MODERN
OBSTETRICS & GYNECOLOGY
of North Atlanta, P.C.

Consent to Treatment and Other Acknowledgments

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following: While routinely performed without incident, there may be material risks associated with any procedure. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.

I hereby expressly authorize and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to Modern OB/GYN of North Atlanta and all professionals (including independent contractors) providing for such care and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to Modern OB/GYN of North Atlanta and the third-party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits).

A copy of this document may be utilized the same as the original.

Name: _____

DOB: _____ / _____ / _____

Today's Date: _____ / _____ / 20_____

Revised 07/2025

Financial Policy/Cancellation Policy

Thank you for choosing us as your healthcare provider. We are committed to you and your healthcare needs. Please understand that payment of your bills is considered part of your care. The following is a statement of our financial policy. We require that all of our patients read and sign it prior to treatment or consultation.

All patients must complete our information and provide insurance information before seeing the doctor/provider**.**
PAYMENT IN FULL IS DUE (UPON REQUEST) AT THE TIME OF SERVICE.
For your convenience, we accept Cash, Credit or Debit cards.

(Please initial after each number.)

1. _____ It is the responsibility of the patient to confirm that the physician/provider is participating with the insurance plan and that your benefits are active. Our office will file claims to your insurance company for professional services rendered. We cannot bill your insurance carrier unless you give us your current insurance information. Please remember, **INSURANCE COVERAGE IS A LEGAL CONTRACT BETWEEN THE PATIENT AND THE INSURANCE COMPANY.** Benefits may differ depending upon what type of contract you have with the carrier. If your insurance company has not paid your account in full at the end of 90 days, the balance will automatically be transferred to your responsibility for payment in full. Please be aware that some or perhaps all the services provided may be non-covered services and not considered necessary under the Medicare Program or other medical insurances.

2. _____ All **co-pays and deductibles are due at the time of treatment**. We require payment in full for your portion (coinsurance, deductible or out-of-pocket fees) at the time of service. In office we accept Visa, MasterCard, Discover, American Express and cash. If a check is returned from your bank, there will be a **$40** returned check fee added to your total amount due. Ultimately, you are responsible for all charges incurred in our office. The insurance contractual obligation does not allow us to write off co-pays or deductible amounts.

3. _____ In the event a patient is due a refund, the refund will be applied to the original form of payment.

4. _____ As a courtesy, we have contacted your insurance company to verify benefits. Based on this provided information, we are able provide your estimated patient responsibility for services rendered. This is an estimate and not a guarantee of benefits. There may be additional charges once claims have been processed by your insurance company.

5. _____ If the patient cannot keep the scheduled appointment, **it is the patient's responsibility to give our office at least 24 hours cancellation notice.** We reserve the right to charge an **$85.00** fee for missed or cancelled appointments with less than 24 hours notice. Please help us serve you and other patients better by keeping scheduled appointments.

6. _____The patient understands that if their account balance is over 90 days past due, their account will be in default and may be referred to a collection agency. If this occurs, the patient may lose the ability to be seen until their account is paid in full.

7. _____All lab procedures are done by an outside lab and will not be included in the charges for Modern OBGYN. All lab tests performed are billed separately by the outside lab. The patient understands that all charges not covered by insurance is the patient's responsibility. The patient will direct any questions regarding a bill or statement from the outside lab to the lab directly.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT FINANCIAL RESPOSIBILITY AS DESCRIBED ABOVE.

_____ DOB: _____ / _____ / _____

Patient, Legal Guardian or Responsible Party Signature

Today's Date:_____ / _____ / 20_____

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Patient Consent & Acknowledge of Receipt of Privacy Notice

I, _____understand that as a part of the provision of healthcare services, Modern Obstetrics & Gynecology of North Atlanta, P.C. creates and maintains health records describing my health information. This includes but is not limited to my health history, symptoms, diagnoses, examination and test results, treatment, and any plans for future treatment, personal information, and insurance data.

I have read and/or have been provided with a copy of the Notice of Privacy Practices that provides a complete description of the uses and disclosures of certain health care information.

By signing this form, I consent to the use and disclosure of the protected health information about me for the purpose of treatment, payment and health care operations. I understand that I have the right to revoke this consent in writing except where disclosures have already been made in reliance on my prior consent**.**

Patient's Printed Name: _____

Signature: _____ **Date:** _____ / _____ / _____

Witness: _____ _____ **Date:** _____ / _____ / _____

I, hereby authorize and give permission to Modern Obstetrics & Gynecology of North Atlanta, P.C., to disclose and discuss any information related to my medical condition(s) to/with the following persons:

_____	_____
Name	Relationship
_____	_____
Name	Relationship

OR: ☐ **Do not share my information with anyone outside of my PCP, referring MD, and insurance company.**

I wish to be contacted in the following manner:

☐ Home/Work/Cell Number: _____ **OR** ☐ Written Communication:

☐ OK To Leave a Detailed Message ☐ OK To Mail To My Home Address

☐ Leave A Simple Message with A Call Back Number ☐ OK To Fax To This Number: _____

By my signature below, I authorize the release of any medical or other information deemed necessary by Modern OBGYN of North Atlanta, P.C., including transferring of medical records to support medically necessary referrals to other health providers.

Signature of Patient: _____ **Date:** _____ / _____ / _____

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Medical Records Release Request

Patient Information:

Patient Name: _____ Contact Number: _____
DOB: _____/_____/_____ Social Security ID: _____
Home Address: _____
City, State and Zip: _____

I, _____ authorize the above listed person/s, firm, or entity(or its agents, representatives or employee) to release for inspection and copying and use, any and all of the Personal Health Information (PHI) listed below that pertains to my treatment, hospitalization or care from date/s of: _____/_____/_____ to _____/_____/_____

To/From: (please circle)
Modern OBGYN of North Atlanta
10692 Medlock Bridge Road, Suite 100A
Johns Creek, GA 30097
Fax: 404-446-2497
Office: 404-446-2496

To/From: (please circle)
Name: _____
Address: _____
City, State,Zip: _____
Fax: _____

Note: All records requests that come *into* our office either written or verbal will initially be processed by our Medical Records Coordinator. From that point, requested information will be forwarded to the provider for approval and signature. No records are to be released without the provider's approval and Administrative Certification. Please note, there will be a Fee of $35.00 if the records are released ***to you*** directly.

What Records Do You Need:

- ☐ Entire Record
- ☐ Radiology/Xray Reports
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Laboratory Results
- ☐ Labor & Delivery Records
- ☐ ER/Hospital Reports
- ☐ Other: _____

Which Provider Do You See:

- ☐ Dr. John Reyes
- ☐ Dr. Ingrid Reyes
- ☐ Dr. Natu Mmbaga
- ☐ Dr. Zin Alonso
- ☐ Dr. Tina Lu
- ☐ Dr. Natalie Clericuzio
- ☐ Dr. Miranda Long
- ☐ Dr. Shelley Zippay
- ☐ Dr. Whitney Cook
- ☐ Other _____
- ☐ Emily Dixon
- ☐ Skyler Jacobs
- ☐ Katie Vaughn
- ☐ Lana Wertz
- ☐ Kristine Raynard
- ☐ Erica Richmond
- ☐ Lyndsey Pulliam
- ☐ Juliet Pulliam
- ☐ Kristi Vines-Presley
- ☐ Emily Chung
- ☐ Joanne Lee
- ☐ Paige Marolf
- ☐ Amber Becker
- ☐ Hemali Patel
- ☐ Anna Hepburn

Reason For Records Request: ☐ Relocation ☐ Insurance Change ☐ Patient Discontent ☐ Second Opinion
☐ Employment Request ☐ Other: _____

Patient Signature of Release: _____
Date: _____/_____/_____

_____ Initials of Certifier
_____ Date Completed/Sent/Mailed

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Modern Ob/Gyn of North Atlanta, P.C. Patient Medical History

Please complete the following information as accurately as possible. Your answers on this form will help your provider understand your medical concerns and conditions better. If you cannot remember specific details, please give best estimates. We realize this a very lengthy form, but we are asking you to provide a comprehensive history for our Electronic Medical Record which results in improved care for you.

Name: _____ **DOB:**_____ **Date:**_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner **SS#:** _____ / _____ / _____

Address: _____ **Apt/Suite #:** _____

City: _____ **State:** _____ **Zip:** _____

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

Occupation: _____ **Email:** _____

Preferred Method of Communication: ☐ Phone ☐ Mail ☐ e-mail ☐ Text

How did you hear about us? _____ **Referred by:** _____

Spouse's Name: _____ **Spouse's Phone:** _____

Spouse's Occupation: _____ **Spouse's DOB:** _____

Emergency Contact Name: _____ **Emergency Contact Phone:** _____

Primary Care Physician: _____ **Phone:** _____ **Fax:** _____

Pharmacy Name: _____ **Phone:** _____ **Location:** _____

Insurance Information:

Primary Insurance: Carrier _____ **Policy ID Number** _____

Do you have a Secondary Insurance? (For example, under spouse or parents) ☐ **Yes** ☐ **No**

Secondary Insurance: Carrier _____ **Policy ID Number** _____

Reason for Visit:

What is the reason for your visit: ☐ Annual Exam ☐ First Obstetric Visit ☐ GYN Problem

If you are here for a problem, what are your concerns? _____

_____

_____

_____

_____

Health Maintenance / Preventive Screening History:

Colonoscopy	□ Yes □ No	If yes, date ____ / ____ / ____	Results:	□ Normal	□ Abnormal
Dexa Scan	□ Yes □ No	If yes, date ____ / ____ / ____	Results:	□ Normal	□ Abnormal
Mammogram	□ Yes □ No	If yes, date ____ / ____ / ____	Results:	□ Normal	□ Abnormal

Pap Smear History:

Pap smear	□ Yes □ No	If yes, date ____ / ____ / ____	Results:	□ Normal	□ Abnormal
LEEP	□ Yes □ No	If yes, date ____ / ____ / ____	Results:	□ Normal	□ Abnormal
Colposcopy	□ Yes □ No	If yes, date ____ / ____ / ____	Results:	□ Normal	□ Abnormal
History of HPV?	□ Yes □ No	If yes, date ____ / ____ / ____			
Received HPV vaccine?	□ Yes □ No	If yes, date ____ / ____ / ____	□ Inj.1	□ Inj.2	□ Inj.3

Medical History:

Major Illness	***Yes***	***Major Illness***	***Yes***
Anemia		Hepatitis □ A □ B □ C	
Anxiety		High blood Pressure	
Arthritis/Joint Pain		High Cholesterol	
Asthma		Hypothyroid	
Blood clot/DVT		Hyperthyroid	
Blood Transfusions		Interstitial Cystitis	
Breast Cancer		IBS (irritable bowel syndrome)	
Cancer- list type:		Jaundice	
Chronic Lung Disease		Migraines	
Depression		Osteopenia	
Diabetes Type1		Osteoporosis	
Diabetes Type 2		Ovarian Cancer	
Fibroids		Seizures	
Fracture		Sexually Transmitted Disease	
GERD		Stroke	
Heart Disease		Tuberculosis-TB	
Other Medical Conditions:			

Past Surgical History: □ **No past surgical history**

Year	***Surgery***	***Complications?***

Current Medications: □ **None**
**If there is not sufficient space, please attach copy of medications list to this form.*
Prescription and non-prescription medicine, vitamins, home remedies, birth control pills, herbs:

Medication	***Dosage (mg)***	***Frequency***	***Prescribing Physician***

Allergies: *(Food, Drugs, Environmental)* □ **None** □ **Latex** □ **Iodine**

Allergy	***Interaction***	***Allergy***	***Interaction***

Family Medical History: Please indicate below significant medical problems of family members. Indicate which family member by checking the appropriate column and the AGE OF ONSET: □ **No Family History** □ **Adopted**

	None	*Mother*	*Father*	*Brother*	*Sister*	*Grand Mother (Maternal*	*Grand Mother (Paternal)*	*Grand Father (Maternal*	*Grand Father (Paternal)*	*Aunt*	*Uncle*
Blood Clots/DVT											
Breast Cancer											
Cervical Cancer											
Colon Cancer											
Diabetes											
Ovarian Cancer											
Hypertension											
Stroke											
Uterine Cancer											
Other Cancers not mentioned											
Other diseases not mentioned											

Genetic Screening: □ **None** **Includes patient, baby's father, or anyone in either family*

Indicate Yes or No	***Yes***	***No***		***Yes***	***No***
Tay-Sachs			Sickle Cell Disease or Trait		
Neural Tube Defect			Maternal Metabolic Disorder		
Other inherited Genetic or chromosomal Disorder			Special Needs/Autism		
Thalassemia			Medication/Street Drugs/Alcohol		
Hemophilia			Muscular Dystrophy		
Cystic Fibrosis			Huntington Chorea		
Down Syndrome			Congenital Heart defect		
Patient or father of the baby had/has a child with birth defects not listed			Recurrent pregnancy loss or a still birth		

Gynecology:

Age at first period:	Date of last period: _____
Frequency of period:	Describe Period: □ Light □ Normal □Heavy
Length of period:	Current Contraceptive Method:
Do you have concerns regarding your period? Describe:	Are you in menopause? □Yes □ No □ Unsure Are you on hormone replacement therapy? □Yes □No

Obstetrics:

	Number		Number
Total number of pregnancies		Abortions Induced	
Full Term Births		Miscarriages	
Pre-Term Births		Living Children	

No.	*Birth Date*	*# Weeks at delivery*	*Sex*	*Birth Weight*	*Delivery Type*	*Complications*	*Location of Delivery*
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

Social History:

Are you currently sexually active? ☐ No ☐ Yes If yes, what age did you become sexually active? _____

Current sexual partner(s) is/are: ☐ Male ☐ Female ☐ Male and Female

Have you had more than 5 sexual partners in a lifetime? ☐ No ☐ Yes

Have you ever had any sexually transmitted diseases? (STDs): ☐ No ☐ Yes

If yes, what kind? _____

Are you interested in STD screening? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes ☐ Social Drinker ☐ Daily If yes, how many drinks per week? _____

Do you use recreational drugs? ☐ No ☐ Yes

If yes, what kind? _____

Do you use tobacco? ☐ No ☐ Yes

If yes, Current every day _____ Current some days _____ Former _____ Never _____

If current, how many cigarettes a day? _____

If an occasional smoker, please describe: _____

_____

Lifestyle: Please check off answer and provide details if applicable:

Have you been a victim of abuse or domestic violence? ☐ No ☐ Yes

Do you feel safe at home? ☐ No ☐ Yes

Do you live alone? ☐ No ☐ Yes

Do you perform self -breast exam? ☐ No ☐ Yes

Do you drink milk or consume dairy products daily? ☐ No ☐ Yes

Do you take calcium tablets? ☐ No ☐ Yes

Do you exercise? ☐ No ☐ Yes If yes, how many times a week do you exercise? _____

BLOOD TRANSFUSION/PRODUCTS:	YES	NO	IF NO, PLEASE BRIEFLY EXPLAIN WHY.
WOULD YOU ACCEPT A BLOOD TRANSFUSION OR BLOOD PRODUCTS IN THE EVENT OF A LIFE-THREATENING SITUATION?			

Please add any additional information: _____

_____

_____

_____

AUTHORIZATION AND RELEASE:

I hereby certify that I have completed the above information to the best of my knowledge. I authorize, consent, request, and agree to actively participate in such services as routine assessments, the performance of diagnostic tests and procedures, care and treatment as self-referred or as ordered by my physician, his/her assistant or designees.

_____ _____

Patient's Signature **Date**

Please mail or fax your completed form to our office prior to your appointment. If you cannot return your form prior to your appointment, you must arrive 30 minutes early so we can enter your information into the computer. Thank you for your attention and cooperation.

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