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

Welcome To Our Office!

PATIENT NAME_____ SSN#_____
LAST FIRST MI

ADDRESS_____
STREET CITY STATE ZIP CODE

HOME # _____ CELL # _____ ALTERNATE # _____

RELIGION_____ CHURCH_____ DOB___/___/___ AGE_____ SEX_____ RACE____ MARITAL: M S D W

EMPLOYER_____ PHONE_____
ADDRESS_____
SPOUSES NAME_____ DOB___/___/_____ SSN_____
SPOUSES PHONE_____SPOUSES EMPLOYER_____

HOW DID YOU HEAR ABOUT OUR PRACTICE?_____ REFERRED BY_____

EMERGENCY INFORMATION
NOTIFY IN CASE OF EMERGENCY _____RELATIONSHIP_____ PHONE_____

INSURANCE INFORMATION
PRIMARY INSURANCE_____ POLICY ID#_____
GROUP#_____ EFFECTIVE DATE_____ INSURED'S NAME_____ _____
RELATIONSHIP TO INSURED_____ INSURED DOB_____ INSURED'S SSN_____

*SECONDAY INSURANCE*_____ POLICY ID#_____
GROUP#_____ EFFECTIVE DATE_____ INSURED'S NAME_____ _____
RELATIONSHIP TO INSURED_____ INSURED DOB_____ INSURED'S SSN _____

IF YOU ARE A MINOR (UNDER 18 YRS) PLEASE COMPLETE THIS SECTION
MOTHER'S NAME_____ DOB___/___/_____ SSN_____
MOTHER'S PHONE_____
FATHER'S NAME_____ DOB___/___/_____ SSN_____
FATHER'S PHONE _____
PARENTS ADDRESS (IF DIFFERENT FROM ABOVE)
_____

PAYMENT IS DUE AT TIME OF SERVICE

In consideration of services rendered, the undersigned agree to pay BRADEN RICHMOND, MD the charges thereof, insurance not withstanding, in the even 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, MD to release any medical information relating to my insurance claims. I authorize my insurance company to make direct payment to BRADEN RICHMOND, MD for medical services rendered.

_____ _____
PATIENTS SIGNATURE DATE GUARDIANS SIGNATURE (if minor) DATE

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

'Special Care For Women'

OBESTETRICS, GYNECOLOGY, AND INFERTILITY

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) **None** **Not Applicable** **Abstinence** **Natural Planning**
Condoms **Diaphragm** **Pill** **Patch** **Ring** **Depo**
Nexplanon **IUD** **Tubal Ligation** **Vasectomy** **Hysterectomy**
Other method: _____

Date of Last Period:_____

History of Pregnancies: Full Term Births _____
Premature Births _____
Miscarriages _____
Abortions _____
Number of living children _____

Please list the Pharmacy & the location that you use_____
(This is where your medications will be sent)

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 FLIP OVER TO COMPLETE THE OTHER SIDE OF THIS PAGE

Do you smoke? Yes No
If yes, age at onset _____
# of cigarettes a day _____

Drink alcoholic beverages? Yes No
If yes, circle: rarely socially most days
Do you use illegal drugs? Yes No

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

Brain Y N _____
Vision Y N _____
Hearing Y N _____
Heart Y N _____
Lungs Y N _____
Liver Y N _____
Stomach Y N _____
Intestines Y N _____
Kidneys Y N _____
Bladder Y N _____

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

____ Arthritis
____ Asthma
____ Bleeding Disorder
____ Clotting Disorder
____ Blood Transfusion
____ Clot in the leg (DVT)
____ Diabetes
____ High Blood Pressure
____ Lupus
____ Mental Disorder
____ Seizures
____ Skin Disease
____ Thyroid Dysfunction
____ Other _____
____ Other _____

Family History

	Age if Living	Age at Death	If Deceased: Cause of Death	Has Any Blood Relatives Ever Had	Please Circle	Which Relatives
Father:				Breast Cancer	Yes No	
Mother:				Diabetes	Yes No	
Brother/Sister:				Osteoporosis	Yes No	
				Cancer	Yes No	
				High Blood Pressure	Yes No	
				Heart Disease	Yes No	
				Kidney Disease	Yes No	
Husband:				Liver Disease	Yes No	
Children:				Alcoholism	Yes No	
				Drug Addiction	Yes No	
				Mental Disease	Yes No	
				High Cholesterol	Yes No	
				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

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: _____

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 _____

IF YOU WOULD LIKE TO RECEIVE TEXT MESSAGE REMINDERS PLEASE LEAVE PHONE NUMBER

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

731 Leighton Ave
Suite 401
Anniston, AL 36207

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 are 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 only order tests 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 fees, including any legal fees, pertaining to the collection 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)**

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

'Special Care For Women'

OBESTETRICS, GYNECOLOGY, AND INFERTILITY

TYLER CENTER
731 LEIGHTON AVE
SUITE 401
ANNISTON, AL 36207

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

Please initial each section below to indicate you have read and understand the information:

_____ **Assignments of insurance and payments:** I do hereby authorize payment of all insurance benefits to Braden Richmond, MD. I understand I AM RESPONSIBLE for any unpaid balance or non covered service, I AM RESPONSIBLE to understand my deductible and copays for such balances.

_____ **Authorization to release information:** I do hereby authorize Braden Richmond, MD to release medical information which may be necessary for the completion of insurance claims or receipt of benefits.

_____ **Financial Responsibility:** I do hereby agree to pay the reasonable cost of collection, including a reasonable attorney's fee, for the collection of the amount if assigned to attorney for collections.

_____ **Photography:** I authorize Braden Richmond, MD to take a photo to enter into the electronic medical records. I also authorize any photography related to my care as a patient.

_____ **Missed Appointments:** I understand I will be charged $25 if I do not cancel my appointment within 24 hours of my scheduled visit. There will be a $75 charge for any missed procedures. (When you do not cancel or show for your appointment it leaves slots that could have been given to other patients.)

May we leave personal information on an answering machine, if reached using your provided phone number: _____ Yes _____ No

_____ _____

Date **Signature of patient/Authorized Representative**

'APPOINTMENTS/CANCELLATION/NO SHOW POLICY'

APPOINTMENTS

Office visits are by appointment only. The receptionist may ask about the reason for your visit to help us schedule the doctor's time efficiently. Please arrive 15 minutes early for your appointment. Patients who are 15 minutes late for the appointment may be asked to reschedule at the physician's discretion. Remember to bring all your prescription information to each office visit.

CANCELLATIONS

We appreciate you for being a patient in our office! We value ALL of our patients and strive to provide the best care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for YOUR particular needs. We kindly ask that if you must change an appointment, please give us AT LEAST 24 hours notice. This courtesy make sit possible to give your reserved time to another patient who needs it. When your appointment is made, a room is reserved, your records are prepared, and any special instruments are readied for your visit.

MISSED APPOINTMENT [NON-CANCELLED]

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without canceling, someone else who could have been seen your place is delayed unnecessarily. We track missed (non-canceled) and rescheduled appointments. A "No Show/Late Cancellation" is defined as missing an appointment without canceling at least 24 hours before scheduled time. For Monday appointments this would mean notifying us by Thursday prior. There will be a $25.00 charge for a missed/non-canceled appointment. Insurance will not cover charges for no show/late cancellation fees. Repeated "No Show" appointments may result in discharging you from the practice. Repetitive "rescheduling" of appointments, even before 24 hours, is disruptive to our ability to care for you, and for other patients. Rescheduling 3 appointments in a row, or 4 times in a three-month period will result in being scheduled as a "walk-in" only. You could only be seen after arriving at the office and waiting to be seen.

PAYMENT

Payment is due in full at the time of service. NO EXCEPTIONS.

Patient Name	Patient 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

_____

Patients or Patients Representative's Signature **Date**

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

_____ Relationship:_____

_____ Relationship:_____

_____ Relationship:_____

_____ Relationship:_____

NOTICE OF PRIVACY PRACTICES

Effective October 1, 2017

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.

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 HEALTHCARE 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 healthcare 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 I 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 use to: make sure that medical information that identifies you is kept private; give you this noticed 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 INDIVIUAL 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 the 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, your 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 inspect and copy medical information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing to **Lindsey Cofield**. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing, or other supplies associate with your request. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

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 certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

RIGHT TO REQUESTS 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 has 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, 256-435-2229, 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.

RIGHT TO AN ELECTRONIC COPY OF ELECTRONIC MEDICAL RECORDS: If your PHI is maintained in an electronic format (known as an electronic medical record or electronic health record), you have the right to request that an electronic copy of your record be given to your or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable, hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

RIGHT TO GET NOTICE OF A BREACH: You have the right to be notified upon a breach of any of your unsecured PHI.

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