A Woman's Place
♀
A Medical Corporation
Tatiana Fromlak, M.D., Inc. F.A.C.O.G.
Board Certified

729 Sunrise Avenue, Suite 800 • Roseville, Ca. 95661
(916) 782-3791 • (916) 782-1717

Patient Symptoms 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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Annual Exam/Gynecology Preventative Care Exam
Payment Disclosure and Agreement

An Annual Exam or Preventative gynecology Exam might or might not be covered by your insurance company. Benefit contracts vary and some do not allow preventative care. If you are not sure if an annual/preventative exam is a benefit of your plan, you should call your insurance company.

What is an annual/preventative exam?
An annual exam is a once-a-year visit to your provider for a general health check, including a breast exam, pap smear and review/ordering of age appropriate screening tests.
An annual exam visit does not include discussion of new/old problems or detailed review of chronic conditions.

This exam is prevention focused, not problem focused.
If you have a new health problem or other diagnoses that need to be addressed during your preventive office visit, e.g. breast pain, painful urination, vaginal discharge, skin rash, or headaches, or other health issues we may bill part of the exam at 100 percent for your annual preventive exam and part of your office visit to address/treatment of your diagnosis. The portion of your visit related to the treatment of your diagnosis would apply toward your deductible, coinsurance and copay.

I _____, have requested a preventative exam on this date of _____, and have been informed that if my insurance does not cover this exam, I will be responsible for any liability incurred. Further, lab, x rays and any other ancillary service will be billed separately from the physician's fees. Further, any other health issues addressed during this exam will be billed in addition to preventative visit.

Patient Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Print Witness Name: _____

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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

A Woman's Place A Medical Corp Tatiana Fromlak M.D.,Inc.
Summary of Notice of Privacy Practices

The Health Insurance Portability and Accountability act of 1996 ("HIPAA") requires that, effective April 14, 2003, we provide you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. Each section is covered in detail in our full Notice, which we encourage you to read in its entirety. *We are required to ask you to sign a one-time acknowledgment that you have received this summary. A copy of the full Notice is available upon your request.*

Yours Rights As A Patient

You have many new and important rights with respect to your protected health information ("PHI"). These are summarized below and described in detail in our full Notice of Privacy Practices.

Use of Protected Health Information

We are permitted to use your PHI for treatment purposes, to facilitate our being paid, and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose PHI under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them permissible.

For entities that are not covered under HIPAA to which we must send PHI for treatment, payment, or operational purposes, we require that they sign a contract in which they agree to protect the confidentiality of this information.

Disclosures Of Protected Health Information Requiring Your Authorization

For disclosures that are not related to treatment, payment or operations, we will obtain your specific written consent, except as described below.

Disclosures Of Protected Health Information Not Requiring Your Authorization

We are required by state and federal law to make disclosures of certain PHI without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

Communication To You Of Confidential Information By Alternative Means

If you make a written request, we will communicate confidential information to you by reasonable alternative means, or to an alternative address.

Restrictions To Use And Disclosure

You may request restrictions to the use or disclosure of your PHI, but we are not required by HIPAA to agree to such requests. However, if we do agree, then we are bound to honor your request. In the course of our use and disclosure of your PHI, only the minimum amount of such information will be used to accomplish the intended goal.

Access To Protected Health Information

You may request access to or a copy of your medical records in writing. We will provide these within the time period specified, unless we are forbidden under HIPAA or by applicable state law to provide such records. If we deny access, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial.

Amendments To Medical Records

You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical record.

Accounting Of Disclosures Of Protected Health Information

You may request in writing an accounting of disclosures of your PHI. This accounting excludes disclosures made in the course of treatment, payment, or operations, and disclosures that were made as a result of your written authorization.

Other Uses Of Your Health Information

Optional uses, as permitted under HIPAA, are listed in our complete Notice of Privacy Practices.

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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 payment. 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-Cal** 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: _____

A Woman's Place ♀

Tatiana Fromlak, M.D., I.N.C.

729 Sunrise Avenue, Suite 800 • Roseville, Ca. 95661
(916) 782-3791 • (916) 969-6626 • (916) 782-1717

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

A WOMAN'S PLACE,
A MEDICAL CORPORATION
TATIANA FROMLAK, M.D., INC. F.A.C.O.G.
BOARD CERTIFIED, OBSTETRICS & GYNECOLOGY
729 SUNRISE AVE, STE 800 ROSEVILLE, CA 95661

Health History Questionnaire

DATE OF BIRTH: _____

LAST NAME_____FRIST NAME _____MI:_____

ALLERGIES TO MEDICATIONS: _____

ALLERGIES TO LATEX YES ☐ NO ☐

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?

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:** _____

A WOMAN'S PLACE

A Medical Corporation

Tatiana Fromlak, M.D., Inc. F.A.C.O.G
BOARD CERTIFED
729 SUNRISE AVE SUITE 800, 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: _____