TAMMY E. BAKER, MD

OBSTETRICS *GYNECOLOGY*

Patient Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Tammy Baker, M.D. I understand that this office is permitted by federal privacy laws to make uses and disclosures of my health information for purposes of treatment, payment, and health care operations. I understand that this office may contact me to provide appointment reminders, and information about treatment alternatives and other health-related benefits and services that may be of interest to me.

I understand that this office may disclose my protected health information: (1) to public health or legal authorities charged with preventing or controlling disease, injury, or disability; (2) to public authorities as required by law to report child abuse or neglect; (3) to the FDA with respect to adverse events involving food, supplements, products, and product defects, or post-marketing surveillance information; (4) to governmental authorities if authorized by law and necessary to prevent serious harm to me and others; (5) to appropriate health oversight agencies or for health oversight activities; (6) in the course of a discovery request or other lawful process; (7) for law enforcement purposes as required by law; (8) to funeral directors or coroners consistent with applicable law; (9)to organ procurement organizations or other applicable entities for the purpose of donation and transplant; (10) to researchers for IRB approved research; (11) to prevent or lessen a serious, imminent threat to the health or safety of others; (12) for specialized government functions as required by law such as for national security or public assistance purposes; (13) to a correctional institutions (if applicable) necessary for the health and safety of myself and others; (14) as necessary to comply with Workers Compensation laws.

I understand that this office may make the following uses and disclosures of my protected health information unless I express my objections to such disclosures on this acknowledgement:

To notify, or assist in notifying, a family member, personal representative, or other person responsible for my care, about my location, and my general condition, or death.

Agree: _____ Object: _____

To provide health information to a family member, other relative, close personal friend, or any other person identified by me that is relevant to that person's involvement in my care or in payment for such care. I understand that, even if I object to such disclosures, this office may make such disclosures if necessary in an emergency.

Agree: _____ Object: _____

To assist in disaster relief efforts.

Agree: _____ Object: _____

I understand that other uses and disclosures besides those identified in this notice will be made only as otherwise authorized by law or with my written authorization which I may revoke except to the extent information or action has already been taken in reliance on my prior authorization.

_____
Patient Name (Print)

_____ _____
Signature of Patient or Parent/Guardian (if minor) Date

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PHONE (865) 522-3440

TAMMY E. BAKER, MD

OBSTETRICS *GYNECOLOGY*

Financial Policy

Patient Name: _____

(Please print)

Dr. Bakers office is committed to meeting your health care needs! We are pleased that you have chosen us! Listed below are our financial policies. If you have any questions, please discuss them with our financial team.

Patient Responsibility

1. All co-payments are due at the time of visit.
2. Co-insurance and unmet deductibles are due prior to being taken back for scheduled office visits, surgeries, and procedures. Once benefits are verified and your financial responsibility calculated, you will be notified of the payment amount and due date.
3. You are ultimately responsible for payment of charges for services you receive from our office.
4. In accordance with your insurance member handbook, it is your responsibility to provide accurate insurance information and to present your insurance ID card at the time of your visit. If you do not have insurance or do not present a valid insurance card, you will be responsible for payment at the time of service. We will provide you with a copy of our billing form so that you can obtain reimbursement from your insurance company.
5. It is your responsibility to ensure that Dr. Baker is in your insurance network.
6. If your plan requires a referral, it is your responsibility to obtain this prior to being seen by our provider.
7. It is your responsibility to notify the office of any change in your mailing address and phone number(s).
8. Cancellations for appointments and procedures must be received at least 24 hours prior to the scheduled appointment. Cancellations for scheduled surgery must be received at least 5 days prior to the scheduled surgery date and time.
9. Payment is due for rendered services 7 days from receipt of your billing statement. Unpaid previous balances must be paid in full prior to any additional visit unless arrangements have been made with our financial counselor.

Fees

The return check fee is $30.00.

1. There will be an additional charge of 25% of the balance owed for any past due balance that is submitted to an outside agency for collections.
2. Patients who fail to keep and fail to cancel a scheduled appointment may be charged a $45.00 No Show Fee. There is a $200.00 cancellation fee for scheduled surgeries that are cancelled less than 5 business days from the date and time of surgery unless cancellation is due to insurance denial or medical necessity.
3. Medical records requests must be received in writing at least 10 days prior to the date needed. Fees for medical records are set in accordance with allowable amounts as defined by the State of Tennessee. Fees must be received prior to record delivery. No more than 5 pages may be faxed. We strong discourage faxing medical records unless the recipient has a dedicated and personal fax for delivery.
4. When a physician treats you via telephone after hours it is for emergencies only. Therefore, for routine problems that require history, diagnosis and treatment (i.e., calling a prescription or refill into a pharmacy), the provider may bill at $50 service fee.

Administrative Services

There is a fee for patient Administrative Services $20.00 charge for each required Administrative Service payable prior to service completion. This includes administrative services such as forms completion for family medical leave and disability, letters for insurance authorizations for brand or non-formulary drugs, letters for employers, school, health clubs, and any other administrative item not covered by insurance.

There is a fee for patient administrative services for surgeries that are scheduled, but then electively cancelled by the patient not due to illness or noncoverage by insurance. Precerting and scheduling surgery is a time intensive process. This fee if surgery is cancelled is $100.00

Patient Signature: _____

Date: _____

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OBSTETRICS ***GYNECOLOGY***

Name:_____ Date:_____

Please list ALL **prescription medications** that you are currently taking and the name of the doctor who prescribed the medication:

MEDICATION	DOSAGE	PRESCRIBING DOCTOR

Please list any **over-the-counter medications** you are currently taking or have taken in the last two weeks:

_____

_____

_____

_____

_____

Please list the names of the Physicians you are currently seeing:

_____

_____

_____

_____

_____

Medications.doc

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OBSTETRICS *GYNECOLOGY*

Patient Agenda Form

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

Name: _____ Date: _____

1. What concerns do you want to be sure to discuss at today's appointment?

_____
_____
_____

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

_____
_____

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

_____
_____

4. Please list any medication changes (including OTC, vitamins and supplements)

Drug Name: Dose: Time(s) of Day Taken Refill needed? (30 or 90 days)

_____
_____
_____

5. Please list your preferred pharmacy (name, phone #, location including zip code):

_____

6. Please list all allergies: _____

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

8. Have you been prescribed a narcotic by any provider in the last 30 days? _____

9. Contact Information

Cell #: _____ Receive text/voice notification reminders: yes or no

Home #: _____ Work #: _____

E-mail address for reminders:

Preferred method of communication (circle one): Cell Work Home Mail E-mail

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Annual Physical Review

Name: _____ Reason for Visit: _____

Women who are not in a monogamous relationship or who have had more than one sex partner in the last year or who are under the age of 25 and have ever been sexually active should undergo annual screening for sexually transmitted diseases (STD). **Would you like testing done today? □ Yes □ No**

*****ALLERGIES:** _____

□Single □ Married □ Divorced □ Separated □ Widowed □ Domestic Partner

Sexual Orientation: □ Heterosexual □ Bisexual □ Lesbian

Menstrual History: Last Menstrual Period: _____ # Days of Flow: _____

Amount: (heavy, normal, light) _____ Length between Periods: _____

Have you ever been pregnant? □Yes □ No How many times: _____ Vaginal Deliveries (#) _____ Cesarean (#) _____

How old were you when you first had intercourse: _____

Are you currently sexually active? □ Yes □ No

In your sexual history, have you had □ more than □ less than six (6) partners in your lifetime?

What form of birth control do you currently use? □ Pills □ IUD □ Diaphragm □ Vasectomy □ Norplant

□ Depo Provera □Tubal Ligation □Condoms □ Abstinence □ Rhythm Method □ None Needed

Do you use hormone replacement? □ Yes □ No Rx: _____

Medical History: Check if you have had any of the following:

□ Cancer	□ Abnormal Pap Smear	□ Pelvic Infection
□ Sexually Transmitted Disease	□ Phlebitis / Blood Clots in Legs	□ High Blood Pressure
□ Heart Disease	□ Mitral Valve Prolapse	□ High Cholesterol
□ Migraine Headaches	□ Anemia	□ Thyroid Problems
□ Diabetes	□ Tuberculosis	□ Hepatitis
□ Depression	□ Alcoholism	□ Digestive problems
□ Drug Addiction	□ Infertility	

Please list any medication that you are currently taking: _____

_____

Date of Last: Colonoscopy: _____ Bone Density: _____ HPV Vaccine: _____ (Gardasil) _____

Do you perform breast exams on yourself? □Yes □ No How often? _____

Have you had a mammogram on your breasts? □ Yes □ No If so, when? _____

Have you ever had an abnormal mammogram? □ Yes □ No If so, when? _____

Have you ever had an abnormal pap smear? □Yes □No If yes, What kind of treatment? _____

Do you have a pap smear yearly? □ Yes □ No

(PLEASE COMPLETE BACK SIDE OF PAGE)

Surgical History:

Have you had any female surgery? ◻ Yes ◻ No If so, what type? (check the following): ◻ Breast ◻ Hysterectomy ◻ D&C ◻ Ectopic Pregnancy

◻ Fibroid Tumors ◻ Ovary ◻ Laparoscopy ◻ Cesarean Section ◻ Laser/ LEEP/ Cryo of Cervix ◻ Other

Reason for Surgery/ Findings: _____

_____

Please list any other surgery: (i.e., appendectomy, heart surgery) _____

_____

Have you ever smoked? ◻ Yes ◻ No How Much? _____ ◻ Quit Years? _____

Do you drink alcohol? ◻ Yes ◻ No How Much? _____ How Often? _____

Do you use street drugs? ◻ Yes ◻ No What Kind? _____ How Often? _____

Are you or have you ever been threatened or physically, sexually, or mentally abused? ◻ Yes ◻ No

Family History: (*Siblings, Parents, Grandparents*) Please check appropriate box if a family member currently has or previously had one of these illnesses. Check every listing.

◻ Breast Cancer _____ ◻ Ovarian Cancer _____

◻ Other Cancer _____ ◻ Birth Defects _____

◻ Heart Attack _____ ◻ High Blood Pressure _____

◻ Tuberculosis _____ ◻ High Cholesterol _____

◻ Diabetes _____ ◻ Bleeding Disorder _____

◻ Alcoholism _____ ◻ Intellectual Development Disorder _____

◻ Other _____

Review of Systems- *Please check if you are having problems with any of the following:*

Genital / Urinary: ◻ Vaginal Warts ◻ Heavy Vaginal Bleeding ◻ Painful Intercourse ◻ Urination at Night ◻ Vaginal Dryness ◻ Urinary Urgency

◻ Irregular Vaginal Bleeding ◻ Bladder Control / Leakage ◻ Painful Menstrual Period ◻ Pain/Burning with Urination ◻ Urinary Tract Infection

Endocrine: ◻ Fatigue ◻ Hair Loss ◻ Absence of Menstrual Periods ◻ Hot Flashes

Skin/Breast: ◻ Nipple Discharge ◻ Sore That Does Not Heal ◻ Changes in Mole ◻ Rashes/Persistent Itching ◻ Breast Lumps/Tenderness

Neurological: ◻ Frequent Headaches ◻ Poor Coordination ◻ Muscle Weakness ◻ Trouble Sleeping

Psychiatric: ◻ Depression ◻ Anxiety ◻ Memory Changes ◻ Counseling or Treatment ◻ Mood Swings

ENT: ◻ Visual Problems ◻ Allergies/Hayfever ◻ Frequent Sore Throat ◻ Mouth Ulcers ◻ Hearing Loss ◻ Hoarseness ◻ Sinus Problems

Digestive: ◻ Heart Burn ◻ Rectal Bleeding ◻ Diarrhea ◻ Yellow Jaundice ◻ Vomiting ◻ Black Stools ◻ Significant Weight Change (i.e., < or > 10-15lbs./yr.)

Cardiac: ◻ Chest Pain ◻ Irregular Heart Beat ◻ Fainting/Dizziness

Respiratory: ◻ Shortness of Breath ◻ Coughed Blood ◻ Wheezing

Musculoskeletal: ◻ Joint Pain/ Swelling ◻ Muscle Pain ◻ Back Pain

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OBSTETRICS *GYNECOLOGY*

Authorization to Release Health Information

I, _____ hereby authorize _____ to disclose health information regarding the following patient:

Patient Name: _____ Date of Birth: _____

Previous Provider: _____ Patient's Phone: _____

Previous Provider's Phone: _____ Social Security No.: _____

1. The information to be disclosed to the following persons or organizations:
   Tammy E. Baker, M.D. 2013 Highland Avenue Knoxville, TN 37916
   PLEASE DO NOT FAX. SEND BY US MAIL ONLY.

2. Purpose. The purpose of the use or disclosure is: _____

____ At the request of the patient

____ Other: _____

3. Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to the services provided on or around _____ (insert dates):
   I understand that this information may include, but not be limited to, information regarding psychiatric or psychosocial treatment, treatment for drug and/or alcohol use, or information relating to Acquired Immune Deficiency/HIV.

   ____ Entire medical record, other than psychotherapy notes, OR

   ____ The following of the medical record

   ____ Other information: _____

4. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the Dr. Tammy Bakerl. However, the revocation will not have any effect on any uses or disclosures the Hospital may have made before the revocation was received.

5. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire on the later of the following: (A) one year after the date this authorization is signed or (B) on the occurrence of the following event: _____ (e.g., end of research study; final resolution of the litigation).

6. Redisclosure. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

7. Certification. I certify that I am (*check whichever applies*):

   _____ The patient, and the identification I have provided is true and correct.

   _____ The authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: _____.

Signed this _____ day of _____, 20____ Signature: _____

Address: _____ Print Name: _____

Phone No.

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OBSTETRICS  *GYNECOLOGY*

CONFIDENTIAL PATIENT REGISTRATION AND AUTHORIZATION

ALL INFORMATION IS IMPORTANT FOR MEDICAL REVIEW, HOSPITAL ADMISSION AND FOR INSURANCE FILING. THIS DATA MUST BE COMPLETED PRIOR TO BEING SEEN BY THE PHYSICIAN.

Copies of your insurance card(s) and drivers license are required. Champus or Tenncare are not accepted by this practice as either primary or secondary insurance. All plans that cover you must be presented today, as we do not go back and bill a secondary insurance at al later time.
How did you hear about our office? Family:____ Friend:____ Physician:____ Insurance company:____

Regardless of your insurance coverage you – as the patient – are always responsible for the payment of your charges at time of visit unless you have Medicare or an HMO, PPO. Office charges are to be paid by check or cash.

PATIENT'S NAME: _____ Date: _____

Street address: _____

City, State, and Zip Code: _____

Circle one: Married Divorced Widowed Single Separated

Patient's social security number: _____ Birth date:_____ Age:_____

Patient's home phone:_____ Cell phone:_____ Work phone:_____
Where would you like us to contact you regarding visits, abnormal labs, prescriptions? Please initial:
_____**HOME** _____**CELL** _____**WORK**

What is your preferred Pharmacy? _____ Phone Number:_____

Patient's employer's name & address: _____
_____Type of work:_____

Husband's name:_____ Work phone:_____
Husband's employer's name:_____
Husband's social security number:_____ Husband's birth date:_____

Emergency contact (other than above):
Name:_____ Phone:_____
Address:_____

Primary Care Physician:_____Phone:_____Address:_____

Authorization & Assignment: I authorize Dr. Tammy Baker to release any information acquired by my physician/or staff to my insurance carrier. I authorize payments directly to my physician. I recognize and accept responsibility for any balance or fees not covered by insurance, and agree to pay the balance in a prompt manner. In any event this account is referred to an outside agency, credit bureau or attorney for collection, I agree to pay all attorneys fees, collection costs, court costs and/or any other expenses incurred in its collection according to the 1989 statues of the State of Tennessee.

Patient's Signature: _____ Date:_____

Responsible Party's signature and social security (if not patient):_____
(i.e. minor)

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