Daran L. Parham, M.D.
Melissa A. Dietz, M.D.
Kyle A. Wilson, D.O.

FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Our fees are reasonable and customary in accordance with other specialists' offices in this area. In case of financial hardship, please make financial arrangements with the Business Office prior to being seen.

YOUR RESPONSIBILITIES

- **KNOW** whether your provider contracts with your plan. A list of insurance companies with whom we participate is on the Patient Forms page of www.uticaobgyn.com. IT IS YOUR RESPONSIBILITY to call your insurance company to ensure our provider is contracted with your particular insurance plan. *If the provider is not contracted with your insurance company and you want to be seen anyway, please be prepared to pay for services at the time of your visit*. We will provide you a copy of your bill to file with your insurance company for reimbursement or we can directly file your claim as a courtesy. We try to verify insurance benefits before your appointment, however OUR OFFICE IS NOT RESPONSIBLE FOR YOUR INSURANCE COVERAGE. You may get better benefits with a referral or a prior authorization. *Please check your insurance benefits*. If our provider refers you to another provider, IT IS YOUR RESPONSIBILITY to make sure that provider is also on your insurance plan. If our provider orders lab tests deemed to be in your best medical interest, IT IS YOUR RESPONSIBILITY to check with your insurance company about insurance coverage and/or out-of-pocket costs you may be required to pay.

- **INFORM** us PRIOR TO YOUR APPOINTMENT if you have a change in insurance company(ies) or insurance plan(s). Many insurance companies have deadlines for timely filing of claims. If we have inaccurate information at the time of service, you may be responsible for payment in full for all services rendered.

- **BRING** your insurance card and photo ID to all your appointments

- **PAY** co-pay, deductible, co-insurance, or self-pay amounts when checking in for appointments. Parents or legal guardians of underage patients are responsible for paying fees incurred. Outstanding balances are due within thirty (30) days of the statement date, or within thirty (30) days of the last insurance payment noted on the statement, whichever is later. We accept Visa, MasterCard, Discover, American Express, debit cards, cash, personal checks (with photo ID) and for your convenience you may pay your provider using Xpress-pay from our website at www.uticaobgyn.com

- **ADVISE** us two (2) business days in advance if you cannot keep your appointment. As a courtesy, we try to provide reminder calls, emails, and texts; however, knowing your appointment date and time is your responsibility. If you cannot attend your appointment, you may leave a voicemail in our general mailbox if you cannot reach us during business hours. Missing appointments may lead to your dismissal from our practice.

- **ARRIVE** promptly for your appointment, meaning *at least 10 minutes in advance to allow for check-in or 30 minutes in advance to complete required paperwork*. See the Patient Forms page of www.uticaobgyn.com and save appointment processing time by bringing completed paperwork to your appointment. You may be asked to reschedule if you are late to an appointment.

OUR OFFICE'S POLICIES AND RESPONSIBILITIES

FEES / PAYMENTS / INSURANCE

1. As a courtesy, we will directly bill your insurance company for services rendered, but you are ultimately responsible for payment for deductibles, co-payments, co-insurance, percentages, non-covered services, services rendered without proper referral authorization, or denied services.

2. We bill services rendered to you accurately and will not change diagnosis codes to get your claim paid. This action is illegal. If your insurance does not cover certain procedures or office visits, this dispute remains between you and your insurance company.

3. If you (or, in the case of minor patients, your parent or legal guardian) do not pay required amounts at the time of your appointment, we may ask you to reschedule. Continued refusal to respect the physician/patient relationship by paying for services in accordance with the practice's financial policies may result in our practice discharging you as a patient. You will receive a written letter of discharge and have sufficient time to secure services of another provider.

4. RETURNED CHECK POLICY: If your check is returned for insufficient or held funds, you will be charged a $40.00 fee in addition to the balance due. Additional appointments will not be scheduled until your account balance is paid in full. Your account may be submitted immediately for collection if you do not make payment arrangements with our Business Office upon being notified of insufficient funds.

5. COLLECTION: Balances that reach 90 days past due may be sent to our attorney for collection. If sent to our attorney, you would be financially responsible for all collection and legal fees our office incurs through the process used to collect the delinquent balance. **Please remember, your account can legally be turned to our attorney the day it is due. We want to avoid this and are willing to make payment arrangements with you**.

APPOINTMENTS POLICY – Cancellations and Missed Appointments

1. Your time and ours is valuable. Scheduled appointment time is reserved just for you. We make every effort to work efficiently while providing you sufficient time with our providers so that you receive outstanding medical care.

2. We understand that occasionally circumstances may prevent you from contacting us to cancel or reschedule your appointment, and we do not charge you for rare occurrences. However, missed appointments prevent other patients from having your appointment slot and reduce efficiency of our providers.

3. MISSED appointments (when you do not contact us 48 hours in advance to cancel or reschedule your appointment) may result in a $45.00 administrative missed appointment fee *that must be paid before we will schedule* additional appointments for you.

4. *Excessive missed appointments (two (2) or more during a three (3) month period) may result in our practice dismissing you as a patient*. Your health is important to us and we cannot provide proper medical care to patients not attending appointments. You will receive a written letter of dismissal and will have sufficient time to secure services of another provider.

MEDICAL RECORDS, FMLA, WIC OR OTHER FORMS

We are happy to assist you by completing healthcare-related forms and ask that you understand that doing so does take time from our providers and staff.

1. There is an administrative fee of $30.00 (payable in advance) for completion of each set of forms.

2. You will need to complete your portion of the forms and allow at least ten (10) business days after payment of the administrative fee and our receipt of the forms for completion of FMLA, WIC, Disability, or Return to Work forms. We will complete forms as quickly as possible. A form required for the completion of your forms is available on the Patient Forms page of www.uticaobgyn.com or from Front Office staff.

3. Medical records authorization forms permitting us to send and/or receive your protected health information are on the Patient Forms page of www.uticaobgyn.com or available from Front Office staff.

I have read, understand and agree to the above policies. I authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct unless written notification is received via certified mail within 30 days of the statement date. I agree to pay all charges in accordance with the practice's policies and procedures. I agree to assign my insurance benefits to Utica Women's Specialists and the providers therein, if applicable.

Signature of Patient or Legal Representative	Date
Printed Name of Patient or Legal Representative	Responsible Party Name (if different than patient)

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PATIENT REGISTRATION FORM

LAST NAME	FIRST NAME	MI

Address	City	State	Zip

Home Phone	Work	Cell

SSN#	Date of Birth	Age	Marital Status M S W D

Email Address

EMPLOYMENT STATUS Employed Student Self-Employed Retired Other	Occupation
Patient Employer	Patient Employer Phone

Spouse's Name	Spouse Cell Phone
Spouse's Employer	Spouse's Employer Phone

EMERGENCY CONTACT: NAME AND PHONE OF CLOSEST RELATIVE NOT LIVING WITH YOU.

Name	Phone	Relationship

Ethnicity: Hispanic or Latino: Y N	Smoker: Y N

Current Pharmacy Name	Address	Phone

REFERRING DOCTOR

Name	Phone

INSURANCE INFORMATION

Primary Insurance		Secondary Insurance	
Company Name		Company Name	
Policy Holder		Policy Holder	
Policy Holder Date of Birth		Policy Holder Date of Birth	
Policy Holder SSN#		Policy Holder SSN#	
Employer		Employer	
ID#	Group#	ID#	Group #

I agree that the information provided on this form is accurate to the best of my knowledge. I hereby authorize Utica Women's Specialists, LLC to furnish information to my insurance carrier(s) concerning my illness and treatment, and thereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any unpaid balance, regardless of insurance coverage.

Date _____ Signature of Patient or Legal Guardian _____

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UTICA WOMEN'S SPECIALISTS

PATIENT HISTORY

Name_____ Age_____ Date_____

Date of birth_____/_____/_____ Race: ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ Other _____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Address_____

City_____ State_____ Zip_____

Cell Phone (_____)_____ Home Phone (_____)_____

Occupation_____

Husband/Domestic Partner _____ Phone (____)_____

Emergency Contact_____ Phone (_____)_____

Date last period began: ____/____/_____ **What are you using for contraception?** _____

What is the purpose of your visit? _____

If you have a specific problem, please describe:_____

How long have you had this problem? _____

Have you consulted anyone else? ☐ Yes ☐ No Whom? _____

Describe any previous testing and/or treatments: _____

_____

_____

How did you hear about us? ☐ Primary Care Physician (PCP) ☐ Internet/Publication ☐ Friend ☐ Other

If you were referred by your PCP or friend, please list:_____
Name Telephone

Would you accept a blood transfusion to save your life? ☐ Yes ☐ No

OBSTETRICAL HISTORY

☐ No pregnancies

Please list pregnancies, miscarriages and terminations from past to current (use a separate piece of paper if more space is needed):

Date	Length of Pregnancy (in weeks)	D&C	Type of Delivery (V, C/S)	Anesthesia (Y/N)	Place of Delivery	Preterm Labor (Y/N)	Perinatal Mortality (Y/N)	Infant Sex	Weight	Any complications?

PAST MEDICAL HISTORY

☐ No significant past medical history

Have you ever had any of the following? If yes, please indicate date and treatment:

☐ Diabetes/Diabetes of Pregnancy	☐ Allergies	☐ Hemorrhoids
☐ High Blood Pressure	☐ Anemia	☐ Hiatal hernia/Acid reflux
☐ Cancer	☐ Anxiety disorders	☐ High Cholesterol
☐ Stroke	☐ Asthma	☐ HIV (AIDS)
☐ Heart Trouble	☐ Bladder incontinence	☐ Irritable bowel syndrome
☐ Arthritis/gout	☐ Chronic constipation	☐ Kidney Disease/Kidney stones
☐ Epilepsy/Seizures	☐ Depression	☐ Migraine headaches
☐ Blood clots, phlebitis, DVTs	☐ Gastritis/Gastric Ulcers	☐ Mitral Valve Prolapse
☐ Thyroid Disorder	☐ Endometriosis	☐ Osteoporosis
☐ Hereditary Defects	☐ Heart Disease	☐ Scoliosis
☐ Blood Transfusions	☐ Hepatitis A/B/C	☐ Autoimmune disorder
☐ Psychiatric problems	☐ Ear, Nose or Throat problems	☐ Tuberculosis

_____

_____

_____

_____

_____

_____

PAST SURGICAL AND HOSPITALIZATION HISTORY

☐ No Previous Surgeries or Hospitalizations

Do you have any history of the following? **If yes, please give details and dates:**

1. Cholecystectomy _____
2. Appendectomy _____
3. Hysterectomy _____
4. Oophorectomy _____
5. Cesarean Section _____
6. Tonsillectomy _____
7. Laparotomy _____
8. Wisdom Teeth _____
9. Other surgery _____

Have you been hospitalized for any other reason than the surgeries listed above? ☐ Yes ☐ No

If yes, please give details and dates: _____

_____

Please list any allergies to **medications** _____

_____

_____

Please list any **food** allergies (nuts, shellfish, eggs, etc.) _____

_____

Any allergies to: ☐ Latex ☐ Adhesive/Tape ☐ Iodine ☐ Nickel ☐ Contrast Dye

MEDICATION HISTORY

Please list all current prescriptions and over-the-counter medications you currently take.

PRESCRIPTIONS					
Name of Medication	Dosage (total mg)	Number per day	Prescribing Doctor	Reason for medication	Side effects?
OVER-THE-COUNTER MEDICATIONS, VITAMINS, HERBAL, OR NATURAL SUPPLEMENTS					

SOCIAL HISTORY

Do you consume alcohol? ☐ Yes ☐ No ☐ Daily ☐ Socially

Do you currently smoke? ☐ Yes ☐ No How many packs per day? _____ How many years? _____

Have you smoked in the past? ☐ Yes ☐ No How long ago did you quit? _____

Have you used illicit or IV drugs in the past? ☐ Yes ☐ No

Do you consume caffeine daily? ☐ Yes ☐ No

Do you identify as ☐ heterosexual ☐ homosexual ☐ bisexual ☐ other _____

FAMILY HISTORY

☐ No known significant family history of heart disease (HD), cancer, high blood pressure (HTN), diabetes, or other serious illnesses

Family Member				
	☐ HD	☐ Cancer Type _____	☐ HTN	☐ Diabetes
	☐ HD	☐ Cancer Type _____	☐ HTN	☐ Diabetes
	☐ HD	☐ Cancer Type _____	☐ HTN	☐ Diabetes
	☐ HD	☐ Cancer Type _____	☐ HTN	☐ Diabetes

	Age	**State of Health**	**Medical Conditions**	**Age at Death**	**Cause**
Mother					
Father					
Brother					
Sister					
Spouse					

Complete this form if your visit is gynecological in nature.
GYNECOLOGIC HISTORY

Name: _____
Age your period began: _____
Date of last Pap Smear: _____/_____/_____
Have you ever had an abnormal Pap smear? ☐ Yes ☐ No When? _____
Describe any treatment:_____
Have you been exposed to DES? ☐ Yes ☐ No
How often does your period come? ☐ Not Applicable ☐ 21-30 days apart ☐ Greater than 40 days
☐ Less than 20 days ☐ 30-40 days apart

How many days do you normally flow? ☐ Less than 2 ☐ 2-7 days ☐ 7-10 days ☐ More than 10 days
Type of flow? ☐ Light ☐ Medium ☐ Heavy
Menstrual cramps? ☐ None ☐ Mild ☐ Moderate ☐ Severe
If yes, what do you take? _____ Dosage? _____

Do you require additional overnight protection? ☐ Yes ☐ No
Do you stay in bed during your periods? ☐ Yes ☐ No
Do you bleed or spot between periods? ☐ Yes ☐ No
Do you bleed or spot after intercourse? ☐ Yes ☐ No

Date of last mammogram? ____/_____/_____ ☐ Never
Do you have: ☐ Breast lumps ☐ Nipple discharge ☐ Breast tenderness ☐ Fibrocystic changes

Do you have pain during or after intercourse? ☐ Yes ☐ No
Do you have any concerns with sexual function? _____
_____

What form of birth control do you use?

☐ Birth Control Pills (Name) _____ (Number of Mos/Yrs) _____
☐ IUD (Type/Insert Date) _____ ☐ Rhythm/Natural Family Planning
☐ Condoms/Foam/Suppositories ☐ Tubal Ligation
☐ Menopause ☐ Vasectomy ☐ Hysterectomy
☐ Not sexually active ☐ Other _____

Have you reached Menopause? ☐ Yes ☐ No Age of onset: _____
Do you have hot flashes? ☐ Yes ☐ No Night sweats? ☐ Yes ☐ No
Trouble sleeping? ☐ Yes ☐ No Vaginal dryness/painful intercourse? ☐ Yes ☐ No
Have you ever taken hormone therapy? ☐ Yes ☐ No
Medication taken _____ Duration of treatment _____
Reason for discontinuing therapy? _____

Do you have a chronic vaginal discharge? ☐ Yes ☐ No
Have you used any medication for the discharge? ☐ Yes ☐ No What? _____
Do you douche? ☐ Yes ☐ No How often? _____

Have you been treated for a vaginal infection? ☐ Yes ☐ No
What type? ☐ Yeast ☐ Chlamydia ☐ Pelvic Inflammatory Disease
☐ Trichomonas ☐ Gardnerella ☐ Genital warts/HPV virus
☐ Bacterial ☐ Syphilis ☐ Genital Herpes/HSV virus
☐ Gonorrhea

Burning during urination? ☐ Yes ☐ No Blood in urine? ☐ Yes ☐ No
Urinary frequency? ☐ Yes ☐ No
Do you get up at night to urinate? ☐ Yes ☐ No How often? _____
Do you wet yourself when you cough or laugh? ☐ Yes ☐ No

Have you had a urinary tract infection? ☐ Yes ☐ No How often? _____
When was your last UTI? _____ Have you seen an urologist? ☐ Yes ☐ No

Are you in a relationship with someone who threatens you or physically hurts you? ☐ Yes ☐ No
Has anyone ever forced you to have sexual activities that made you feel uncomfortable? ☐ Yes ☐ No

Complete this form if your visit is obstetrical in nature.
OBSTETRIC HISTORY

Name: _____
What was the first day of your last menstrual cycle? _____/_____/_____
Are your periods regular? ☐ Yes ☐ No
What was the date of your positive pregnancy test? _____/_____/_____

Newborn's Physician _____

Do you have any history of the following? **If yes, please give details and dates:**
1. Diabetes of pregnancy _____
2. Trauma, violence _____
3. Rh sensitized? _____
4. Anesthesia problems _____
5. Abnormal Pap? Treatment? _____
6. Date of last Pap _____
7. Abnormal shaped uterus _____
8. Infertility _____
9. Assisted reproduction _____
10. Blood Disorder/von Willebrand's _____

FAMILY HISTORY FOR FATHER OF BABY

Father of the baby _____ Phone (_____)_____

☐ No known significant family history of heart disease (HD), cancer, high blood pressure (HTN), diabetes, or other serious illnesses

Family Member				
	☐ HD	☐ Cancer Type _____	☐ HTN	☐ Diabetes
	☐ HD	☐ Cancer Type _____	☐ HTN	☐ Diabetes
	☐ HD	☐ Cancer Type _____	☐ HTN	☐ Diabetes
	☐ HD	☐ Cancer Type _____	☐ HTN	☐ Diabetes

Will you be 35 years old or older at the time of delivery? ☐ Yes ☐ No

Does anyone in either family have the following?

Thalassemia?	☐ Yes	☐ No	Muscular dystrophy?	☐ Yes	☐ No
Neural tube defects?	☐ Yes	☐ No	Cystic fibrosis?	☐ Yes	☐ No
Congenital heart defect	☐ Yes	☐ No	Huntington chorea?	☐ Yes	☐ No
Down syndrome?	☐ Yes	☐ No	Mental retardation?	☐ Yes	☐ No
Tay-Sachs?	☐ Yes	☐ No	Other inherited genetic or		
Canavan disease?	☐ Yes	☐ No	chromosomal disorder?	☐ Yes	☐ No
Familial dysautonomia?	☐ Yes	☐ No	Maternal metabolic disorder		
Sickle cell?	☐ Yes	☐ No	(i.e. type 1 diabetes)?	☐ Yes	☐ No
Hemophilia?	☐ Yes	☐ No	Fragile X syndrome?	☐ Yes	☐ No

Recurrent pregnancy loss or a stillbirth? ☐ Yes ☐ No

Have you or the baby's father had any children with a birth defect not listed above? ☐ Yes ☐ No
Type: _____

Are there any medical problems in your family that are significant? ☐ Yes ☐ No
Type: _____

Do you live with someone that has Tuberculosis (TB) or have you been exposed to TB? ☐ Yes ☐ No
Do you or your partner have genital herpes? ☐ Yes ☐ No
Have you had a rash or viral illness since your last period? ☐ Yes ☐ No

Have you been treated for a vaginal infection? ☐ Yes ☐ No
What type? ☐ Chlamydia ☐ Bacterial ☐ Pelvic Inflammatory Disease
☐ Trichomoniasis ☐ Gonorrhea ☐ HPV virus
☐ Syphilis ☐ HSV virus

What is your height? _____
What is your usual weight? _____

What is your normal
blood pressure? _____/_____

Do you own cats? ☐ Yes ☐ No
Do you eat fish regularly? ☐ Yes ☐ No

Do you plan to have your tubes tied? ☐ Yes ☐ No
Have you had the Hepatitis B vaccine? ☐ Yes ☐ No

Are you in a relationship with someone who threatens you or physically hurts you? ☐ Yes ☐ No
Has anyone ever forced you to have sexual activities that made you feel uncomfortable? ☐ Yes ☐ No

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Utica Women's Specialists, LLC, Daran L. Parham, M.D., LLC, Melissa A. Dietz, M.D., LLC, and Kyle A. Wilson, D.O., LLC (hereinafter collectively referred to as "UWS") originate and maintain health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who contribute to my care;
- A source of information for applying my diagnosis and treatment information to my bill;
- A means for a third-party payer to verify that services were billed as actually provided, and;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and acquired in the future until such time as I shall revoke it in writing.

I understand that UWS has a PATIENT PRIVACY NOTICE that provides a more complete description of information uses and disclosures and that UWS has offered me a copy of such notice.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. **By Oklahoma law, we are required to notify you that the information authorized for release may include records that may indicate the presence of communicable or non-communicable diseases.** I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

I AUTHORIZE UWS TO RELEASE MEDICAL INFORMATION REQUESTED BY INSURANCE COMPANIES WITH WHOM I HAVE COVERAGE OR ANY PUBLIC AGENTS SOLELY TO DETERMINE BENEFITS FOR SERVICES PROVIDED. FURTHER, IF ANOTHER PROVIDER'S OFFICE OR I VERBALLY, OR IN WRITING, REQUEST MEDICAL INFORMATION BE PROVIDED FOR THE PURPOSE OF COORDINATION OF CARE, I AUTHORIZE SAID INFORMATION TO BE RELEASED FOR THAT REASON. RELEASE OF INFORMATION FOR ANY OTHER PURPOSE WILL REQUIRE MY WRITTEN CONSENT OR THAT OF MY LEGAL REPRESENTATIVE.

I acknowledge that by supplying my personal contact information, I authorize UWS and/or its automated outreach and messaging service to contact me via phone call, voicemail, email and/or text message of appointment related information, balances due and other limited health-related information as permissible by law. I acknowledge that unauthorized parties may unlawfully intercept or access transmission of protected health information (PHI) despite commercially reasonable security efforts by UWS and third-party messaging services and that I shall not hold UWS or its business associates liable for any such unauthorized disclosure.

In addition to the releases outlined above, please indicate below, the persons/organizations to whom we may release your health information:

Name _____ Relationship _____

Name _____ Relationship _____

I request the following restrictions to the use and/or disclosure of my health information**:** _____

_____

_____ _____

Signature of Patient or Legal Representative Effective Date