Patient Registration
CONFIDENTIAL

Welcome to our Office

Date

Patient Name | MARITAL STATUS S M W D SEP | Date of Birth

Race | City, State, Zip

Mailing Address

Phone - Home ( ) | Cell Phone ( ) | S.S.# (required)

Email Address

Referred By | Driver's License #

Patient's Employer | Occupation (indicate if student)

Employment Address | Phone ( )

Smoker? (circle one) Yes No Quit If yes, per day.

Spouse's Name | Date of Birth

Occupation / Employer | Phone ( )

Emergency Contact Name (other than spouse) | Relation

Spouse's S.S. # | Phone ( )

Billing Information & Responsible Party

Payment Required at Time of Service - Unless Prior Arrangements Have Been Made

Billing Name *(other than parent)* | Relation to Patient

Billing Address

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of medical benefits to Dr. Charles Padgett and Dr. Stephen Padgett for medical services rendered. I also authorize the release of my medical records to any referring physician for further medical treatment or in processing applications for financial benefit. If it is necessary to collect unpaid fees for services rendered, I agree to pay the assessed charges by the collection service, legal counsel or court.

❑ I have read the HIPPA Policy and I agree to terms.

Signature:_____ Date:_____

Patient (please print) _____ Date _____

Parent/Guardian (please print) _____ Signature _____

CHARLES E. PADGETT, M.D.
STEPHEN M. PADGETT, M.D.
1211 COOLIDGE STREET - SUITE 405
LAFAYETTE, LOUISIANA 70503

337-233-7524
Fax: 337-233-7567

WELCOME TO CHARLES PADGETT, MD & STEPHEN PADGETT, MD PATIENT PORTAL

In our ongoing efforts to improve the quality of care that Charles Padgett, MD and Stephen Padgett, MD provide, we are pleased to announce the availability of our Patient Portal to better serve you. The Patient Portal is a **secure**, web-based system that allows you to review certain aspects of your medical record. The portal also allows you to securely communicate with us between visits for **NON-EMERGENT** issues and questions. You can even download and securely transmit a summary of your medical record to other web-based applications and providers of care. Over time, we will be phasing in various features and functions that will be available through the Patient Portal.

Portal Acceptance

I have read and understand the above and authorize Charles Padgett, MD and Stephen Padgett, MD to activate my patient portal account using the email address listed below. I understand that it is my responsibility to safeguard the email address and my Patient Portal passwords in order to maintain the security and privacy of my personal health information. I also understand that Charles Padgett, MD and Stephen Padgett, MD will use the Patient Portal as a means of communicating with me when appropriate. I further understand that the Patient Portal is not to be used for urgent medical needs, nor does it replace the need for me to keep my regular appointments with my doctor:

Patient Name:_____ **Date of Birth:**_____

Email address to use in conjunction with my account:

_____

**The activation email will have more specific information about the Patient Portal Announcement, the Patient Portal Online Access Instructions, and the Patient Portal Guidelines and Usage Instructions.

Portal Decline

I have read and understand the above announcement and choose to decline the use of the Patient Portal at this time.

Patient Name: _____ **Date of Birth:** _____

We are sorry that you currently choose to decline but please let us know if we can answer any specific questions or concerns you may have. If you'd also like to look at more specific information about Patient Portal Announcement, the Patient Portal Online Access Instructions, and the Patient Portal Guidelines and Usage Instructions on your own time, we would gladly make copies available to you.

****PLEASE NOTIFY US IMMEDIATELY IF YOU****
****CHANGE YOUR EMAIL ADDRESS AT ANY TIME****

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Confidential Channel Communication Request

As required by the Health Information Portability and Accountability Act (HIPPA) of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels.

I hereby request the use of the following confidential channels for the communications of information related to my personal health, treatment or payment for treatment. This request supercedes any prior request for confidential channel communications I may have made.

1. May we discuss your Personal Health Information with anyone else? (You must fill in the name and phone number if okay.)

   Spouse_____

   Parent_____

   Child or Children _____

   _____

   Other _____

2. May we leave a detailed verbal message or send written correspondence to:

   _____Home Number _____ Work Number _____ Cell Phone _____ Fax

   _____Home Mailing Address _____ Billing Mailing Address

   _____Work Mailing Address _____ Other(please list) _____

   _____

   If No we will leave message with call back number only!

_____ _____

Patient or Responsible Persons Signature Date

Charles Padgett, M.D. – Stephen Padgett, M.D.
Office Policy Agreement

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW MY INSURANCE BENEFITS. THOSE SERVICES THAT ARE DEEMED NON-MEDICALLY NECESSARY OR NON-COVERED WILL BY MY RESPONSIBILITY.

PAYMENT FOR SERVICES ARE DUE AT TIME THEY ARE RENDERED. This includes co-pays, coinsurance and deductibles stipulated in your insurance policy for our participating insurance companies. You can pay cash, check, money order or credit card. **Failure to pay in full at time of service will result in an additional billing charge of $15.00. You will also be charged a $15.00 fee if your co-pay is not presented at time of service.**

I UNDERSTAND THAT I MUST PROVIDE ALL INSURANCE CARDS AT EACH VISIT. If we are a participating provider with your insurance plan, we will submit a claim on your behalf to your insurance carrier with benefits assigned to us. Unless you provide us with an up to date insurance card, you will be responsible for paying our charges.If you are unable to keep a scheduled appointment, please call no later than **24 hours in advance.** Missed appointments are bad for all concerned and may prevent some other patient from being seen. We reserve the right to charge for missed or late cancelled appointment. We document missed appointments and excessive abuse may result in discharge from the practice. **There is a $50 charge for all pre-scheduled ADD-IN appointments when a patient fails to show or if the appointment is not cancelled in a timely manner.**

We recognize the importance of everyone's time and it is our goal to have you in and out of the office in a timely manner. You may help by arriving on time and having all necessary information. Late arriving patients may be asked to reschedule or maybe worked in AFTER others who arrive on time.

CALLS: All calls will be triaged by the call nurse and returned the same business day in the order received.
SAMPLES: In all fairness, only two sample packs of birth control, hormones etc... will be given at time of annual appointment if available. After that, a written script will be given.
FORMS: Forms must be left at our office for 5 working days and billed at $15-$20 per form. Only pre-paid forms will be mailed or faxed.

Your billing receipt includes all information necessary for submission to your insurance. They should also be kept for tax purposes. If an end of year copy is requested., we will charge $10.

Our billing office can be contacted Monday from 8:30-11:45 & 1:00-4:45, Friday 8:30-11:45. Call if prior payment arrangements must be set up with Office Manager.

I agree that should my claim by denied or remain unpaid for a period exceeding 60 days, I will assume full responsibility for payment. If the account is turned over for collections, I agree to pay all fees associated with collecting unpaid balance.

Please indicate your agreement with this policy by signing below.

_____ _____

Signature Date

TODAYS DATE:_____

OB/GYN PATIENT HEALTH HISTORY QUESTIONNAIRE

Name: _____

Reason for visit: _____

Referring physician: _____

Medication Allergies: _____

Other allergies: _____

LATEX ALLERGY _____YES _____NO

Medications currently taking: (please list drug name, strength, frequency)

_____

_____

_____

_____

GENERAL HISTORY:

Marital status: _____ Occupation_____

Level of education _____

Smoking status: _____ never _____quit _____smoker/ how many per day _____

Alcohol use: _____none _____socially _____ daily **Exercise:** _____daily _____times/week _____inactive

Medical History: (check all that apply; use additional lines for those conditions not listed)

_____Hypertension _____High Cholesterol _____Diabetes _____Anemia

_____Arthritis _____Heart Disease _____Kidney dis _____Liver dis

_____Migraines _____Anxiety d/o _____Depression _____Reflux

_____Blood clot _____Osteopenia _____Osteoporosis _____thyroid dis

_____Breast issues _____Cancer: is yes, specify type:_____

Additional issues not listed: _____

_____

(Surgical History: please list any GYN surgeries or abdominal surgeries you may have had;

ex: D&C, Laparoscope, C-Section, Hysterectomy, Bladder surgery, Tubal, myomectomy, ovarian surgery, Gastric surgery, etc)

_____

_____

Family History: (list immediate family members with a history of the following GYN conditions)

Breast cancer: _____

Uterine cancer: _____

Ovarian cancer: _____

Cervical cancer: _____

Osteoporosis: _____

Blood clotting disorder: _____

Other cancers: (list member and type): _____

Last menstrual cycle: _____ Hysterectomy: _____ Menopause _____

Current method of Birth control:

_____ NFP _____Condoms _____Withdrawal _____Spermicide

_____Birth control pill _____Vaginal ring _____Injection _____ Nexplanon

_____IUD _____Tubal _____Vasectomy

Last Pap Smear: _____ Normal _____ Abnormal _____

If Abnormal, did you have any of the following:

Colposcopy _____ Cryotherapy _____ Cervical Cone _____ LEEP _____

Last Mammogram: _____ Normal _____ Abnormal _____

Biopsy: No _____ Yes _____ If yes, which breast _____ Findings: _____

Bone Density: _____ Normal ____ Osteopenia ____ Osteoporosis ____

History of Sexually Transmitted diseases:

(if treated in past for any of the following, please list: HPV, HSV, chlamydia, gonorrhea, genital warts, trichomonas)

_____

Pregnancy History:

Total pregnancies: _____ Miscarriages _____ Abortion _____ Live births _____

Number of living children _____

List pregnancies below:

1. Year _____ Vaginal _____ C-Section _____ Weeks at delivery _____

   Weight of baby _____ Hospital _____

   Dr who delivered _____

   Complications _____

2. Year _____ Vaginal _____ C-Section _____ Weeks at delivery _____

   Weight of baby _____ Hospital _____

   Dr who delivered _____

   Complications _____

3. Year _____ Vaginal _____ C-Section _____ Weeks at delivery _____

   Weight of baby _____ Hospital _____

   Dr who delivered _____

   Complications _____

4. Year _____ Vaginal _____ C-Section _____ Weeks at delivery _____

   Weight of baby _____ Hospital _____

   Dr who delivered _____

   Complications _____

5. Year _____ Vaginal _____ C-Section _____ Weeks at delivery _____

   Weight of baby _____ Hospital _____

   Dr who delivered _____

   Complications _____