Jennifer Meadows, MD
Mikaela Rush, MD

CEDAR PARK WOMEN'S CENTER

Welcome to our office

Name: _____ Today's Date: _____
First Middle Last

Home Address: _____
City: _____ State: _____ Zip: _____ Cell( ) _____
Telephone: ( ) _____ Birthdate: _____ Age: _____
Email Address: _____ May send information here? _____
Primary Care Doctor: _____ Referring Doctor: _____
Occupation: _____ SSN: _____
Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____ Work Phone( ) _____
Pharmacy name and location _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____ Birthdate: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: ( ) _____

Name of Spouse: _____ Birthdate: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Employer's Telephone: ( ) _____

In case of emergency, contact: _____ Relationship: _____
Home Phone: ( ) _____ Work Phone: ( ) _____

How did you learn about our practice? _____

Do you wish correspondence to be confidential?	Yes	No
Do you wish phone calls to be confidential?	Yes	No
May we contact you at work?	Yes	No

Insurance Information

Patient's Name: _____ Today's Date: _____
First Middle Last

[Primary Insurance]
Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Subscriber's Name: _____

Subscriber's DOB: _____ Subscriber's SS#: _____

Policy ID # : _____ Group #: _____

WE CURRENTLY DO NOT BILL SECONDARY INSURANCES. We are happy to supply you with a form to submit to your secondary for reimbursement.

Our office will file insurance for all reimbursable services, to your **PRIMARY** insurance carrier. At this time we do not bill secondary insurances. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

Method of Payment for Today's Visit: ___Cash ___Check ___Visa/MC

Signature of Patient or Responsible Party: _____

Date: _____

I authorize the release of any medical information necessary to process my claim.

Signed:

_____
(Patient or responsible party)

Date: _____

I authorize payment of medical and surgical benefits to

- ☐ Jennifer Meadows, M.D.
- ☐ Mikaela Rush, M.D.

Signed: _____
(Patient or responsible party)

Date: _____

Medical History

Name: _____ Age: _____ Date of Birth: _____ Today's Date: _____
At what phone number may we leave a personal message? (___) _____ Occupation: _____
Marital Status: _____ Pharmacy: _____ Location: _____

PERSONAL MEDICAL HISTORY: Please circle a personal medical history of ANY of the following:
Heart Disease High Blood Pressure Kidney Disease Seizure Disorder Cancer Mental Illness Anxiety/Depression
Thyroid Disorder High cholesterol PCOS Asthma Smoking _____ packs per day Alcohol Abuse Drug Abuse

Allergies To Medication: _____ **No Allergies To Medication**

List any CURRENT medication/supplement/vitamin: _____

List any surgeries you've had: _____

GYN HISTORY:
Last menstrual period (first day) _____ Age at first menstruation: _____ Frequency of periods _____ days
How long does your period last? _____ days Present birth control method _____
Last pap smear _____ normal abnormal Have you had a past abnormal pap smear? Yes No When? _____
Last mammogram (date) _____ normal abnormal Last bone density _____ normal abnormal
Are you sexually active? Yes No Not currently Sexual preference? Male Female Do you have sexual difficulties? Yes No
Have you ever been sexually abused? _____ Do you feel safe in your current relationship? Yes No

STD HISTORY: Please circle a personal medical history of ANY of the following and write the year/treatment given:
Chlamydia _____ Gonorrhea _____ HPV (warts) _____ Herpes _____ Trichomonas _____
PID _____ Syphilis _____ Hepatitis B or C _____ HIV/AIDS _____

PREGNANCY HISTORY:
Total pregnancies _____ Full term births _____ Premature births _____ Stillbirths _____ Miscarriage _____
Ectopic pregnancies _____ Which side? Left Right Abortions _____ Adopted children _____
Please List Pregnancy Details:
Date of birth: _____ Male Female Weight: _____ Vaginal C-Section Complications: _____
Date of birth: _____ Male Female Weight: _____ Vaginal C-Section Complications: _____
Date of birth: _____ Male Female Weight: _____ Vaginal C-Section Complications: _____
Date of birth: _____ Male Female Weight: _____ Vaginal C-Section Complications: _____
Date of birth: _____ Male Female Weight: _____ Vaginal C-Section Complications: _____
Date of birth: _____ Male Female Weight: _____ Vaginal C-Section Complications: _____

FAMILY HISTORY: Please checkmark a family history of any of the following:

If there is **a family history of cancer, please specify WHICH TYPE:** _____

	Mother	Father	Mat GM	Pat GM	Mat GF	Pat GF	Aunt/Uncle	Sibling
Cancer								
Heart Disease								
Thyroid Disease								
High Blood Pressure								
Diabetes								
Kidney Disease								
Genetic Disorder								
Lung Disease								
Mental Illness								
Other								

CEDAR PARK
WOMEN'S CENTER

Authorization Form for Release of Protected Health Information with Family or Friends

Patient Name: _____ **DOB:** _____

I grant permission for my healthcare provider and their representatives of CPWC to discuss my care using this disclosure form to share relevant information about my healthcare or discuss financial information for payment on my account with family or friends.

- **I consent to CPWC to leave a detailed message on my voicemail/answering machine regarding my lab/test results** ☐ **Yes** ☐ **No**

☐ **I do not want any of my information shared with family or friends**

Release my protected health information to the following person(s)/entity:

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

The information you may release subject to this authorization is following:

Appointment date/time ☐ **Yes** ☐ **No** Explanation of diagnosis and/or procedures ☐ **Yes** ☐ **No**

Lab reports ☐ **Yes** ☐ **No** Billing information ☐ **Yes** ☐ **No**

I understand that my healthcare information at Cedar Park Women's Center is protected. I have received this Notice of Privacy Practices and this document will be on record with CPWC.

_____

Patient Signature Date

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to Cedar Park Women's Center.

Jennifer L. Meadows, M.D.

Mikaela Rush, M.D.

CEDAR PARK
WOMEN'S CENTER

Cedar Park Women's Center Patient Consent Form

By signing this form, you are granting consent to Cedar Park Women's Center to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have legal right to review our Notice of Privacy Practice before you sign this consent and we encourage you read it in full.

Our Notice of privacy practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our health information officer at: (512) 260-3636.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to evoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Patient Names (Print): _____

Signature: _____

Date: _____

Office Use Only:

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this acknowledgement but did not because _____.

_____
Signature of Privacy Officer

CEDAR PARK
WOMEN'S CENTER

Please read, initial and sign below

***(Initial)*_____**FINANCIAL RESPONSIBILITY: I understand that payment is due at the time of service. I understand that I am ultimately responsible for payment on my account. This may include but not limited to:

- *Entire balance when there is no insurance coverage; with insurance coverage, all and any co-pays, co-insurances and deductible payments.*
- *Any balances due within 30 days after insurance has been processed.*

I understand that I am responsible for any authorization or referral my insurance may require, and verification of IN-NETWORK status prior to the time of service. I understand that I am ultimately responsible for payment on my account.

***(Initial)*_____**LAB SERVICES: I am aware that any samples collected at my visit (Blood, Urine, Tissue, Genetic Testing, etc) are sent to an outside lab for processing. I understand that these services will be billed to me separately by the lab. I will need to contact the lab directly for their charges.

***(Initial)*_____**INSURANCE COVERAGE: I understand that is my responsibility to update Cedar Park Women's Center with current, accurate insurance information at each visit. I will be responsible for any balance due as a result of not disclosing this information.

(Initial)*_____**FEE FOR FMLA/DISABILITY FORMS COMPLETION: I understand that I will be responsible for paying $25.00 for forms completions by Cedar Park Women's Center or staff. ***This does not include the New Patient Forms. (Example: FMLA forms, disability forms, etc.) Please allow 10 business days for completion of any forms, and plan accordingly. This fee is due prior to the forms being completed, and is not covered by insurance.

***(Initial)*_____**FEE FOR MATERNITY SONOGRAM CD: We can make a CD of your Anatomy Sonogram pictures for $15.00. This fee is due at the time of the sonogram, and is not covered by insurance.

***(Initial)*_____**FEE FOR MISSED APPOINTMENTS: I understand that there is a $40.00 fee for missing a scheduled office visit appointment. If you are scheduled for an ultrasound the fee is $50.00. We require 24 hour notice for appointment cancellation. This is not covered by insurance.

Patient Name: _____

Signature: _____

Date: _____

1401 Medical Parkway B, Ste 410 Cedar Park, TX 78613 Office (512)260-3636 Fax (512)260-3911