Sieu P. Truong, M.D.
Samina S. Makani, M.D.
477 N. El Camino Real Ste. C304, Encinitas, CA 92024
Ph: (760) 635-3777 **Fax:** (760) 942-7163

Annual Information Forms

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

Cell Number: _____ **Email:** _____

Alt. Number_____ **(we are not contracted with any HMO insurances)**

Address: _____**City/State:** _____ **Zip:**_____

Insurance: _____ **ID Number:** _____

Pharmacy: _____**Pharmacy St/Cross St:**_____

Emergency Contact Information:

Emergency contact name: _____
Phone number: _____**Relationship to patient**: _____
Is it okay to give medical information to your emergency contact? ☐NO ☐YES

Well Woman Update:

General Practitioner/Primary Care Provider: _____

Last bone density exam _____ (year) Where?_____
Last colonoscopy _____ (year) Where? _____
Last mammogram _____ (year) Where? _____
Last Pap smear _____ (month/year) Where? _____

Menstrual Cycle:

☐ Post-menopausal ☐ Hysterectomy: ☐ Partial or ☐ Total

First Day of Last Period: _____ **Are your cycles** ☐ Regular ☐Irregular
How often do you get your menstrual cycle? Every _____ to _____ days, lasting for _____ days.
Are you sexually active? ☐Never ☐Not Currently ☐Yes
Method of contraception: _____

Social History:

Marital status: ☐Married ☐Single ☐Engaged ☐Significant other ☐Divorced ☐Widowed

Tobacco Use ☐ NO ☐YES Packs/day:_____ ☐Former, quit at age _____

Alcohol Use ☐NO ☐YES Drinks/week: _____

How many times per week do you exercise? (Circle One) 0X 1X 2X 3X 4X 5X+

Since your last visit have you been diagnosed with any new health problems? ☐NO ☐YES

If yes please describe _____

Have you had any recent surgery? ☐NO ☐YES

If yes please describe _____

CONSENT FOR TREATMENT: By signing this form, I consent and authorize my health care provider, assistants or designees to examine and treat.

Signature of patient/legal guardian: _____Date:_____

Printed name of patient/legal guardian: _____Relationship to patient: _____

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AGREEMENT TO OFFICE POLICIES (Part 1)

NO SHOW/CANCELLATION POLICY: Patients who cancel or reschedule an appointment with less than **24 business hours' notice** or who do not arrive for their scheduled appointment will be charged a **no-show fee**. The fee is **$50 or $75**, depending on the type of appointment.

To provide the best care for all of our patients, we ask that you allow **up to one hour** for your visit. While we make every effort to stay on schedule, our providers may occasionally run behind due to medical emergencies or the additional time some patients require for complex or sensitive care. We appreciate your patience and understanding.

LATE ARRIVAL POLICY: We understand that unexpected delays, such as traffic or emergencies, can occur. Please allow extra travel time to help ensure you arrive on time for your appointment.

Patients who arrive more than **15 minutes late** without notifying our office may be considered a **no-show**. If you arrive after the 15-minute grace period, whether you are able to be seen will be at the discretion of your provider and will depend on the provider's schedule and patient care needs. If we are unable to accommodate your appointment, you may be asked to reschedule and may be subject to our cancellation/no-show policy.

APPOINTMENT REMINDER POLICY: Our office may provide appointment reminders via text message as a courtesy to our patients. Please note that these reminders are not guaranteed and may not be delivered or received due to factors outside of our control, including carrier issues, incorrect contact information, or technical disruptions.

It is the patient's responsibility to keep track of all scheduled appointments and to update their contact information with our office as needed. Failure to receive a reminder does not exempt a patient from our no-show or late policy.

FEES:

- I understand that there is a **$50 or $75 cancellation/no-show fee** if I miss my scheduled appointment or cancel/reschedule without providing at least **24 business hours' notice**. The fee is based on the length and type of my appointment.
- I understand that there is a **$20 fee** for my provider to complete forms on my behalf (e.g., disability, FMLA, school, or other non-medical forms).
- I understand that there is a **$30 fee** for copies of my medical records released directly to me when the request exceeds **30 pages**. This fee applies after our office has received a signed Authorization for Release of Medical Records and the records are prepared for release.

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AGREEMENT TO OFFICE POLICIES (Part 2)

BALANCES: In order to provide efficient service and reduce billing delays, our staff may review and collect any outstanding balances at the time of your visit, when scheduling appointments, or during phone interactions. This may include copays, deductibles, or past due balances. If you have any questions about your account, we are happy to assist you.

SURGERY/PRE-OPERATIVE FEES: All required surgical fees due to our office are expected to be paid at the time of your pre-operative appointment unless other arrangements have been made with your physician and our office. You will be notified of any applicable pre-operative fees prior to your appointment.

Please note that these fees are for services provided by our office only and do **not** include charges from the hospital, surgical facility, anesthesia provider, pathology, laboratory, or any other third-party providers. Those fees will be billed separately.

TERMINATION OF PATIENT RELATIONSHIP:

1. Patients who miss **three (3) consecutive scheduled appointments without notice** will receive a written warning. Any additional no-shows following this may result in termination from the practice. We value appointment availability for all patients, and missed appointments limit access to timely care for others.
2. Patients with an outstanding balance will continue to receive regular billing statements. If the balance remains unpaid, the patient will receive two written notices (Letter 1 and Letter 2) regarding the outstanding account. If there is no response after reasonable attempts to contact the patient, including phone outreach, the patient may be discharged from the practice for non-payment.
3. Our office is committed to providing a respectful and safe environment for both patients and staff. Disruptive, abusive, or threatening behavior toward staff or providers will not be tolerated and may result in termination of care at the discretion of the practice.

By signing below, you acknowledge that you have read, understand, and agree to comply with all of the office policies listed above in Part 1 and Part 2 of our Agreement to Office Policies:

Signature: _____ Date: _____

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HIPAA

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM FOR WOMENS INTEGRATIVE HEALTH

Printed Name: _____ Date of Birth: ____/____/_____

I have received a Notice of Privacy Practices Initials _____

Release of Information

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:(This includes your spouse, children, parents, grandparents and any care takers who can have access to this patient's records)

Name: _____ Relationship: _____
Phone: _____
Name: _____ Relationship: _____
Phone: _____
Name: _____ Relationship: _____
Phone: _____

This ***Release of Information*** will remain in effect until terminated by me in writing.

Preferred contact method:

Home Phone #_____ Cell Phone #_____
Can we leave automatic appointment reminders on your home or cell phone? Yes_____ or No_____
Can we send appointment reminders by text message to your cell phone? Yes_____ or No_____
Can we leave a detailed message? Yes_____ or No_____
If you would like results or orders emailed to you, please provide your email:_____
Providing your email is consenting that you are aware our emails are not encrypted.

MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE, SHOULD I REQUEST MY MEDICAL RECORDS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.

_____ _____
Print name Signature

_____ _____
Parent/Legal Guardian Date

**Doctor will not release Minor's medical information to parent without consent from minor, unless Minor's life or health is in jeopardy.

I understand that this could include medical treatment, lab tests, education, or other diagnostic procedures. I understand that my provider is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations and/or as required by law. I understand that copayments for office visits including telemedicine appointments are due at the time of service. **I understand that if I fail to give at least a 24 business hour notice of my intent to cancel to reschedule an appointment, I will be charged either a $50 or $75 fee based on length and nature of my appointment.**

Signature of patient/legal guardian: _____Date:_____

Printed name of patient/legal guardian: _____Relationship to patient: _____

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IMPORTANT INFORMATION REGARDING CHANGES FOR ANNUAL EXAMS

Insurance companies now dictate how physicians code and therefore bill for these services. There are two types that you need to be aware of that define office encounters, Preventive Physical Exams (Annual Exams) and Office Visits (Evaluation and Management Encounters, E&M Services)

- Preventive Physical Exams (Annual Exams)
  This is usually a visit/encounter to review preventative health issues such as:
  - Past Medical History
  - Interim medical history since last physical (including last colonoscopy/mammography)
  - Health habits/Diets
  - Abnormal bleeding
  - Pertinent Family History
  - Thorough physical exam including Pap Smear and necessary lab work
  - Birth control counseling

This visit **is not** designed to address specific complaints or to manage known medical problems. It's designed to educate you on changes you can make to live a healthier life and to identify potential health problems early.

- Office Visits (Evaluation and Management Encounters, E&M services)
  This encounter is designed for the evaluation and management of single or multiple complaints or disease processes (existing and/or new) such as:
  - High Blood Pressure
  - Thyroid problems
  - Decreased Libido
  - Insertion of IUD
  - Depression
  - Hormones/Menopause

If during your preventive physical exam, you and your physician decide to include management of your existing and/or any new medical problems, **you will likely be charged for both the preventative physical exam and the office visit.**
Depending on your insurance benefit, you may be required to pay the higher specialist copay and/or these charges may be applied to your out of pocket expenses such as deductible or co-insurance.
You will be responsible for any services rendered today that are not covered by your insurance carries. It is important for you to understand your individual insurance benefit coverage because each carrier processes claims differently.

Patients Name (Print): _____Date:_____
Patient's Signature:_____Date of Birth:_____