIC COUNSELING

PATIENT INFORMATION

Patient Name:_____ DOB: _____/ _____/ _____

Are you adopted? No_____ Yes_____

What is your ethnic background? (ex: African, Ashkenazi Jewish, Italian) _____

FAMILY HISTORY

Please make below if there is a personal or family history of any of the following cancers. If yes, then indicate family relationship in the appropriate column.

Cancer Type	Self	Siblings	Family Member Mothers Side	Family Member Father's Side
Bone Cancer				
Breast Cancer – Male				
Breast Cancer Before Age 60				
Colorectal Cancer Before Age 50				
Melanoma + Another Cancer Discussed in this Form				
Melanomas in an individual – Two or More				
Ovarian Cancer				
Pancreatic Cancer				
Soft Tissue Cancers (fat, muscle, nerves, fibrous, tissues, blood vessels, or deep skin tissues)				
Stomach, Kidney/Urinary Tract, Brain or Small Bowel Cancer				
Uterine Cancer Before Age 50				
Other Cancer: Please List Any That Have Not Been Mentioned.				

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PATIENT NAME:_____ **DOB:**_____

Authorization to Discuss Medical Information

Drs. Innes, Ku and Gulick are committed to quality patient care. We are advocates of maintaining patient confidentially. Our physician policy is to speak only to patients and/or guardians personally in regards to their confidential medical information. Also, we will not leave any confidential medical information on a voice mail system without permission to do so. By filling out this form and signing below, you are giving the physicians at our office permission to communicate more detailed information to other individuals and/or your voicemail. Examples include but are not limited to: your lab and test results, information about your condition, prescription refills or changes, appointment scheduling and/or insurance details.
Our office will keep this consent form in your chart. **THIS FORM WILL BE EFFECTIVE UNTIL OTHERWISE NOTIFIED BY THE PATIENT WITH A WRITTEN REQUEST**.

Patient Name:_____Date of Birth:_____

Patient Signature:_____Date:_____

I_____(initial) authorize the physicians Dr. Innes, Ku, Gulick and staff to leave a detailed voice message regarding my medical care at the following phone number(s). You may write specific instructions below.

Patient Phone #1_____

Instructions:_____

Patient Phone #2_____

Instructions:_____

I_____(initial) authorize the physician and staff in our office to speak with the following individual(s) about my medical care. You may write instructions below.

Name:_____Relationship:_____Date:_____

Instructions:_____

Name:_____Relationship:_____Date:_____

Instructions:_____

***** I AUTHORIZE RELEASE OF INFORMATION TO INSURANCE COMPANIES AND PAYORS. *****

_____

Signature