BRADEN RICHMOND, M.D., F.A.C.O.G.

'Special Care For Women'

Welcome To Our Office!

PATIENT NAME _____ SSN# _____
LAST FIRST MIDDLE

YOUR TELEPHONE # _____ ALTERNATE # _____ CELL# _____

ADDRESS _____
STREET CITY STATE ZIP

RELIGION _____ CHURCH _____ DOB. ___/___/___ AGE _____ SEX _____ RACE _____ MARITAL STATUS ☐S ☐M ☐W ☐D

EMPLOYER'S NAME _____ PHONE: _____

ADDRESS _____

SPOUSE'S NAME _____ DOB: ___/___/___ SSN# _____

SPOUSE'S EMPLOYER _____ PHONE _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____ REFERRED BY _____

EMERGENCY INFORMATION

NOTIFY IN CASE OF EMERGENCY _____ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____ INSURED'S NAME _____

INSURED'S BIRTHDAY ___/___/___ INSURED'S SSN# _____ RELATIONSHIP TO INSURED _____

INSURED'S EMPLOYER _____

CONTRACT # _____ GROUP # _____ EFFECTIVE DATE _____

SECONDARY INSURANCE COMPANY _____ INSURED'S NAME _____

INSURED'S BIRTHDAY ___/___/___ INSURED'S SSN# _____ RELATIONSHIP TO INSURED _____

INSURED'S EMPLOYER _____

CONTRACT # _____ GROUP # _____ EFFECTIVE DATE _____

COMPLETE THIS SECTION IF YOU ARE AN UNMARRIED MINOR (UNDER 18)

FATHER'S NAME _____ DOB: ___/___/___ SSN# _____

FATHER'S EMPLOYER _____ PHONE: _____

MOTHER'S NAME _____ DOB: ___/___/___ SSN# _____

MOTHER'S EMPLOYER _____ PHONE: _____

PARENT'S

ADDRESS (IF DIFFERENT FROM YOUR OWN) _____

CONTRACT # _____ GROUP # _____ EFFECTIVE DATE _____

METHOD OF PAYMENT: ☐ CASH ☐ CHECK ☐ MASTERCARD / VISA *PAYMENT IS DUE AT TIME OF SERVICE*

In consideration of services rendered, the undersigned agree to pay BRADEN RICHMOND, M.D. the charges thereof, insurance not withstanding, in the event of collection action is initiated to collect such charges, the undersigned agrees to pay all costs and expenses of collection, including attorney's fees and court costs. I authorize BRADEN RICHMOND, M.D. to release any medical information relating to my insurance claims. I authorize my insurance company to make direct payment to BRADEN RICHMOND, M.D. for medical services rendered.

_____ _____
SIGNATURE DATE SIGNATURE DATE

BRADEN RICHMOND, M.D., P. C.

OBSTETRICS, GYNECOLOGY AND INFERTILITY

PATIENT MEDICAL HISTORY

Date_____ Date of Birth_____ Age_____

Name: _____
First Middle Last

Nature of problem or reason you are being seen (include a brief description:) _____

_____

_____

_____

_____

Date of last: Pap smear month/year_____ Where _____

Mammogram month/year_____ Where _____

Have you ever had an abnormal Pap smear?_____ Date_____ Final Result: _____

Have you ever had an abnormal Mammogram?_____ Date _____ Final Result: _____

Birth control method: (please circle) Abstinence Condoms Depo. Diaphragm Hysterectomy IUD Lunelle Norplant None Not Applicable Pill Spermicide

Date of last period:_____ Sponge Tubal Ligation Vasectomy Other_____

History of Pregnancies: Full Term Births_____

Premature Births_____

Please List the Pharmacy You Use _____ Miscarriages_____
This is where your medications will be sent.

Abortions_____

Number of living children _____

Previous Surgery and Year (Include C-Sections):

_____

_____

_____

_____

Family Doctor:_____

Previous Illnesses/Hospitalizations and Dates:

_____

_____

_____

_____

List Drugs you are allergic to (describe type of reaction):

_____

_____

Current Medications (Include strength and schedule)

_____

_____

_____

_____

_____

_____

PLEASE COMPLETE THE OTHER SIDE

Do you smoke? Yes No

Drink alcoholic beverages? Yes No

If yes, age at onset _____

If yes, circle: rarely socially most days

# of cigarettes a day _____

Do you use illegal drugs? Yes No

Have you ever had a serious illness with your (If yes please describe):

Brain Y N _____

Liver Y N _____

Vision Y N _____

Stomach Y N _____

Hearing Y N _____

Intestines Y N _____

Heart Y N _____

Kidneys Y N _____

Lungs Y N _____

Bladder Y N _____

Do you have a history of: (Y or N)

_____ Arthritis
_____ Asthma
_____ Bleeding disorder
_____ Blood in your stool
_____ Blood transfusion
_____ Clot in the leg (DVT)
_____ Diabetes
_____ High blood pressure
_____ Lupus
_____ Persistent headaches
_____ Seizures
_____ Skin disease
_____ Thyroid dysfunction
_____ Other_____
_____ Other_____

Family History

Age	If Living Health	Age At Death	If Deceased Cause	Has Any Blood Relative Ever Had	Please Circle	Which Relatives
Father				Breast Cancer	Yes No	
Mother				Diabetes	Yes No	
Brother/Sister 1.				Osteoporosis	Yes No	
2.				Cancer	Yes No	
3.				High Blood P.	Yes No	
4.				Heart Disease	Yes No	
5.				Kidney Disease	Yes No	
Husband				Liver Disease	Yes No	
Children 1.				Alcoholism	Yes No	
2.				Drug Addiction	Yes No	
3.				Mental Dis.	Yes No	
4.				High Cholesterol	Yes No	
5.				Anesthesia Problem	Yes No	

How old were you when your periods started? . . . . . _____

How many days between the beginning of each period (such as 28 days)? . . . . . _____

Are periods monthly? . . . . . Y N

How many days does your period last? . . . . . _____

Is your flow (circle): Light Medium Heavy Extreme

How is your pain with your periods (circle)? Minimal Mild Moderate Severe

Signature: _____ Date: _____

Thank You! Your complete answers on this form will help us better evaluate your total health.

BRADEN RICHMOND, M.D., F.A.C.O.G.
SPECIAL CARE FOR WOMEN

Missed, Cancelled, and Late Appointment Policies Form

On our registration form we inform all patients of our request for a 24 hour cancellation notice for appointments. If you can't keep your appointment, please let us know as soon as possible so we can offer it to someone else. Your consideration is appreciated because the sooner you call us the greater our chances of providing this time to someone else.

If a patient fails to show for an appointment and does not provide 24 hour notice prior to cancelling then we will charge $20.00. On a second "No Show" consecutively the charge will be $25.00. These charges will not be billed to your insurance provider. Your appointment time is allotted to you so we will charge you for failure to call.

Please understand that procedure appointments such as Ultrasound, PST, Colposcopy, Leep, Ablation, Urodynamics and others will be a $50.00 charge.

This policy applies to the following missed appointments:

- The appointment was not the person's first visit.
- The individual was previously informed of the policy.
- The cancellation was not due to a medical emergency.
- Failure to cancel in more than 24 hours notice
- This applies to all patients.

Late Appointment Arrivals

We ask you to arrive on time for your appointment. If you are more than 15 minutes late you will still be seen for your appointment; however, it will be after the other patients who have arrived on time to their appointments.

Thank you for your cooperation in helping us provide the best care possible to our patients!

Print Name _____

Patient or Legal Guardians Signature: _____ ***Date:*** _____

BRADEN RICHMOND, M.D., F.A.C.O.G.

SPECIAL CARE FOR WOMEN

To ensure the best communication possible between our patients and our office, please let us know how you would like to be contacted for appointment reminders, messages from Dr. Richmond, and test results, such as pap smear, etc. Also, we find that phone numbers change frequently. Please ensure that we have your correct address and phone number, and provide any and all phone numbers that may be used to contact you. Thank you!

Preferences

*******WE MUST HAVE AT LEAST '3' CONTACTS LISTED. IF YOU DO NOT HAVE ADDITIONAL NUMBERS, PLEASE LIST A RELATIVE OR FRIEND SO WE CAN REACH YOU IF NEEDED. THANKS! *******

HOME PHONE: _____

CELLULAR PHONE: _____

WORK PHONE: _____

ALTERNATE PHONE: _____

OTHER PHONE: _____

WILL IT BE FINE TO LEAVE A MESSAGE IF THERE IS NO ANSWER? _____ **(Y/N)**

We encourage you to provide an email address, even if it is not your preferred contact method. This can be used for contact purposes, yearly reminders, and practice updates. This information is NOT shared, and is for the purpose of contacting you, by our practice, ONLY.

YOUR EMAIL ADDRESS _____

DESIGNATED # FOR TEXT MESSAGE_____

Patient or Legal Guardians Signature: _____ ***Date:***_____

BRADEN RICHMOND, M.D., F.A.C.O.G.
'Special Care For Women'
OBSTETRICS, GYNECOLOGY, AND INFERTILITY

1465 1ST AVE. SW.
SUITE A
JACKSONVILLE, AL 36265

TELEPHONE: 256-435-2229
FAX: 256-782-2904

NON-COVERED SERVICES POLICY

As my patient, I want to provide the best care possible. There may be certain services that I feel are necessary for the maintenance of good health that is not covered by your insurance contract. You will be expected to pay for those services in full. For example, I may order an ultrasound, lab test, etc, that may not be covered by your contract. Let me reassure you that I will order test that I feel are necessary for your treatment and care. If you have any questions about your insurance coverage such as whether a particular service is covered or not, one of our employees will be glad to assist you. If your insurance does not cover the services you receive, you will be responsible for any and all legal fees pertaining to the collect of your account.

I have read your policy and agree to pay for services not covered by my insurance contract as indicated by my signature:

_____ _____

(Signature) **(Date)**

Special Care for Women

Dr. Braden Richmond, MD

I acknowledge by signing below that I have received the

NOTICE OF PRIVACY PRACTICES AND NOTICE OF INDIVIDUAL RIGHTS.

Patient or Patient's Personal Representative Date:

You have my permission to release my medical information to the following people:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MUCH MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we may use and disclose medical information. For each category of uses and disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE: This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law for health-related benefits and services; to individuals involved in your care or payment for your care; research to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, you request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE: We reserve the right to change this notice.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact Linda Richmond, Office Manager, 435-2229 ext 5. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.