Gulf Coast Healthcare

2825 East Nasa Parkway, Seabrook, Texas, 77586 Phone: 281-532-3160

Name: _____ Date of birth: _____

FEMALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Date: _____

Date of birth: _____ Age: _____ Weight: _____ Occupation: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work: _____

Preferred contact number: _____

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email address: _____ May we contact you via email? ☐ Yes ☐ No

In case of emergency contact: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Primary care physician's name: _____ Phone: _____

Address: _____
Address / City / State / Zip

Marital status (check one): ☐ Married ☐ Divorced ☐ Widow ☐ Living with partner ☐ Single

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Insurance Information:

Insurance company: _____ Identification#: _____ Group#: _____
Primary Insured Name: _____ Birthday: _____ Phone#: _____
Address if different: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Address: _____ City: _____ State: _____ Zip Code: _____
Employer Phone #: _____ Subscribers relationship to insured: _____

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FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Drug allergies

Drug allergies: _____ If yes, please explain: _____

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No Do you have a latex allergy? ☐ Yes ☐ No

Medications currently taking: _____

Current hormone replacement? ☐ Yes ☐ No If yes, what? _____

Past hormone replacement therapy: _____

Family history:

☐ Heart disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer's/dementia ☐ Breast cancer ☐ Other_____

Pertinent medical/surgical history:

- ☐ Breast cancer
- ☐ Uterine cancer
- ☐ Ovarian cancer
- ☐ Polycystic ovaries/PCOS
- ☐ Acne
- ☐ Excess facial/body hair
- ☐ Infertility
- ☐ Endometriosis
- ☐ Epilepsy or seizures
- ☐ Fibrocystic breast or breast pain
- ☐ Uterine fibroids
- ☐ Irregular or heavy periods
- ☐ Menstrual migraines
- ☐ Hysterectomy with removal of ovaries
- ☐ Partial hysterectomy (uterus only)
- ☐ Ophorectomy removal of ovaries only

Birth control method:

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Birth control pills
- ☐ Vasectomy
- ☐ IUD
- ☐ Infertility
- ☐ Other _____

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FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Medical history:

- ☐ High blood pressure or hypertension
- ☐ Heart disease
- ☐ Atrial fibrillation or other arrhythmia
- ☐ Blood clot and/or a pulmonary embolism
- ☐ Depression/anxiety
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ☐ Arthritis
- ☐ Hair thinning
- ☐ Sleep apnea
- ☐ High cholesterol
- ☐ Stroke and/or heart attack
- ☐ HIV or any type of hepatitis
- ☐ Hemochromatosis
- ☐ Psychiatric disorder
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lupus or other autoimmune disease
- ☐ Other _____

Social:

- ☐ I am sexually active. OR ☐ I want to be sexually active. ☐ I do not want to be sexually active.
- ☐ I have completed my family. OR ☐ I have NOT completed my family.
- ☐ My sex life has suffered. OR ☐ I have not been able to have an orgasm or it is very difficult.

Habits:

- ☐ I smoke cigarettes or cigars_____ er day. ☐ I use e-cigarettes_____a day. ☐ I use caffeine_____a ay.
- ☐ I drink alcoholic beverages_____ er week. ☐ I drink more than 10 alcoholic beverages a week.

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Health Assessment For Women (Female Symptom Questionnaire)

Name: _____ **Date:** _____

E-Mail Address: _____

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "never".

Symptoms	Never (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Hot flashes					
Sweating (night sweats or increased episodes of sweating)					
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)					
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)					
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)					
Sexual problems (change in sexual desire, in sexual activity and/or orgasm and satisfaction)					
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)					
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)					
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)					
Difficulties with memory					
Problems with thinking, concentrating or reasoning					
Difficulty learning new things					
Trouble thinking of the right word to describe persons, places or things when speaking					
Increase in frequency or intensity of headaches or migraines					
Hair loss, thinning or change in texture of hair					
Feel cold all the time or have cold hands or feet					
Weight gain or difficulty losing weight despite diet and exercise					
Dry or wrinkled skin					
Total:					

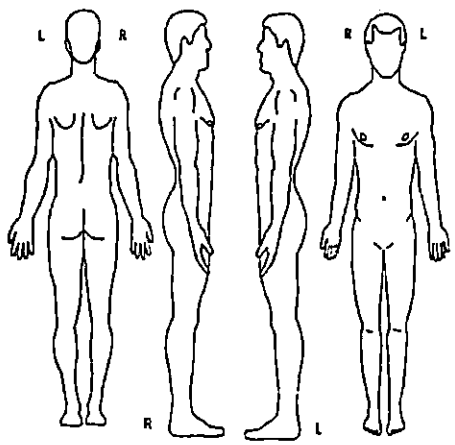
Severity	Score
Mild	1 - 20
Moderate	21 - 40
Severe	41 - 60
Very Severe	61 - 80

Gulf Coast Healthcare
2825 E NASA Parkway | Seabrook, TX
77586
Phone: 281.532.3160
Fax: 281.532.3480

PATIENT INFORMATION / HISTORY FORM

Referring Physician: _____
Primary Care Physician: _____
Briefly describe your main problem: _____
_____

Indicate on the pictures below the area(s) of your pain. Use "X" for pain and "0" for numbness.



When did your complaints start? (approximate date)
_____
How did your pain start?
_____
Is your pain: occasional Intermittent frequent constant

Present level of intensity (cirle one) 0 1 2 3 4 5 6 7 8 9 10

No Pain Mild Moderate Severe Excruciating

What words best describe your symptom(s): (Circle as many as apply)

Sharp Burning Throbbing Aching Cramping Dull Hot
Crushing Stabbing Shooting Electricity Tingling Cold

Other _____
What eliminates or eases the symptom(s)? (Circle as many as apply)
Lying down Standing Exercise Medication Muscle Relaxants Nothing
Other:_____

Do you have loss of control of your bowels or bladder? Yes NO

Do you have pain that shoots down your arms or legs? Yes NO

Do you have any increasing weakness in your arms? Yes NO

Whom do you live with? _____

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PATIENT INFORMATION / HISTORY FORM

Please list all past hospitalizations / surgeries you have had:

_____

_____

Please list all current prescription medications and any vitamins:

_____

_____

_____

Do you have any MEDICATION ALLERGIES? Yes: No:
If yes, list drug and reaction: _____

_____

List any pain medications you have tried in the past: _____

_____

Do you take any of the following medicines: (Circle any that apply)
Coumadin Aspirin Plavix Lovenox Heparin

Please indicate which tests you have had to evaluate your present pain (with date):
MRI:_____ CT Scan: _____Myelogram: _____ Bone Scan: _____Discogram: _____EMG: _____
Other: _____

Please list any procedures you have received for your pain (with date): _____

_____

Please list any other treatments you have received for your pain (TENS, Chiropractic, Physical Therapy, Biofeedback): _____

WORK HISTORY:
What is/was your occupation? _____

Full Time Part Time Unemployed Temporary Self-Employed Full Time Student

Employers Name: _____
Employers Address: _____

Do you drink Caffinated Drinks? Never <1 per day 1-2 /day 3-4 /day 5+/day Days Per Week
Do you exercise: Never <1 1-2 2-3 3-4 5+
Walking Jogging Cycling Swimming Golf Tennis Strength Training Other: _____

Drug/Substance Abuse? No Yes If Yes, Discuss With Doctor

Have You Ever Had A Serious Accident/Injury? Yes No
Auto: _____
Work Related: _____
Personal: _____
Sports Injury: _____
Other: _____

Financial Policy and Agreement

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Please understand that payment of your bill is considered a part of your treatment. The following is provided to avoid any misunderstanding or disagreement concerning payment for services, tests, and supplies provided by our office.

- **Insurance**

Our office participates with a variety of insurance plans. It is your responsibility to:

1. Bring your current insurance card to every visit and notify us of any changes in your insurance coverage.
2. **Be prepared to pay your co-pay, coinsurance and/or deductible at the time of service.** Payment may be made by cash, check, MasterCard, or Visa. All co-pays and deductible amounts owed are due at time of service. If your insurance applies any of your charge to your annual deductible or coinsurance, that portion is due and payable by you at the time of service. If you have elected to use our practice and our physicians out of your network of coverage please check with your insurance regarding benefit levels. Your employer or provider of insurance determines your benefit coverage by contracting with a particular insurance company. If you have questions regarding your coverage, please speak with your human resources representative or use the payer web address listed on your card. It is your responsibility to understand your benefit coverage.
3. We will submit a claim to your insurance company for you through our Billing Company, Advanced Reimbursement Solutions and Goldstar Medical Billing. Balances not paid per contract with your primary insurance company may be billed to your secondary insurance.
4. You understand that your insurance carrier can choose to assign benefits to Gulf Coast Healthcare or your insurance may make payment directly to you.
5. You understand and agree that you are financially responsible for all health care service charges that are paid to you directly by your insurance carrier.

- **Payment Details**

We accept Cash, check, and most major credit cards. We have the capability to accept payments over the phone with your debit or credit card account information. We reserve the right to process your payment electronically based on the information you provide us.

- **Surgical and Laboratory Services**

If you are having procedures at Gulf Coast Healthcare, the facility and surgical services are separate providers and will be billed separately from the office services provided to you. Laboratory services provided at our office are also provided by Gulf Coast Healthcare and will also be billed separately from the office services provided to you.

- **Non-covered services**

If you are seeking a non-covered service, do not have insurance, or if you are covered by an insurance for which we are not a provider, we require that you be prepared to pay our fees at the time services are rendered. You may inquire with our staff about self-pay cash discounts for payment at the time of service.

If temporary financial problems affect timely payment on your account you may set up a payment plan.

Specific coverage issues should be directed to your insurance company's member services department (the number should be located on the back of your insurance card).

This office charges for all services that are significant and separately identifiable. Patients that are seen for physical exams and require treatments for illnesses or problems may be charged separately for each service when both are provided on the same day.

This office can only code and file a claim for a patient's visit with a diagnosis that was encountered and documented in the medical record. .

- **Collections**

All balances billed are due upon receipt of a statement. Unpaid balances greater than 90 days are subject to our collection process.

- **Returned Checks**

There is a $20.00 fee charged for all returned checks.

- **Small Balance Policy**

If a credit or due balance exists on your account equal to $9.99 or less, and is more than 90 days old, the account will be automatically adjusted according to our small balance policy. If you are seen within the 90 day period, the small balance will either be credited to your account or requested at the time of service. Following the 90 day period, we will not issue any refunds or send statements for balances equal to $9.99 or less.

- **Appointment Cancelations/No-shows**

If you cancel, miss or no-show for three (3) appointments you may be dismissed from the practice for not complying with the plan of care you and your physician have discussed.

- **High Deductible Health Plans (HSA, HRA, FSA participants)**

Please inform us prior to your visit if you are a participant in a High Deductible Health Plan (HDHP), a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA) or a Flexible Spending Account (FSA). You must be prepared with the plan information and pay the patient responsible portion from the HSA, HRA or FSA at the time of service.

- **Minor Aged Patients**

Adults accompanying minor patients (parent or guardian) will be required to complete a Release of Liability and Permission Form. The parent or guardian is responsible for payment of any financial balances for that minor not covered by insurance. For unaccompanied minors, treatment will be denied unless the proper paperwork is received, and the insurance card lists the minor's name.

I have read, understand and agree with this Financial Policy.

Printed Name (Patient or Guarantor)

Signature (Patient or Guarantor) Date:

Office Staff Signature Date:

Assignment of Benefits

Assignment of Medical Benefits and Payment Responsibility to Gulf Coast Healthcare, PLLC (hereinafter referred to as "Providers"). I, the undersigned patient ("Patient"), acknowledge that Providers reserve the right to use the services of Billing upon Providers' discretion for any part of the claims procedure.

1. **Legal Assignment of Insurance Benefits**: In exchange for and in connection with any and all of the service(s) provided to me ("Services") by Providers, I hereby irrevocably assign to Providers all of my rights, benefits, privileges, protections, claims and any other interests of any kind whatsoever, without limitation, including, without limitation, direct payment to Providers for the Services, appeal rights, rights to fiduciary duties, rights to sue, rights to payment, rights to penalties or interest, rights to plan documents, and rights to information, notices and disclosures from any source, (collectively "Rights") that I had, have or may have in the future pursuant to or in connection with any insurance plan, health benefit plan, trust, fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind (collectively "Health Coverage"), such that I am hereby transferring all and retaining none of these Rights under any Health Coverage to which I am now, previously, or may be entitled to in the future. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, I instruct my applicable insurance plan, health benefit plan, trust, fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind to please advise and disclose to Providers in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived on any pending claims for benefits under the respective policies. I agree that, should the amount received be insufficient to cover the entire claim I will be responsible for payment of any coinsurance and/or deductible that remains unpaid by my health insurance company, workman's compensation plan and/or auto accident insurance; I will be responsible to Providers for payment of the entire invoice. 2. **Denial of Claim**: I understand that Providers will make every effort to obtain payment for all health care services or products provided by Providers from my insurance company. I agree that I will be jointly and severally financially responsible for any portion of the Providers invoice that is not paid; I understand that I am responsible for any health insurance deductibles and co-payments; I hereby irrevocably assign the benefits payable for any services rendered by Providers to me and authorize Providers to submit a claim to any medical insurance company that I may have for payment to Providers. 3. **One Time Claim Submission**: I understand that Providers will make every effort to obtain payment for all services and or products provided by Providers. I understand that Providers will submit a clean claim one time only and if the claim is not paid, in whole or in part, by my workman's compensation plan and/ or auto accident insurance, Providers will look to me for payment of any Providers services and/or products supplied to me. I agree that I will be jointly and severally financially responsible for any portion of the claim, in whole and in part, that is not paid. 4. I certify that the information given by Patient to Providers in applying for payment to my workman's compensation plan and/or auto accident insurance or any other medical insurance that I may have, is correct. I agree that if assigned insurance benefits owed to Providers by me are paid to me, I shall immediately notify Providers of such, and immediately endorse benefits check to Providers. 5. **Appointment as Authorized Representative And Right to Sue**: I hereby designate Provider's designated billing company as my duly authorized representative in connection with all matters arising from or relating to Services, Rights and Health Coverage, such that billing completely and without reservation stands in my shoes and takes my place for all purposes, and is granted absolute power and legal authority to do, seek, claim, appeal or obtain anything that I would have been entitled to do, seek, claim, appeal or obtain in my own capacity pursuant to or in connection with the Services, Rights or Health Coverage, in any legal, private, administrative, formal or informal process or forum whatsoever and without limitation, including any internal or external appeal, review, grievance or any other process, procedure or entitlement under any Health Coverage.

6. Agreement to Cooperate: In addition, I hereby agree to personally cooperate with, and take all steps necessary, required or reasonably requested by, any Health Coverage, to effectuate, perfect, confirm or validate my assignment and/or authorization of billing as my authorized representative, and I promise to assist and cooperate with Providers and billing as needed or reasonably requested by Providers or billing in connection with any action in any forum, whether legal, formal or informal, without limitation, commenced or maintained by Providers or billing in connection with the Services or relating to any Rights provided under the Health Coverage. I understand that, in the event I do not fulfill any of the above obligations, I will remain personally liable for payment for the Services to the furthest extent of the law. By signing below, I acknowledge my authorization of treatment and receipt of all documentation in accordance with my treatment.

_____ _____

Signature of Beneficiary/Participant/Parent/Legal Guardian Date

SUBMIT

_____

Printed Name of Beneficiary/ Participant/Parent/Legal Guardian