Stefanie A. Schultis, M.D
110 Lakeview Drive Ste 100 Covington, LA 70433
985-898-1940
www.stefanieaschultismd.com

Revised 1-9-2020

Patient Demographics

PATIENT INFORMATION	**INSURANCE INFORMATION/CASH PATIENT**
Name	
Date of Birth: Age:	HMO PPO OTHER Cash Patient
Social Security #:	MUST COMPLETE INSURANCE INFORMATION
Address:	Name of Insurance:
City, State, Zip:	Name of Insured:
Home#: Cell#:	Relationship:
Work#: Primary#:	Social Security#:
Email:	Date of Birth#:
Religion: Ethnicity:	Employer:
Employer:	Policy#: Group#:
Occupation:	Secondary Insurance:
Marital Status:	
Spouse/Guardian:	Name of Insured:
Date of Birth: Social Security#:	Relationship:
Employer:	Date of Birth: Social Security#:
Occupation: Phone#:	Policy#:
Primary Care Physician:	Group#
Referred by:	
Preferred Pharmacy: Phone#	

Notify in Case of Emergency other than Spouse/Guardian
Name: Relationship: Phone#:

I hereby authorize Dr. Stefanie Schultis and/or her staff to communicate my test results.

Can we call you at: **Home:** YES NO **Cell:** YES NO **Work:** YES NO

Can we leave a message at: **Home:** YES NO **Cell:** YES NO **Work:** YES NO

How did you hear about us?

I hereby authorize Dr. Stefanie Schultis and/or her staff to communicate my test results and/or my medical records to the following:

Name:_____Relationship:_____

Name: Relationship:

Patient or Responsible Party Signature: Date:

STEFANIE A. SCHULTIS, M.D., FACOG

Women's Health Questionnaire

Revised 1-14-2020

PATIENT: The purpose of this questionnaire is to help you remember everything that should be checked by the doctor. Please fill it out completely.
PLEASE PRINT

Name:_____DOB_____AGE_____ Marital Status M D S W

CIRCLE THE MAIN REASON YOU CAME TO SEE THE DOCTOR

(1) Pain (2) Irregular Bleeding (3) Possible Pregnancy (4) Discharge (5) Urinary Symptoms (6) For cancer test
(7) Family Planning (8) Second Opinion (9) Annual Exam (10) Other conditions:_____

MENSTRATION: Started at age_____ Number of days from start of one period to start of the next period_____
Number of days period lasts_____ Date of last period (1st day) _____

OBSTETRIC HISTORY: How many times have you been pregnant? _____ How many full term babies did you have? _____
Prematures? _____ Miscarriages? _____ Still borns? _____ Ages of children? _____

Please list your physicians (internists, surgeons, etc.

_____ Address_____

_____ Address_____

_____ Address_____

Please list any past or present medical conditions (i.e., Diabetes, Hypertension, Blood Clots, Asthma)

_____ _____ _____ _____

_____ _____ _____ _____

Are you presently taking any medications or supplements?

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Have you ever been hospitalized for anything other than operations and childbirth? If so, please list.

_____ _____ _____ _____

_____ _____ _____ _____

Have you ever had surgery? Please list operations and **dates**:

_____ _____ _____ _____

_____ _____ _____ _____

Have you ever had any serious injuries? Yes No _____

Have you ever had any blood transfusions? Yes No _____

Are you allergic to any medications? Yes No Please list_____

To whom may we leave results of laboratory tests and medical information if you are not available?

Name_____ Phone _____

When you have completed this form, the nurse will weigh you and check your blood pressure. You will then be taken into the doctor's office. Please feel free to tell the doctor your history in your own words. Thank you.

Patient Signature_____ Date_____

STEFANIE A. SCHULTIS, M.D.

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110 Lakeview Drive Suite 100
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Important Facts About Insurance Benefits

Preventive and Screening Services

Our office makes every effort to follow the current coding practices for reporting medical services as directed by Federal law and the American Medical Association. These regulations can be quite complicated and generate many questions from our patients. The purpose of this handout is to clear up any confusion caused by these complicated rules regarding the billing of Preventive and Screening Services.

The **Well Woman or Preventive Medicine** charges for services provided by our practice includes:

- The Preventive examination includes a complete history and examination in addition to a breast and pelvic exam. There will be questions about other medical conditions and counseling on risk factors such as smoking, diet and exercise, stress, self-breast exams, menopausal symptoms and hormone replacement therapy.
- Conveyance of Pap Smear specimen to the laboratory is included
- Appropriate laboratory and diagnostic tests, such as a mammogram and DEXA may be ordered and will be billed by those entities.

As outlined above, discussions about problems and conditions you are being treated for that are under control are considered an integral part of the Well Woman exam and cannot be billed as a "Sick Visit" under Federal Compliance Rules.

If a separate problem is identified during the course of the Well Woman or Preventive exam, we are required to submit our claims based on the documentation in the medical record of the service provided to you. This may require an additional charge to your insurance company resulting in another co-payment.

Our doctors cannot comply with any requests to improperly alter the medical records for the purpose of obtaining payment by billing for a "Sick Visit' when no other major problems were evaluated.

You, as the patient will be responsible for all co-payments and deductibles at the time of service.

Our business office will be happy to assist you with any questions.

We thank you for choosing us to assist you with your healthcare needs. Providing high quality healthcare remains our first priority.

Respectfully,

Stefanie A. Schultis, M.D.

Stefanie A. Schultis, M.D.
110 Lakeview Drive Suite 100
Covington, LA 70433
985-898-1940

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted and required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, or your child, to pay your health care bill, to support the operation of the physician's practice, and any other use required by law.

Treatment
We will use and disclose your/your child's protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital surgery may require that you relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations
We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include, as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures

Will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing except to the extent that you physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information
Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information,

You have the right to request restriction of your protected health information.
This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).

You may have the right to have your physician amend your protected health information
If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made. if any. of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice,

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before APRIL 14, 2013

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak to our HIPPA Compliance Officer, Heather Harris in person or by phone at 985-898-1940

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature_____

Print Name_____Date_____

Stefanie A. Schultis, M.D.
110 Lakeview Drive Suite 100
Covington, LA 70433
985-898-1940

General Consent to Treat/Patient Authorization/Acknowledgement of Benefits Release

The following are the conditions for services provided by Stefanie A. Schultis, M.D. for the patient whose name appears at the bottom of this page.

CONSENT FOR MEDICAL TREATMENT
I/we voluntarily consent to medical treatment and diagnostic procedures provided by Stefanie A. Schultis, M.D. and other personnel. I/we consent to the testing deemed advisable by my physician. I/we acknowledge that no guarantees have been made as to the result of treatments or examinations.

AUTHORIZATION FOR RELEASE OF INFORMATION
Stefanie A. Schultis, M.D. is authorized to release any medical information required in the processing of applications or submission of information for financial coverage, discharge planning, further medical treatment, insurance and/or any third party payer, test results and findings made during the course of the examination or treatment. I/we agree to release of medical and other information about me given to government federal or state regulatory agencies as required by law.

ASSIGNMENT OF INSURANCE BENEFITS
I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the practice of Stefanie A. Schultis, M.D. I/we understand that I am responsible for any charges not covered by insurance or other forms of benefits. I/we shall pay all collection fees and costs. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I/we have received a copy of the NOTICE OF PRIVACY PRACTICES. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the NOTICE MAY BE CHANGED at any time.

_____Date_____
Patient Signature / Legal Guardian