Tricia E. Markusen, M.D.
Monterey Women's Health Medical Group, Inc.
Donelle A. Laughlin, M.D.
Gynecology • Obstetrics • Osteoporosis

Patient Information

Name: _____ Birth Date: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May we leave messages on home/cell voicemail Y N Email address: _____

Marital Status: M S W D Language: _____ SSN: _____

Race: American Indian Asian Indian Black/African American European Japanese Korean Native Hawaiian or Pacific Islander White Other: _____

Ethnicity: Central American Cuban Dominican Hispanic/Latino/Spanish Latin American Mexican Not Hispanic/Latino Puerto Rican South American Spaniard

Employer's Name & Address: _____

_____ Occupation: _____

Referred by/ how did you hear about us: _____

Primary Care Physician: _____ Pharmacy Preference: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information:
(Please present you insurance cards at the time of your visit so we can copy them)

Primary Insurance: _____ Name of Policy Holder: _____

Policy Holder DOB: ___/___/____ Policy Holder SSN: _____ Employer: _____

Policy ID#: _____ Group #: _____

Secondary Insurance: _____ Name of Policy Holder: _____

Policy Holder DOB: ___/___/____ Policy Holder SSN: _____ Employer: _____

Policy ID#: _____ Group #: _____

Guarantor Information:

Name of Responsible Party (if other than Patient): _____

Address of Responsible Party: _____

Phone: _____ Relationship to Patient: _____

Signature: _____ **Date:** _____

Tricia E. Markusen, M.D. & Donelle A. Laughlin, M.D.

889 Pacific Street, Monterey, CA, 93940

Phone: (831) 649-0175 Fax: (831) 646-0220

NOTICE OF CHARGE FOR NON-COVERED SERVICES AND PATIENT AUTHORIZATION OF PAYMENT

PATIENT ACKNOWLEDGES AND AGREES:

THIS PRACTICE CHARGES AN ANNUAL DIRECT PATIENT FEE OF $55.00 FOR THE ADDITONAL SERVICES AND BENEFITS DESCRIBED HEREIN.

To ensure timely and effective delivery of the highest quality of care to our patients, this practice provides services that are not covered or otherwise reimbursable under a private health insurance policy, private health plan, or government program ("Additional Services and Benefits"). These Additional Services and Benefits specifically include:

- access to medical providers, registered nurse, and administrative assistants through our online patient portal;
- access to assistance from our office in completion of stated disability forms, employer leave forms, school forms, and life insurance forms without an office visit;
- after hour telephone consultations and prescriptions.

The list of Additional Services and Benefits may be amended or modified to the extent necessary to reflect changes in the practice's policies and procedures. The Additional Services and Benefits are not covered or otherwise reimbursable under private health insurance policies, private health plans, or government programs. This practice will bill any private health insurance policy, private health plan, or government program in which Patient is enrolled for all covered services.

BY SIGNING BELOW, PATIENT REPRESENTS THAT PATIENT FULLY UNDERSTANDS AND AGREES TO BE FINANCIALLY RESPONSIBLE FOR THE ANNUAL DIRECT PATIENT FEE OF $55.00 FOR THE ADDITIONAL SERVICES AND BENEFITS DESCRIBED HEREIN.

Patient Name: _____

Date: _____

Signature: _____

OFFICE USE ONLY PT ID_____ PAYMENT TYPE_____ DOCTOR_____

Tricia E. Markusen, M.D.
Donelle A. Laughlin, M.D., Inc.
Obstetrics • Gynecology • Osteoporosis

Medical History

Date _____

Name _____ Marital Status _____

Address _____ Occupation _____

City/State _____

Phone: Home _____ Work _____
May we call you at Home? Y N May we mail to you? Y N
May we call you at Work? Y N Can we leave messages/results on voice mail? Y N
Can we leave messages/results with family members? Y N

Which Pharmacy do you prefer? _____
Do you prefer generic medications? Y N

Medical History: Have you ever had any of the following:

- ☐ Anemia
- ☐ Asthma
- ☐ Blood Clots or Thrombophlebitis
- ☐ Breast Problems
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Epilepsy/Seizures
- ☐ Gallbladder Problems
- ☐ Headaches
- ☐ Rheumatic Fever
- ☐ Thyroid Problems
- ☐ High Blood Pressure
- ☐ Kidney Disease or Infection
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Mitral Valve Prolapse
- ☐ Diverticulitis
- ☐ Arthritis
- ☐ Other Medical Problems:
  1. _____
  2. _____
- ☐ **Surgery** (Please List)
  1. _____
  2. _____
  3. _____
  4. _____
  5. _____

Current Medications
1. _____
2. _____
3. _____
4. _____

Allergies to Medications _____

Are you taking any Dietary Supplements/Herbal Remedies? Please List _____

Gynecologic History

Age periods started _____ Usual # days of flow _____ Age at Menopause _____
Cycle: ☐ Regular every _____ days ☐ Irregular
Usually: ☐ Heavy ☐ Medium ☐ Light

Number of pregnancies _____
Number of Miscarriages _____
Number of Abortions _____
Number of Premature Births _____
Number of Stillbirths _____
Number of Living Children _____
Problems with Fertility? _____

Have you had any complications with pregnancy or childbirth?

_____

Current Contraception (Pills, condoms, etc.) _____
How long have you used this method? _____

Have you ever had:
☐ Chlamydia ☐ Gonorrhea ☐ Genital Herpes ☐ Genital Warts ☐ Syphillis
☐ Pelvic Inflammatory Disease ☐ HIV

When was your last Pap Test? _____ ? Abnormal Pap Tests: When _____

When was your last Mammogram? _____ ? Abnormal Mammogram: When_____

Have you had a colonoscopy/sigmoidoscopy? Y N When? _____
Have you had a Bone Mineral Density Test? Y N When ? _____
Did your mother take a medication called "DES" when she was pregnant with you? Y N

Do you have any problems leaking urine? Y N

Do you have any problems during sex? Y N

Do you have any concerns regarding your safety at home? Y N

Family History: Has anyone in your family had:

☐ Breast Cancer Who:_____ ☐ Ovarian Cancer Who:_____ ☐ Colon Cancer Who:_____ ☐ Osteoporosis Who:_____

☐ Other Cancer Type _____ Relationship to Patient _____

☐ Heart Disease Relationship to Patient _____
☐ Stroke Relationship to Patient _____
☐ Diabetes Relationship to Patient _____
☐ High Blood Pressure Relationship to Patient _____
☐ Genetic Problems (i.e. Downs Syndrome) Relationship to Patient _____

Social History
☐ Smoker _____Pack(s)/day ☐ Alcoholic Beverages _____drinks/week ☐ Street Drugs
☐ Exercise Regularly?

What is your reason for your visit today? _____

_____

Who referred you to this office? _____

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Financial Policy

1. Services will be billed to your insurance as a courtesy.
2. For patient with **in-network coverage**, after insurance payment has been received, you will be billed for your portion.
3. For patients with **out-of-network** coverage, you will be responsible for payment at the time services are provided. We will refund you after your insurance payment has been received.
4. For patients **without insurance**, we ask that you pay in full at the time of your visit.
5. For patients with Medicare, we will submit your charges to Medicare and your secondary insurance. If you do not have a secondary insurance, you will be responsible for the 20% that is due after Medicare has paid. You are responsible for deductibles, co-pays and any non-covered services.
6. If payment is not received within 30 days, a $25.00 late fee will be assigned to your account.
7. If payment is not received within 2 billing periods (60 days delinquent), an additional $50.00 late fee will be assigned.
8. If you have not contacted our office or made payment after 90 days, a final notice letter will be sent out. If a payment is not received, we will be forced to send your account to our collections agency and we will no longer be able to provide you with medical care.
9. We accept cash, checks and Visa/MasterCard. There is a $35.00 fee for returned checks.
10. You will not be charged a late fee as long as you make your first payment within 30 days, and continue to make monthly payments if you have set up a payment plan.
11. If services or claims are denied by your insurance deemed not a medical necessity, services and balance due will be patients responsibility.

If you have any questions about our financial policy, please call (831)649-0175 ext 5

Authorization to Release Information

I hereby authorize the above named physicians to release to my insurance carrier any information acquired in the course of my examination and treatment.

Assignment of Insurance/Medicare Payments

I request that the payment of private insurance carriers or authorized Medicare and secondary insurance payments be made to Tricia E. Markusen, M.D., Monterey Women's Health Medical Group, Inc., and/or Donelle A. Laughlin, M.D. for any service furnished me by that provider.

I have read and agree to the Financial Policy, Assignment, and Release of Information paragraphs stated above that apply to me. A copy of this agreement shall be as valid as the original.

Patient or responsible party signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

Tricia Markusen, M.D. and Donelle Laughlin, M.D.
889 Pacific St.
Monterey, CA 93940

Tricia Markusen, M.D. and Donelle Laughlin, M.D.
Privacy Officers

I acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- □ Parent or guardian of minor patient
- □ Guardian or conservator of an incompetent patient
- □ Beneficiary or personal representative of deceased patient

Name of Patient: _____

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization. A $15 to $25 processing fee may apply.*

AUTHORIZATION

I hereby authorize: _____
Physician/ Healthcare Facility name & address

Phone: _____ Fax: _____

To release information regarding my medical history, illness, or injury, consultation, prescriptions, treatment, diagnosis, prognosis, including x-rays, correspondence and/or medical records by means of mail, fax, or other electronic methods.

To: Monterey Women's Health Medical Group, Inc.
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889 Pacific Street, Monterey, CA, 93940
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The medical information will be used for the following purpose: _____
This authorization is:

( ) Unlimited (all records, excluding Substance Abuse, Mental Health, HIV diagnosis/treatment)
( ) Limited to the following medical information: _____
I also consent to the specific release of the following records:
Drug/Alcohol/Substance Abuse _____ (initial) Test for Antibodies to HIV _____ (initial)
Psychiatric/Mental Health _____ (initial) HIV Diagnosis/Treatment _____ (initial)

DURATION: This authorization shall be effective immediately and remain in effect until _____ (date)

RESTRICTIONS
Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of authorization.

_____ _____
Signature of patient or *legal personal representative* Relationship *if other than patient*

_____ _____
Patient's Name (PRINT) Date

_____ _____
Patient's Social Security Number Patient's Date of Birth