Balance
RACHEL DALTHORP, M.D.
balancewomenshealth.com

New Patient Policies and Procedures

Thank you for choosing Balance Women's Health. We provide individualized and attentive care with the goal of addressing symptoms at their source by using a comprehensive bio-psycho-social medical model. We strive for optimal health not just symptom control. We work to enhance a woman's quality of life and assist her in meeting her full potential by promoting a healthy mind, mood and body. You will find that Dr. Dalthorp provides a complete range of services, including comprehensive psychiatric, sexual and general health evaluations, medical and neurological examinations, group therapy, weight loss services and more. We hope this information will help you get the most out of our services.

Appointments
Patients are seen by appointment only. Our office hours are 8:00 am - 4:30 pm Monday through Thursday and 8:00 am - 12:00 pm on Friday. We close for most major holidays. When you call for an appointment, please tell our staff the nature of your appointment. If you are unable to keep your appointment, please contact our office at (405)378-2727 as soon as possible. We do require 24 hour notice if you need to cancel/reschedule an appointment. If we do not receive 24 hour notice, there will be a $25 charge. The policy is not intended to be punitive; rather, it allows us to continue to provide a high level of care to all of our patients. We customarily provide a reminder call the day before an appointment; however, this reminder call is a courtesy and does not exempt the patient for a missed appointment fee. Excessive no-shows or missed appointments may lead to discharge from clinic. In order to keep our office on schedule and as a courtesy to our other patients, if you arrive more than 15 minutes late for you for your appointment you will need to reschedule. It will be considered a missed appointment if you are more than 15 minutes late and we are forced to reschedule your appointment.

On Your First Visit
Please try to get here 15-20 minutes early. Please have all of your paperwork completed prior to your arrival at the office. If you are unable to complete your paperwork prior to your appointment, please arrive 30 minutes early, so that you may complete it in the office.

After Hours
Our answering machine is available for non-emergent messages. If an urgent matter arises after hours, please contact your nearest emergency room or call 911.

Office Closings
From time to time, Oklahoma weather creates inclement conditions which may impede our ability to see scheduled patients. In the event that we close our office, we will call our scheduled patients as far in advance as possible to inform them of the office closing. In addition, we will leave a recorded message on our answering machine for any patients who call our office after hours or on those days we are closed. If you live out of town and your local schools are closed due to weather conditions, our policy is that you are not required to give us the usual 24 business hour notice. However, we do ask that you kindly give us a call to inform us that you will not be at your appointment due to weather conditions and that your local schools are in fact closed. We can reschedule your appointment at that time as well.

Payment of Services
Payment is due at the time of services. Dr. Dalthorp is on many insurance panels and will bill your insurance for services. You are responsible for copays, deductibles, and services your insurance does not cover. Additionally, some insurance policies require authorization for visits before you are seen in our office. While we may assist with this, it is ultimately the patient's responsibility to ensure that all forms and authorizations are obtained prior to the initiation of treatment.

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Prescriptions
You can get prescriptions refilled by having your pharmacy fax a request to us at (405)378-2776 or call us at (405)378-2727. It's a good idea to ask for a refill before your medication runs out. It may take up to 72 hours to process your request.

Results of Laboratory Tests
Your results will be available as soon as they are received from the laboratory and reviewed by our nurses. Result turn-around time varies based on the test ordered. And of course, we'll call you immediately if your results require immediate attention or medication.

Medical Records
Requests for medical records must be made in writing. In addition, an appropriate HIPAA form must be complete. Please allow 2 weeks for processing of medical records request. There may be a fee associated with these requests.

Social Media Policy
The opinions and or views expressed on Balance Women's Health social media platforms represent the thoughts of individuals and online communities, and not those necessarily of Balance Women's Health. Information posted on one of our sites is not intended to be medical advice and is not intended to replace consultation with a qualified physician or other healthcare provider. Links to other websites from Balance Women's Health social media sites are provided as a service to readers, but such linkage does not constitute endorsement of those sites, and as such we are not responsible for the content of external websites. By submitting content to any of Balance Women's Health social media sites, you understand and acknowledge that this information is available to the public. Balance Women's Health is not responsible for the content of any comments or responses posted to any web site or social media site. Please contact your healthcare provider for specific medical advice and/or treatment recommendations. Call 911 in the case of any emergency.

Confidentiality
We commit to keeping your medical records confidential. The information in them will never be released to any person or organization without your written permission, unless required by law. You will receive a copy of our Privacy Notice at your first visit. The 'Acknowledgement Form' you will be asked to sign includes the option for you to designate the names of other people that you may want to be able to access your information (i.e., family, etc.). Copies of these forms are also available on our website.

Acknowledgement and Receipt
I have reviewed the New Patient Policies and Procedures from Balance Women's Health and am aware that these policies are subject to change.

Patient Signature: _____ Date: _____

We look forward to providing you care and thank you for the opportunity.

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NEW PATIENT INFORMATION

Last Name_____First _____MI_____

Address_____City_____State_____Zip_____

Home Phone ( )_____Cell Phone ( )_____Work phone ( )_____

Date of Birth_____Sex_____Marital Status_____SSN_____-_____-_____

Employment Status_____Student Status_____

Employer_____Address_____

Primary Care Physician_____

Referring Physician _____

Emergency Contact_____Relationship_____

Address_____Phone ( )_____

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT COMPLETE THIS SECTION

Name of responsible party_____Relationship_____

Address_____Phone ( )_____

Employed by_____Phone ( )_____

Employer's Address_____

MEDICAL INSURANCE INFORMATION

Primary Insurance Name & Address_____

Policy number_____Group number_____Office visit co-pay_____

Policyholder _____Policyholder Date of Birth_____

Secondary Insurance Name & Address_____

Policy number_____Group number_____

Policyholder_____Policyholder Date of Birth_____

E-mail address:_____

Race (please circle): Asian Native Hawaiian or other Pacific Islander Black or African American White Other

Ethnicity (please circle): Hispanic or Latin Not Hispanic or Latin Primary Language: _____

Local Pharmacy (Name & Address)_____

Mail Order Pharmacy (Name & Address) _____

ASSIGNMENT OF BENEFITS-FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance made directly to Rachel Dalthorp, M.D. and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

Expanded Authorization Option:

Please list any persons you would like to authorize to have access to your billing, appointment or health information* such as your spouse, caretaker, or other family member:

Name: **Relationship:**

_____

_____

*With the exclusion of information that is protected under State and Federal Law.

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:

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New Patient Intake Form

Name: _____ DOB:_____ Age:_____ Date of Appointment: _____

Primary Care Physician: _____

How did you hear about Balance Women's Health? _____

What primary concerns brought you to Balance Women's Health?

O	Mood & Hormone Health	O	Wellness & Aesthetics	O	Psychotherapy & Counseling
O	Women's Psychiatry	O	Women's Sexual Health	O	Weight Loss & Products

Are you interested in alternatives to traditional medications such as supplements and lifestyle modifications? O Yes O No

Medical History

O	abnormal vaginal bleeding	O	chronic fatigue	O	osteoporosis
O	anemia	O	fibrocystic breast disease	O	ovarian cysts
O	asthma	O	fibromyalgia	O	PCOS
O	autoimmune disorder	O	head trauma/concussions	O	stomach problems
O	blood clots	O	headaches	O	stroke
O	chronic pain	O	heart disease	O	uterine fibroids
O	diabetes mellitus	O	high blood pressure	O	thyroid disease
O	eating disorder	O	high cholesterol	O	cancer
O	endometriosis	O	kidney disease		Type(s)_____
O	epilepsy	O	liver disease		_____
O	Other(s): _____				

List all prior surgeries and hospitalizations:

O	appendectomy	O	hysterectomy	O	tonsillectomy
O	cesarean section	O	ovarian surgery	O	tubal ligation
O	gallbladder surgery	O	thyroid surgery	O	other _____

_____

_____

Hospitalizations:

_____

_____

_____

_____

Family History

Father		**Mother**		**Siblings**	
O	Diabetes	O	Diabetes	O	Diabetes
O	Cancer	O	Cancer	O	Cancer
	Type: _____		Type: _____		Type: _____
O	Cardiovascular Disease	O	Cardiovascular Disease	O	Cardiovascular Disease
O	High blood pressure	O	High blood pressure	O	High blood pressure
O	Mental illness	O	Mental illness	O	Mental illness
O	Obesity	O	Obesity	O	Obesity
O	Other: _____	O	Other: _____	O	Other: _____

Review of Systems

<u>General/Constitutional</u>			<u>Gastrointestinal</u>		
Trouble falling asleep	O Yes	O No	Constipation	O Yes	O No
Trouble staying asleep	O Yes	O No	Diarrhea	O Yes	O No
Pregnant	O Yes	O No	Nausea	O Yes	O No
Breastfeeding	O Yes	O No	Vomiting	O Yes	O No
Weight change	O Yes	O No	<u>Musculoskeletal</u>		
<u>Endocrine</u>			Joint stiffness	O Yes	O No
Cold intolerance	O Yes	O No	Painful joints	O Yes	O No
Excessive thirst	O Yes	O No	<u>Neurologic</u>		
Heat intolerance	O Yes	O No	Weakness	O Yes	O No
<u>Respiratory</u>			Dizziness	O Yes	O No
Cough	O Yes	O No	Headache	O Yes	O No
Shortness of breath	O Yes	O No	Memory loss	O Yes	O No
<u>Cardiovascular</u>			Seizures	O Yes	O No
Chest pain	O Yes	O No	Tingling/Numbness	O Yes	O No
Palpitations	O Yes	O No			

List all current prescription medications and how often you take them: (if none, write none)

Medication Name: Dosage: Estimated Start Date:

_____

_____

_____

_____

_____

Allergies: _____ Current Weight: _____ Height: _____

Current over-the-counter medications or supplements:

_____

_____

_____

General/Lifestyle History

Highest educational level or degree attained: O high school diploma/GED O college degree O graduate degree

Are you currently: O working O not working by choice O unemployed O disabled O retired

How long have you been in your present position?

O 1-3 months O 6-12 months O 1-3 years O 3-5 years O 6-10 years O 10+ years

What is/was your occupation: _____

Do you exercise regularly: O Yes O No number of days per week: O 1-2 days O 3-4 days O 5-6 days O 7 days

Type(s): O high impact O low impact O weight training

Do you smoke? O Never O Former Smoker O Current Smoker

If current smoker, how many cigarettes do you smoke a day? _____ Are you interested in quitting? O Yes O No

Do you drink alcohol? O Yes O No If yes, how often do you drink? _____

Social History

Do you have a good support system: O Yes O No

Are you married? O Yes O No How many years?_____

Are you: O Divorced O Single O Widowed How many years? _____

If not married, are you currently in a relationship: O Yes O No How long?_____

Do you have children? O Yes O No If yes, list ages and gender:_____

Have you ever been arrested: O Yes O No Do you have any pending legal problems: O Yes O No

Have you traveled outside the US? O Yes O No

Do you have history of being abused emotionally, sexually, physically or by neglect: O Yes O No

Do you belong to a particular religion or spiritual group: O Yes O No

If yes, do you find your involvement makes things more difficult or stressful: O Yes O No

If yes, do you find your Involvement is helpful: O Yes O No

Pregnancy History:

Have you ever been pregnant? O Yes O No

If yes, did it take you greater than one year to conceive? O Yes O No

If yes, did you have major problems during pregnancy or delivery? O Yes O No

Number of pregnancies:_____ Number of live births_____

Are you considering pregnancy in the next two years? O Yes O No

Gynecology History:

Are you still having menstrual periods? O Yes O No

If you are still having menstrual periods, please answer the following questions, otherwise skip to the next section.

Length of flow: O 1-2 days O 3-4 days O 5-6 days O 7-8 days O 9 or more days

Do you have physical or emotional discomfort before your periods? O Yes O No

Do you take medication for menstrual cramps? O Yes O No

Have you ever had bleeding between periods? O Yes O No

Is your flow usually: O Light O Medium O Heavy

Do you have a period every month? O Yes O No

Was your last period normal? O Yes O No

Age at first period: _____ First day of last period: _____

If you are no longer having menstrual periods, please answer the following questions, otherwise skip to the next section.

What age did you have your last period?_____

At what age did your mother go into menopause?_____

Have you had hot flashes or any possible symptoms of menopause? O Yes O No

If yes, please describe:_____

Have you ever taken any hormones (estrogen, progesterone, testosterone, other)? O Yes O No

If yes, please describe:_____

Sexual History:

Are you sexually active? O Yes O No

Are you satisfied with your sex life? O Yes O No

If no, please select the problem(s) with your sexual function: (mark one or more)

- O Problems with little or no interest in sex
- O Problems with decreased genital sensation (feeling)
- O Problems with decreased vaginal lubrication (dryness)
- O Problems reaching orgasm
- O Problems with pain during sex
- O Other: _____

Contraceptive History:

Are you using a contraceptive method? O Yes O No

If Yes, what method?

O birth control pills	O IUD
O condoms	O Nexplanon
O Depo-Provera	O spermicidal
O diaphragm	O tubal ligation
O hysterectomy	O other