A WOMAN'S PLACE

A Medical Corporation

Tatiana Fromlak, M.D., Inc. F.A.C.O.G
BOARD CERTIFED
576 N Sunrise Ave STe 240, ROSEVILLE, CA 95661

Date_____

CONFIDENTIAL

Patient information

Last Name:		First Name:	
Middle Initial:		Sex:	Marital Status: M S D W
Current address:		Apt No:	City:
State:	ZIP Code:	SSN:	
DOB:	Home Phone:	Cell Phone:	
Age:	Email:	Occupation:	
Employed By:	Business Address:		Ste:
City:	Zip:	State:	Phone
Emergency Contact Name:		Emergency Contact Phone#:	
Language:		Race:	
Smoking Status:		Ethnicity:	
Referred By:		Primary Care:	
Pharmacy Name:		Pharmacy Address:	
City:	State:	Zip:	

GUARANTOR INFORMATION

Last Name:		First Name:	
Current Address:(if different from above)			Apt No:
City:		State:	
Zip:	SSN:	DOB:	
Age:	Email:	Occupation:	
Employed By:	Business Address:		
City:	State:	Zip:	Business Phone:

INSURANCE INFORMATION

Insurance ☐ Yes ☐ NO	Company:	
Subscriber:	Subscriber DOB:	Policy#:
Group#:	ID#	Code#:

Relationship: Spouse____ Child_____ Self_____ Other____

I hereby authorize my Doctor to furnish and disclose all known facts concerning my care to my insurance company and to other physicians for medical/and or billing purposes only. I hereby authorize my insurance company or fund to make payments directly to my Doctor or any insurance benefits otherwise payable to me for professional services, but not to exceed the stated charges for these services. I understand that I am responsible for any charges not paid by my insurance company, or any charges not paid within sixty (60) days of billing the insurance company. A copy of this authorization will be a valid as the original.

Signature:_____**Date**_____

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Patients Financial Agreement

IF YOU HAVE MEDICAL INSURANCE:
We will file claims to your medical insurance company for the services that are provided by our office. In order for the claims to process correctly, please ensure that the information that is provided to our office on the Patient Information Form is current. If there are any changes in your insurance information please let us know immediately.

Deductibles, Co-Payments, and Coinsurance:
Co-payments are due at the time service is rendered. If you (patient) have a financial responsibility such as a coinsurance and/or deductible, payment is due at the time of service. Our office will only give an approximate amount of payment; and the estimated portion is due at the time of service. Any additional amount due after insurance adjustment is made is the patient responsibility.

Authorizations:
It is the patient's responsibility to provide our office with a current copy of your insurance card at the time of service. If the card is not available it is the patient's responsibility to pay at the time of service.

Providers/Referrals Coverage:
We are able to provide you with our list of providers and/or a referral. However, we are not responsible for ensuring that the provider is covered under your particular plan. It is your responsibility to verify that the provider is covered by your insurance prior to your visit. If the insurance company denies the claim, you will be responsible for the balance.

Medical insurance coverage is a contract between you and your insurance company. WE ARE NOT a party to this contract. We will not be involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. You are ultimately responsible for the timely payment of your account.

PAYMENT METHODS AND OTHER INFORMATION:
We accept cash, check and VISA or MasterCard.
Past due accounts can be set up on payment plans if necessary at no additional cost.
All late cancellations and no-shows will be billed $50 automatically. (We require 24-hour notice in advance to avoid charges.)

A SPECIAL NOTE: In situations of divorce, separation, court orders, etc., the party initiating treatment will be financially responsible for the account (including no-shows and late cancels).

All Returned checks will have a $25.00 dollar service charge. All Future check privileges will be denied.

LAB AND X-RAYS
Laboratory fees are separate from this office. If you belong to an HMO or PPO and must use a specific facility for x-rays and laboratory services, please inform the nurse or the person ordering your test. THIS OFFICE IS NOT REPSONSIBLE FOR ANY LAB OR X-RAY PROCEDURE FEES. IT IS THE PATIENT'S REPSONSIBILTY TO INFORM OUR OFFICE OF WHICH FACILITY AND LABORATORY SHE/HE MUST USE.

Specify where to send your specimens: _____

Please be informed that this office in not accepting any Medi-cal patients.

We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

I acknowledge that I have read and agree to the above Financial Policy.

Signature: _____ Date: _____

Witness: _____Date: _____

A WOMAN'S PLACE,
A MEDICAL CORPORATION
TATIANA FROMLAK, M.D., INC. F.A.C.O.G.
BOARD CERTIFIED, OBSTETRICS & GYNECOLOGY
576 N SUNRISE AVE, STE 240, ROSEVILLE, CA 95661

Health History Questionnaire

DATE OF BIRTH: _____

LAST NAME_____FIRST NAME _____MI:_____

ALLERGIES TO MEDICATIONS: _____

ALLERGIES TO LATEX YES ☐ NO ☐

Circle your answers below

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED

Gynecological History:

AGE OF FIRST PERIOD _____ **DATE OF LAST PERIOD:** _____

REGULAR/IRREGULAR PERIODS? IF IRREGULAR, HOW OFTEN? _____HOW MANY DAYS OF FLOW _____

ARE YOUR MENSTRUAL CRAMPS? MILD MODERATE SEVERE?

ANY BLEEDING BETWEEN PERIODS? **YES NO**

ANY BLEEDING AFTER MENOPAUSE? **YES NO**

DATE OF LAST PAPSMEAR: _____

HAVE YOU HAD ANY ABNORMAL PAPSMEARS? **YES NO IF YES, WHEN?** _____

ANY PROCEDURES DONE FOR TREATMENT: NONE COLPOSCOPY LEEP CRYO COLD KNIFE CONE

OTHER _____

HAVE YOU HAD THE VACCINATION FOR HPV? **YES NO**

HAVE YOU EVER HAD INTERCOURSE? **YES NO**

DO YOU HAVE PAIN WITH INTERCOURSE? **YES NO**

BIRTH CONTROL METHOD? BIRTH CONTROL PILLS IUD NEXPLANON DIAPHRAGM

FOAM & CONDOMS TUBAL LIGATION VASECTOMY OTHER _____

HAVE YOU HAD A VAGINAL INFECTION? YEAST TRICHOMONAS BACTERIAL

ARE YOU HAVING TROUBLE WITH VAGINAL DISCHARGE? **YES NO IF YES, DESCRIBE** _____

HAVE YOU HAD A VENEREAL DISEASE? GONORRHEA CHLAMYDIA HERPES WARTS SYPHILIS

HAVE YOU HAD A PELVIC INFECTION? **YES NO**

HOW MANY PREGNANCIES? _____HOW MANY CHILDREN? _____ NUMBER OF MISCARRIAGES OR ABORTIONS? _____

HEALTH MAINTENANCE

HAVE YOU HAD A MAMMOGRAM? YES **NO IF YES, WHEN**_____

HAVE YOU HAD A COLONOSCOPY? **YES NO IF YES, WHEN** _____

HAVE YOU HAD A BONE DENSITY TEST (DEXA)? **YES NO IF YES, WHEN** _____

ARE YOU UP TO DATE WITH VACCINATIONS? **YES NO**

PAST MEDICAL HISTORY: PLEASE CHECK ANY CONDITION THAT APPLIES TO YOU

HEART DISEASE	_____	ANEMIA	_____
HIGH BLOOD PRESSURE	_____	STOMACH PROBLEMS	_____
BLOOD TRANSFUSION	_____	HEPATITIS	_____
LUNG DISEASE	_____	DIABETES	_____
ENDOMETRIOSIS	_____	DEEP VEIN BLOOD CLOTS	_____
THYROID DISEASE	_____	OTHER MEDICAL PROBLEMS	_____

SURGICAL HISTORY: PLEASE PROVIDE DATE OF PROCEDURE

_____

_____

_____

_____

_____

FAMILY HISTORY: STATE WHO HAS THE DISORDER

BREAST CANCER_____
OVARIAN CANCER _____
OTHER CANCERS_____

DIABETES _____
HIGH BLOOD PRESSURE _____
BLOOD CLOTS/ DVT _____

ARE YOU CURRENTLY TAKING MEDICATIONS? YES NO IF YES, WHICH ONES?

_____

_____

ARE YOU CURRENTLY TAKING HORMONES? YES NO IF YES, WHICH ONES?

_____**HOW LONG?** _____

DO YOU SMOKE CIGARETTES? IF YES, HOW MANY A DAY _____

DO YOU DRINK ALCOHOL? NO OCCASIONALLY FREQUENTLY

DO YOU USE? MARIJUANA COCAINE HEROIN OTHER STREET DRUGS

DO YOU HAVE ANY OF THE FOLLOWING? Circle all that apply

FREQUENT HEADACHES * TROUBLE WITH EYES * TROUBLE WITH EARS * NOSE BLEEDS

WEIGHT CHARGES * NAUSEA* VOMITING * DIARRHEA * CONSTIPATION * SHORTNESS OF BREATH

COUGHING * CHEST PAIN * DIZZY SPELLS * FATIGUE * EASY BRUSING * BLOODY STOOL

LOSE OF URINE OR STOOL

PROLEMS WITH URINATION? BURNING URGENCY BLOODY PAINFUL UNRINATION

Signature: _____ **Date:** _____

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(916) 782-3791 • (916) 782-1717

Patient Symptom and treatment request

Patient Name _____ Birth Date _____

Briefly describe the symptom(s) or reason(s) you are seeing the doctor today.

1. _____
2. _____
3. _____
4. _____
5. _____

List all current medication(s)

1. _____
2. _____
3. _____
4. _____
5. _____

_____ _____
Patient signature Date

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization

Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights

As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please feel free to contact us.

Acknowledgment of Receipt of Notice of Privacy Practices

The use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I, _____ (printed name of patient or personal representative), acknowledge that A Woman's Place, A Medical Corp. Tatiana Fromlak M.D., INC. or their duly authorized representative has provided a written copy of their Notice of Privacy Practices for Protected Health Information to (check one)

___myself or __specify: _____

_____ _____

Patients Signature **Date**

If you are signing as a personal representative, documentation of your legal right to do so must be provided.

_____ _____ _____

Signature of Patient or Personal Representative Date Printed Name

_____Relationship to Patient (if not self)

This section is for the use of the office of A Woman's Place, A Medical Corp. Tatiana Fromlak M.D., INC. only

We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

_____

_____ _____ _____

Signature of Representative Date Printed Name

_____

Title

This form is to be filed in the patient's medical record

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Date: _____

Patient: _____ **Birth date:** _____

I, _____ , give **Tatiana I. Fromlak, M.D.** my permission and consent to discuss my medical treatment, diagnosis or any medical related information with

_____
(Name of person)

_____ **Date:** _____
Patient Signature

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Dear Patient,

MEDI-CAL

_____ Tatiana Fromlak, M.D. is not currently contracted with any **Medi-Cal** lines of business/insurance. It is against the law for Dr. Fromlak to see **Medi-Cal** patients in exchange for direct payments. It is also against the law for **Medi-Cal** patients not to inform the provider of their **Medi-Cal** status.

Therefore, by signing below you are stipulating that you do not have **Medi-cal** insurance nor are you currently applying for **Medi-Ca**l insurance or any **Medi-Cal** line of business and will notify Dr. Fromlak's office should you obtain **Medi-Cal** insurance. If you do obtain **Medi-Cal** insurance during the course of your care you will be discontinued from further/future visits with Dr. Fromlak and we will forward your records to your new OBGYN.

Signature: _____ **Date:** _____

Covered California

_____ Tatiana Fromlak, M.D. is not currently contracted with any **Covered California Plan** lines of business to include **BLUE CROSS PATHWAY,** and **BLUE CROSS.** By signing below you agree not to file any grievance against Tatiana Fromlak, M.D. for services rendered. I understand it is the patient's responsibility to verify coverage and plan participation.

Signature: _____ **Date:** _____