Betty Jo Dulaney M.D., P.C.

Patient Information Sheet

Please complete all blanks

PATIENT'S INFORMATION

LAST NAME: ____________ FIRST: ____________ MIDDLE INITIAL: ______ D/O/B: ______

ADDRESS: ____________ ZIP: ______ S/S/N: ____________ RACE: ______

HOME PHONE: ______ CELL: ______ EMAIL ____________ PREFERRED CONTACT: HOME CELL WORK (CIRCLE ONE)

MARITAL STATUS: ______ ARE YOU PREGNANT? ______ WHO REFFERRED YOU TO US?______

EMPLOYMENT

[IF STUDENT CHECK HERE______]

EMPLOYER: ____________ ADDRESS: ____________ ZIP: ______ PHONE: ______

OCCUPATION: ____________ CHECK ONE: FULL TIME: ___ PART TIME: ___

SPOUSE OR PARENT'S INFORMATION

LAST NAME: ____________ FIRST: ____________ MIDDLE INITIAL: ______ D/O/B: ______

ADDRESS: ____________ ZIP: ______ S/S/N: ____________ RACE: ______

EMPLOYER: ____________ OCCUPATION: ____________ PHONE: ______

IN CASE OF AN EMERGENCY

NAME: ____________ DAYTIME PHONE: ____________RELATIONSHIP TO PT: ______

NAME (NOT LIVING WITH YOU): ____________ PHONE: ____________ RELATIONSHIP TO PT: ______

PRIMARY INSURANCE

PLEASE NOTE-THE INSURED IS THE POLICY HOLDER. IF YOU ARE NOT THE POLICY HOLDER, PLEASE LIST THEIR INFORMATION

INSURANCE: ____________ INSURED NAME: ____________ D/O/B: ______ INSURED'S EMPLOYER: ______

INS ADDRESS: ____________ ZIP: ______ PHONE NUMBER: ______ RELATION TO PT: ______

POLICY NUMBER: ____________ GROUP NUMBER: ____________

SECONDARY INSURANCE

INS CO: ______ INSURED NAME: ____________ D/O/B: ______ INSURED'S EMPLOYER: ______

INS ADDRESS: ____________ ZIP: ______ PHONE NUMBER: ____________

POLICY NUMBER: ____________ GROUP NUMBER: ____________

PLEASE READ AND SIGN

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. DULANEY AND I AUTHORIZE DR. DULANEY TO RELEASE ANY INFORMATION AQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT AS REQUIRED BY MY INSURANCE COMPANY. I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE FOR THE PAYMENT OF ALL CHARGES AT THE TIME SERVICES ARE RENDERED INCLUDING ANY CHARGES IN EXCESSOF MY INSURANCE RESONABLE AND CUSTOMARY, WHETHER OR NOT THEY ARE COVERED BY MEDICARE OR ANY OTHER INSURANCE. I UNDERSTAND THAT I AM RESPONSIBLE FOR VERIFY MY INSURANCE COVERAGE AND PRE-CERTIFYING MY BENEFITS WITH MY INSURANCE COMPANY. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY COLLECTION COST AND/OR ATTORNEY FEES INCURRED IN THE COLLECTION OF THIS ACCOUNT. I GIVE PERMISSON TO DR. BETTY JO DULANEY M.D., P.C. FOR MEDICAL TREATMENT INCLUDING, BUT NOT LIMITED TO, EXAMINATION, INJECTIONS, BLOOD TEST, DIAGNOSTIC TESTING OR MEDICAL PROCEDURES DEEMED NECESSARY FOR DIAGNOSIS AND TREATMENT. I HAVE ALSO READ AND UNDERSTAND THE PATIENT RIGHTS AND RESPONSIBILITIES, AS WELL AS THE HIPPA GUIDELINES AND I UNDERSTAND THAT A COPY IS READILY AVAILABLE UPON MY REQUEST. FURTHERMORE, I VERIFY THAT THE ABOVE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: X ____________________ **DATE:** ______

***SIGNATURE OF PARENT IF PATIENT IS A MINOR*: X** ____________________ **DATE:** ______

BETTY JO DULANEY, M.D., PC

ASSIGNMENT FORM/HIPAA/ACCOUNT PERMISSION

Assignment and release **Initials __________**

I assign directly to Betty Jo Dulaney, MD, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance as well as collection fees or interest that may be added if the account should be placed with an outside collection agency. I authorize the use of my signature on all insurance submissions. Betty Jo Dulaney, MD, PC may use my health care information and may disclose such information to the named insurance company/companies (as listed on the patient registration form) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. Furthermore, I authorize Dr. Dulaney to release my records to other physicians as needed to provide assistance in the course of my care/treatment.

HIPAA **Initials __________**

I am verifying that I have seen the privacy regulation form (HIPAA) posted on the clip board which provides me with the information of how my Protected Health Information (PHI) can be used and I understand that a copy will be made available to me upon my request.

*****_**Leave a message on your Answering Machine**_ **_______Accept ______Decline**

Discuss your account/payments/test results

We cannot discuss your account/payment details/or test results with anyone without your written permission (this includes your spouse or any other family member) unless they have a power of attorney letter on file. By your initial (above) and signature (below), you are giving us permission to discuss your account/payment details/or test results with the listed person(s).

Name of approved person we may talk to:

Name:______________________________________ Relationship: _________________________________

Name:______________________________________ Relationship: _________________________________

PHARMACY INFORMATION (Where would you like prescriptions sent?)

____________________ (_____)___________ ___________________________ ______________

Pharmacy Name Phone # Address Cross Street

I give permission to obtain formulary information and information about other prescriptions prescribed by other providers provided by PBM and permission to send prescriptions/refills requests though Sure Scripts an electronic prescribing company.

Initials__________

Preferred Communications:

We now offer notifications for general information for appointments/reminders/general non specific lab information/prescriptions. If you would like to start receiving this information please indicate below. Please understand that Texting/ emailing fees from your carrier may apply and you can change or cancel notifications at any time just by letting us know.

____I would like to receive text notifications to cell phone #_____________________

____I would like to receive email notifications to email address________________________

____I DO NOT want text or email notification

I have read, understand, and give my permission to the above statements including statements that have been initialed.

Patient name: ___________________________ Date: _______________________________________

Signature: ____

(Signature of patient, parent, guardian, or personal representative)

Betty Jo Dulaney, M.D.P.C.
2157 Judicial Drive
Germantown, TN 38138
Ph#901-309-6745

Patient Agenda Form

Name ____________________________Date _____________________________

Please take a moment to answer the questions below in order to best use the time spent today with your provider.

1. What do you want to discuss/have done at today's appointment?

____

2. What symptoms do you want your provider to be aware of?

____

3. What providers (hospital, ER, Urgent Care , Specialist, etc.) have you seen since your last visit?

____

4. Please list **ALL** your medications (including what we prescribe or any other providers)
please include over the counter meds/vitamins

Drug Name   Dose   how often taken?   Refill needed? (30 or 90 days)

____

____

____

____

5. ***Please circle below***

Do you drink alcoholic beverages? Yes No

Do you use recreational drugs? example (Marijuana/Cocaine/Heroin etc.) Yes No

Do you smoke cigarettes or us tobacco? Yes No

6. Please list all allergies:____

7. Do you have specific requests for:
- New medications/Tests/Referrals/Completion of forms/Work or School Forms

____

PREGNANCY
FAMILY HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS

(THIS INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY)

Pt name: ______________________ Date: ______________

	Yes or No	Explain(who)
Is there any history of Jewish Ancestry?		
Thalassemia (Italian, Greek, Mediterranean. Or Asian ancestry)?		
Neural tube defect (meningomyelocele, spina bifida, anencephaly)?		
Congenital heart defect?		
Down syndrome?		
Tay-Sachs (Jewish, French Canadian ancestry)?		
Canavan's Disease?		
Sickle cell disease or trait (African ancestry)?		
Hemophilia or other blood disorders?		
Muscular dystrophy?		
Cystic fibrosis?		
Huntington's Chorea?		
Mental retardation/autism (if yes, was person tested for Fragile X)?		
Other inherited genetic or chromosomal disorder?		
Maternal metabolic disorder (DM, PKU, etc)?		
Patient or FOB with a birth defect not listed above?		
Recurrent pregnancy loss or stillbirth?		

INFECTION HISTORY

Do you live with someone who has Tuberculosis or Tuberculosis exposure?		
Do you or your partner have a history of genital herpes?		
Do you or your partner have a history of chlamydia, gonorrhea, HIV, or syphilis?		
Do you have cats in the home?		

GENETIC TESTING

PT NAME: ______________________________ DOB: _______________________

HARMONY PRENATAL TEST *(CPT CODE 81507 & 81599)*

The Harmony test consists of blood from Mom and can be drawn anytime after 10weeks. This test detects Down Syndrome, Trisomy 13 and Trisomy 18 with a 99% detection rate. If you would like to know if your baby is affected by these chromosomal problems *before* you deliver your baby, this is the test that is recommended.

Some insurance companies do not cover Harmony. I understand that my insurance company may not cover this test and I will be financially responsible for the charges that my insurance company does not cover.

SIGN: _____________________ DATE: ______________ ACCEPT_____ DECLINE _____

SCREENING FOR OPEN NEURAL TUBE DEFECTS *(CPT CODE 82105)*

Maternal serum Alpha-fetoprotein is an effective screening which consists of blood from Mom. The best time to draw MSAFP is between 16-18 weeks, although available from 15-23 weeks. Dr Dulaney recommends this test be done during each pregnancy.

Some insurance companies do not cover Open neural tube defects. I understand that my insurance company may not cover this test and I will be financially responsible for the charges that my insurance company does not cover.

SIGN: _____________________ DATE: ______________ ACCEPT_____ DECLINE _____

SCREENING FOR CYSTIC FIBROSIS (*CPT CODE 81220)*

Cystic Fibrosis (CF) is a progressive, multisystem disease that primarily impacts the lungs, pancreas, and the digestive tract. CF significantly shortens the lifespan of people affected by it –median survival is approximately 37 years. Because CF is caused by an inherited genetic mutation, *carrier screening is recommended* to identify couples at risk for having a child with the disease.

The incidence of CF is highest among non-Hispanic white individuals (roughly 1 in 2,500) and people of Ashkenazi Jewish ancestry. It is considerably less common (but still occurs) in other ethnic groups.

Cystic Fibrosis carrier screening is a blood test. CF screening is available for all individuals who are pregnant or planning a pregnancy to determine if either parent is a carrier of CF. DNA testing for CF detects approximately 80-90% of Caucasian carriers, approximately 95-97% of Ashkenazi Jewish carriers approximately 60% of African American and Hispanic carriers and approximately 30-40% of Asian carriers. Dr Dulaney recommends you have this test done. This test is necessary once in your life.

Some insurance companies do not cover Cystic fibrosis testing. I understand that my insurance company may not cover this test and I will be financially responsible for the charges that my insurance company does not cover.

SIGN: _____________________ DATE: ______________ ACCEPT_____ DECLINE _____

My signature on this form indicates that I have read, or had read to me, the information regarding the above testing. I understand the specific test(s) that I choose to have. I know that genetic counseling is available to me before and after testing. I have all the information and all my questions have been answered. I signed by each test that I wanted to have and understand the financial obligations.

SIGN: ______________________________ DATE: ________________

NOTE: YOU MAY CALL YOUR INSURANCE TO SEE IF TEST ARE COVERED, SOME INSURANCE COVER TEST BASED ON MEDICAL NECESSITY ONLY AND MAY DECIDE AFTER REVIEW OF RESULTS AND HISTORY NOT TO COVER TESTING. THE ABOVE TEST ARE FOR SCREENING ONLY.