

WOMEN'S SPECIALTY ASSOCIATES

Obstetrics and Gynecology

Dr. Carol Powers
Dr. Alisa Wolner Dr. Julianna Friesen

Welcome!

It is the policy of this practice that all obstetrical patients, new or established, receive prenatal care from all of our physicians during your pregnancy. These appointments will rotate through the physicians during the entire pregnancy. Our physicians rotate their "on-call" schedule daily at the hospital, which is why you will receive care from all of them.

Patients cannot choose which physician they want for an obstetrician, nor can they elect not to be seen by any particular physician.

The delivering physician within our group will be the physician who is "on-call" at the hospital. That will be the same physician you will schedule your post-partum appointment with, and in the case of a cesarean delivery, it will be the same physician you will schedule your post-op visits with.

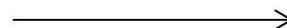
Patients receiving gynecological care only can select whom they want for their gynecologist. Should that patient become pregnant again, they will begin the obstetrical rotation with all physicians.

I have read this information and understand the office policy.

Signature: _____

Printed Name: _____

Date: _____



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The physicians of Women's Specialty Associates are also advocates for your unborn child.

During your pregnancy we may be performing random urine drug screenings at the time of your prenatal visits. If your drug screen indicates a positive result, we may find it necessary to withdraw from your care.

You will also be asked to comply with recommended routine obstetrical labs failure to do so will call for your dismissal from the practice.

Physicians of the practice recommend a vaginal exam at each obstetrical visit.

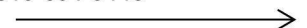
As a record of your consent to said testing, your signature is requested on this form to file into your permanent record.

In the even that you refuse to provide a signature of consent, we will cease to provide care to you, effective immediately.

Signature: _____

Printed Name: _____

Date: _____



WOMEN'S SPECIALTY ASSOCIATES

NAME	AGE	DOB	HOME PH.	CELL PH.
ADDRESS				INSURANCE
YOUR OCCUPATION	RACE	SPOUSE	PEDIATRICIAN	WE ONLY DELIVER AT GENESYS

PLEASE LIST ANY PAST PREGNANCIES, MISCARRIAGES OR ANYTHING PREGNANCY RELATED THAT WE SHOULD KNOW ABOUT.

DELIVERY YEAR	GENDER	INFANTS WEIGHT	TYPE OF DELIVERY	HOURS IN LABOR	DELIVERING PHYSICIAN	DELIVERING HOSPITAL	REMARKS AND GESTATIONAL AGE AT DELIVERY

FIRST DAY OF LAST MENSTRUAL PERIOD: _____

WOMEN'S SPECIALTY ASSOCIATES, P.C.

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REPRODUCTIVE GENETIC HISTORY QUESTIONNAIRE

MEDICAL HISTORY

NAME: _____

YES	NO	DO YOU...	COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	1. Have diabetes?	_____
<input type="checkbox"/>	<input type="checkbox"/>	2. Have seizures or epilepsy?	_____
<input type="checkbox"/>	<input type="checkbox"/>	3. Have kidney disease?	_____
<input type="checkbox"/>	<input type="checkbox"/>	4. You or your husband/partner have a history of cancer treatment?	_____
<input type="checkbox"/>	<input type="checkbox"/>	5. Have any skin disorders including moles, acne, light or dark patches of skin?	_____
<input type="checkbox"/>	<input type="checkbox"/>	6. Have rheumatoid arthritis or systemic lupus erythematosus (SLE)?	_____
<input type="checkbox"/>	<input type="checkbox"/>	7. Have a history of being on a special diet as a baby or a small child?	_____
<input type="checkbox"/>	<input type="checkbox"/>	8. Know the results of routine prenatal blood tests for Rubella (German measles) susceptibility and if yes, check accordingly, <input type="checkbox"/> Immune <input type="checkbox"/> Susceptible (not-immune)	_____
<input type="checkbox"/>	<input type="checkbox"/>	9. Have any other medical condition not mentioned?	_____

FAMILY HISTORY

YES	NO		COMMENTS
<input type="checkbox"/>	<input type="checkbox"/>	10. Are you 34 years or older?	_____
<input type="checkbox"/>	<input type="checkbox"/>	11. Is your husband/partner 55 years or older?	_____
<input type="checkbox"/>	<input type="checkbox"/>	12. Are you and your husband/partner blood relatives?	_____
<input type="checkbox"/>	<input type="checkbox"/>	13. Are you or your husband/partner of <input type="checkbox"/> Jewish <input type="checkbox"/> African American <input type="checkbox"/> Mediterranean descent?	_____
<input type="checkbox"/>	<input type="checkbox"/>	14. Have you had a stillbirth or miscarriage?	_____

Do you or your husband/partner...

<input type="checkbox"/>	<input type="checkbox"/>	15. Have any birth defects, handicapping condition, or disorder that might be hereditary?	_____
<input type="checkbox"/>	<input type="checkbox"/>	16. Have any previous children with birth defects, handicaps or a genetic disease?	_____
<input type="checkbox"/>	<input type="checkbox"/>	17. Have any children who died? (other than an accident)	_____
<input type="checkbox"/>	<input type="checkbox"/>	18. Have any relative who have had a stillborn infant or multiple miscarriages?	_____

19. Have a brother, sister or parent with a handicap, birth defect or a genetic disease? _____
20. Have uncles, cousins, nieces, nephews, grandparents, or grandchildren with birth defects or genetic disease? _____
21. Know of any family member with mental retardation (even mild) or learning disabilities? _____

SOME EXAMPLES OF BIRTH DEFECTS AND GENETIC DISEASE THAT MIGHT BE IN YOUR FAMILY

(Please check any of the following that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Anencephaly (open skull) | <input type="checkbox"/> Down syndrome (mongolism) | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Heart defect | <input type="checkbox"/> Mental retardation |
| <input type="checkbox"/> Hemophilia (bleeding tendency) | <input type="checkbox"/> Deafness | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Hydrocephalus (water on the brain) | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Neurofibromatosis |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Cleft lip/ palate | <input type="checkbox"/> Short stature (under 5ft) |
| <input type="checkbox"/> Limb disease | <input type="checkbox"/> Chromosome abnormality | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> Blindness or eye problem | <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Spina bifida (open spine) |
| <input type="checkbox"/> Bone disorder | <input type="checkbox"/> Malformations or birth defects | <input type="checkbox"/> Tay-Sachs disease |
| <input type="checkbox"/> Neurologic or degenerative disorder | <input type="checkbox"/> Skeletal problems | <input type="checkbox"/> Urinary tract abnormality |
| <input type="checkbox"/> Other _____ | | |

MEDICATION/DRUG EXPOSURES

- YES** **NO** 22. Do you take any prescription drugs or over-the-counter medications?

Have you taken any medications since your last period?

(Please check any of the following that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Accutane or other dermatologic acne medications | <input type="checkbox"/> Diet pills | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Female hormones | <input type="checkbox"/> Male hormones | <input type="checkbox"/> Anticoagulants (blood thinners) |
| <input type="checkbox"/> Multi-vitamins | <input type="checkbox"/> Steroids | <input type="checkbox"/> Anti-thyroid drugs |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Vitamin A | <input type="checkbox"/> Chemotherapeutic drugs |
| <input type="checkbox"/> Other high does vitamins | <input type="checkbox"/> Other _____ | |

- YES** **NO** 23. Have you had any illness or infection recently or do you have any chronic disease not mentioned? _____
24. Have you had frequent or high fevers? Take hot whirlpool baths or sit in saunas? _____
25. Have you recently had x-rays or surgery or are you planning to do so soon?
26. Are you exposed to anesthetic gases, lead, other heavy metals or radiation in your occupation?
27. Are you exposed to pesticides or potentially toxic chemicals at home or elsewhere?
28. Do you drink more than one glass of alcohol per week?
29. Do you have a house hold cat or clean a cat litter box?
30. Do you eat very raw meat?
31. Do you smoke? How many packs of cigarettes per day? _____
32. Do you use any other drugs or medications not previously listed? _____
33. Do you have any other questions or concerns regarding your ability to have a healthy baby? _____

WOMENS SPECIALTY ASSOCIATES ANNUAL PATIENT INFORMATION FORM

PATIENT NAME _____ DATE OF BIRTH _____ AGE _____

SOCIAL SECURITY NUMBER _____ MARITAL STATUS _____

ADDRESS _____ APT _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (____) _____ CELL PHONE (____) _____ Text appointment reminders? Yes ___ No ___

EMPLOYER _____ FAMILY DOCTOR _____ PHONE (____) _____

SPOUSES NAME _____ DATE OF BIRTH _____ PHONE NUMBER (____) _____

HEALTH INSURANCE _____ SUBSCRIBERS NAME _____ D.O.B _____

SUBSCRIBERS SOCIAL SECURITY NUMBER _____ SUBSCRIBERS EMPLOYER _____

EMERGENCY CONTACT NAME _____ PHONE (____) _____ RELATIONSHIP _____

PHARMACY NAME _____ PHONE NUMBER (____) _____

RACE: African American Asian Caucasian Hispanic Other _____ Refused

PRIVACY STATEMENT:

We protect our patient's information and the record that we have about their health and the services received in our office. We must have your written, signed consent in order to disclose your health information to your family doctor, insurance company (including disability claims) for the purposes of your treatment, the payment of your bills, appointment reminders, etc. I have received a copy of the Privacy Notice.
(HIPAA- 164.520 © Effective 04/14/2003) *To be filed and retained for a minimum of six (6) years.

Signature _____ Date _____

Please list the family member or persons, if any, whom we may inform about your general medical condition and diagnosis.

Can we leave a confidential message about your care on your answering machine/voice mail? _____

Do you have an authorized power of attorney? Yes ___ No ___ Do you have an advanced directive? Yes ___ No ___

Would you be interested in information about advanced directives? Yes ___ No ___

→ **FINANCIAL RESPONSIBILITY:** I authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign to the doctor all payment for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by insurance and that I will pay any co-pays on the date of service unless other arrangements are made. I understand that each statement sent without payment will accrue a \$3 fee. *Please note a 3.99% processing fee is applied to all credit and debit transactions

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

→ **MEDICARE AUTHORIZATION:** I request that payment of authorized Medicare benefits be made to Women's Specialty Associates on my behalf. I authorize the holder of my medical information to release to the HCFA and their agents any information needed to determine these benefits for related services. I understand that HCFA is the government Medicare agency.

Medicare Beneficiary Signature

Date

Medicare Number

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Our goal as your physician is to provide you with professional, high quality and effective care. In order for us to achieve timely consultations and enhanced quality of care, we need to work closely with your primary care physician and any other specialist.

Do you have a primary care physician? Yes No

If yes, who is your primary care physician?

Doctor's Name: _____
FIRST *LAST*

Address: _____

Do you authorize us to access your previous prescription history? Yes No

Do you authorize us to provide your primary care physician with our medical recommendations and care you have been receiving in our office? Yes No

If no, please explain why: _____

I have read and understand the information provided in regards to My Medical Neighborhood (see back). I have been counseled on the importance of continuity of care between myself (the patient), my primary care physician and the specialist(s).

Patient signature: _____ Date: _____

Parent/guardian signature: _____ Date: _____

WE ARE PART OF YOUR MEDICAL NEIGHBORHOOD!

Patient Centered Medical Neighborhood

A Patient Centered Medical Home (PCMH) is a team approach to providing comprehensive healthcare to patients in a high quality and cost effective manner.

The Medical Neighborhood is an expansion of the PCMH model connecting primary care physicians, specialty practices, hospitals, and other community health services to work together more efficiently in meeting the specific needs of each patient.



Improve the health of the population

Your Role As the Patient...

- Take part in planning your care
- Learn about wellness and how to prevent diseases
- Follow the care plan that is agreed upon and receive the recommended treatment
- Tell us any prescribed or over the counter medications you are taking
- Have all other physicians who take part in your care send us a report regarding your visit to them
- Continue to see your Primary Care Physician for preventive services

My Role As the Physician...

- Provide you with care that meets your needs and fits with your goals and values
- Work closely with your Primary Care Physician and other Specialists to provide coordinated care
- Ensure efficient flow of information, including timely consultations, referrals and test results
- Support enhanced access and patient-centered, high quality care



GENESYS
PHO