



GYN Evaluation

not use this service for urgent concerns as you can expect up to 2 business days for a response. If you do not receive a response within 2 business days, or if your concern is urgent, please call the office.

Finally, email is available, but it is reserved for communications requiring the uploading of documents. Please include your name & date of birth on scanned documents. This is not the appropriate means of asking for medical advice. Be aware that email is not considered a secure and private means of communication. If you choose to use email or authorize email communication, you accept the risk that your private healthcare information may be compromised.

Coming from out of state for surgery

If you are coming from out of state, you will have an in-depth appointment with your provider in which a thorough history will be taken. A basic physical exam will be done if you are having surgery. This may include a breast and pelvic exam, including a Pap smear, if needed. You will need to plan on staying in town about 3-5 days depending on the type of surgery recommended. During this time, you will meet with the surgeon, get pre-operative testing performed (lab-work, ultrasound, EKG, x-rays, if needed), undergo surgery, and spend at least 1 night after surgery in the area. We have compiled a list of hotels in the area that may be helpful to you. Please feel free to request this list, if it is needed.

Surgeries

Sometimes the cause of gynecologic problems is anatomic in its origin. The purpose of surgery is to diagnose these conditions, such as endometriosis and pelvic adhesions (scar tissue), and, if possible, treat the underlying problem(s). Diagnostic surgery is done under general anesthesia on an outpatient basis. The patient is generally feeling ok by the second day after the operation, but may not be up for returning to work for about four days.

A laparoscopy allows direct observation of the ovaries, the outside of the fallopian tubes and the uterus by means of a camera inserted through a small incision made just inside the naval. Another incision may be made slightly above the pubic bone, or two incisions may be made near the hips. The stitches self-absorb and do not need to be removed. Sometimes endometriosis and pelvic adhesions can be treated with this type of approach, but it is possible that treatment may require a second surgery in order to facilitate a robotically assisted laparoscopic approach, which means two additional small incisions, or even a laparotomy, which is a larger abdominal incision like a cesarean section.

A hysteroscopy allows direct viewing of the inside of the uterus in order to examine its shape and to determine the presence of any abnormalities. This is accomplished by inserting an instrument through the cervix. This is done to evaluate the inner lining of the uterus and the cervical canal for anatomic abnormalities or signs of chronic inflammation inside the uterus.

A dilation and curettage allows for sampling of the cervix and/or endometrium to determine if there is infection, precancerous lesions, and cancerous lesions. It may also be used as treatment to thin a uterine lining or as a surgical means of treating a miscarriage.

Personal History Form

Symptom Review: Please check those symptoms which you have been experiencing.

<u>Constitutional/Allergic/Immunologic</u>	<u>Genitourinary & Breast</u>	<u>Psych</u>
<input type="checkbox"/> chills	<input type="checkbox"/> breast mass	<input checked="" type="checkbox"/> anxiety
<input checked="" type="checkbox"/> fatigue	<input type="checkbox"/> breast tenderness	<input type="checkbox"/> depression
<input type="checkbox"/> fevers	<input type="checkbox"/> nipple discharge	<input checked="" type="checkbox"/> difficulty concentrating
<input checked="" type="checkbox"/> food intolerance	<input checked="" type="checkbox"/> vaginal discharge	<input type="checkbox"/> eating disorder
<input type="checkbox"/> weight gain	<input type="checkbox"/> vaginal dryness	<input checked="" type="checkbox"/> irritability
<input type="checkbox"/> weight loss	<input type="checkbox"/> vaginal itching	<input checked="" type="checkbox"/> PMS
<input checked="" type="checkbox"/> sleep difficulty	<input checked="" type="checkbox"/> irregular periods	<input type="checkbox"/> teariness
HEENT	<input checked="" type="checkbox"/> pelvic pain	Endocrine
<input type="checkbox"/> visual changes	<input checked="" type="checkbox"/> unusual menstrual bleeding	<input checked="" type="checkbox"/> acne
<input type="checkbox"/> hearing changes	<input checked="" type="checkbox"/> painful urination	<input checked="" type="checkbox"/> carbohydrate cravings
<input type="checkbox"/> nosebleeds	<input checked="" type="checkbox"/> urinary frequency	<input checked="" type="checkbox"/> excessive thirst
<input type="checkbox"/> difficulty swallowing	<input type="checkbox"/> urinary incontinence	<input type="checkbox"/> hot flashes
<input type="checkbox"/> neck swelling	<input type="checkbox"/> painful intercourse	<input type="checkbox"/> night sweats
Cardiovascular	<input type="checkbox"/> sexual dysfunction	<input type="checkbox"/> temperature sensitivity
<input type="checkbox"/> chest pain	Muscular Skeletal	HEME/LYMPH
<input type="checkbox"/> fainting	<input checked="" type="checkbox"/> joint pain	<input type="checkbox"/> easy bruising
<input type="checkbox"/> heart palpitations	<input type="checkbox"/> muscle pain	<input type="checkbox"/> swelling
<input type="checkbox"/> swelling	<input checked="" type="checkbox"/> muscle weakness	<input type="checkbox"/> swollen lymph nodes
Respiratory	Integumentary	<input type="checkbox"/>
<input type="checkbox"/> cough	<input checked="" type="checkbox"/> abdominal/facial hair growth	<input type="checkbox"/>
<input type="checkbox"/> shortness of breath	<input checked="" type="checkbox"/> excessive hair loss	<input type="checkbox"/>
<input type="checkbox"/> wheezing	<input type="checkbox"/> brittle nails	<input type="checkbox"/>
Gastrointestinal	<input type="checkbox"/> dry skin	<input type="checkbox"/>
<input checked="" type="checkbox"/> acid reflux	<input type="checkbox"/> rash	<input type="checkbox"/>
<input checked="" type="checkbox"/> appetite gain	<input type="checkbox"/> skin tags	<input type="checkbox"/>
<input type="checkbox"/> appetite loss	Neuro	<input type="checkbox"/>
<input checked="" type="checkbox"/> bloating	<input type="checkbox"/> absence of smell	<input type="checkbox"/>
<input checked="" type="checkbox"/> constipation	<input checked="" type="checkbox"/> dizziness	<input type="checkbox"/>
<input type="checkbox"/> diarrhea	<input checked="" type="checkbox"/> headaches	<input type="checkbox"/>
<input checked="" type="checkbox"/> fecal incontinence	<input type="checkbox"/> memory problems	<input type="checkbox"/>
<input type="checkbox"/> nausea	<input type="checkbox"/> seizures	<input type="checkbox"/>
<input checked="" type="checkbox"/> painful bowel movements	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> vomiting	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name: Jessica Miceli

Date of Birth: 7/16/90

Revised 5/2015

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Rec'd: _____ via hard copy email fax _____
Duxware Demo _____ Docs _____
Sevocity Docs _____ Hx _____ Hx review _____
 Med Recs Req Faxed _____ Appt Date/Time _____
(for office use only)

PATIENT INFORMATION

PATIENT INFORMATION

PATIENT NAME: Miceli Jessica A
LAST FIRST MIDDLE

ADDRESS: ^{PO BOX} 2773

ZIP CODE: 70455 CITY: Slidell STATE: LA

PRIMARY PHONE: 225 226 8489 SECONDARY PHONE: _____

DATE OF BIRTH: 7/16/90 SOCIAL SECURITY NUMBER: 436797346 GENDER: Female

MARITAL STATUS: single SPOUSE FULL NAME (if applicable): Future spouse David Wogen

RACE: American Indian Alaskan Native Asian African American Pacific Islander Caucasian Other

ETHNICITY: Hispanic/Latino/Latina Not Hispanic/Latino/Latina LANGUAGE: English

PRIMARY CARE PHYSICIAN: Susan Caldwell REFERRED BY: Susan Caldwell

EMAIL: Miceli.jessica@yahoo.com HOW DID YOU HEAR OF GIANNA CENTER: Taking Back The Terms

RESPONSIBLE PARTY INFORMATION (if different from patient)

POLICY HOLDER: Jessica Miceli RELATION TO PATIENT: _____

ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

PRIMARY PHONE: _____ SECONDARY PHONE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____ GENDER: _____

Please make a photocopy of the front and back of your insurance card and submit the photocopy with this form.

EMERGENCY CONTACT INFORMATION

NAME: John/Gloria RELATION TO PATIENT: Grandparents

PRIMARY PHONE: 225 686 1912 SECONDARY PHONE: 225 328 8838

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical healthcare, private insurance and any other health plans to the provider. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as the original. I understand that I am financially responsible for all payments whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature: _____ Date: 3/9/17

Personal History Form

Health Maintenance

When was your last flu vaccination? last year When was your last tetanus vaccination? dont remember

Have you received the HPV vaccine series (Gardasil® or Cervarix®)? ✓ Dont remember Yes/Date Rec'd No

Last Pap smear date (month/year) Feb 2017 result: normal abnormal/explain: _____

Were you screened for HPV with your pap? If so, include result. _____

Abnormal Pap smear history & treatments _____

Last mammogram date (month/year) & result _____

Abnormal mammogram/breast exam history & treatments _____

Last Colon Cancer Screening & result _____

Last Bone Density Screening & result _____

Do you have an advanced medical directive (ie living will, etc)? Yes No

Would you like to complete an advanced medical directive? Yes No If yes, visit <http://www.lhcqf.org/lapost>

Preferred Pharmacy/Phone Number: Walmart 985 288 6518

Compounding Pharmacy/Phone Number: _____

Please include vitamins, supplements, and herbals.

Medication Name	Dosage	Route	Frequency	Reason
Example: Synthroid	75mcg	Oral	Daily	Hypothyroid
Vitamin C				
tumeric				
myoinositol				
Baby's breath				
calcium				

Environmental/Medication Allergy	Reaction
Penicillin	itch/swell/vomit
Latex	itch/swell
Dust dustmites etc.	
Roads	
pine trees Sweet gum trees	
cortizone	heart speed sur
molds	

Name: Jessica Miceli Date of Birth: 7/16/90
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Personal History Form

Past Surgical History

Surgery (i.e. wisdom teeth, ear tubes, appendectomy, laparoscopy, etc)	Date
Wisdom Teeth	December, 2008

Family History (important for screening of genetic diseases)

Please list who in the family has the following (only include blood-related children, siblings, parents, and grandparents- specify if maternal or paternal side):

Disease	Describe	Maternal	Paternal	Relationship
Autoimmune Disease		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Birth Defects		<input type="checkbox"/>	<input type="checkbox"/>	
Blood Clot/Pulmonary Embolism		<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Cancer (describe type, especially colon, breast, uterine, ovarian, cervical)	Breast/cervical/melanoma	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Other Cancer		<input type="checkbox"/>	<input type="checkbox"/>	
Cystic Fibrosis	none	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Coagulation Disorder	none	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Depression		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Other Psychiatric Disease		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Down Syndrome <input type="checkbox"/> Mental Handicap	PTSD	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Dad
Endometriosis		<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack/Myocardial Infarction		<input type="checkbox"/>	<input checked="" type="checkbox"/>	
High Blood Pressure/Hypertension		<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Miscarriages		<input type="checkbox"/>	<input type="checkbox"/>	
Neural Tube Defect (i.e. spina bifida)		<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Postpartum Depression		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Sickle Cell Disease or Trait Thalassemia	none	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Stroke		<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease		<input checked="" type="checkbox"/>	<input type="checkbox"/>	

Name: Jessica Miceli

Date of Birth: 7/16/90



CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND PATIENT AGREEMENT

Patient Name (Last, First): Miceli, Jessica SS#: 43679736 DOB: 7/16/90 Patient Tel # 228 226 8489

Initials

JM

Consent for Treatment

I hereby authorize the practice, its agents, employees and physicians or other medical providers who may be called upon to consult or assist in my care as judged necessary by my treating physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to be regarding my care and treatment. I consent that fellows, residents, interns, medical and nursing students and other professional students to observe in or assist in my care and treatment under the supervision of my physician. This consent is valid for the course of my treatment or until revoked.

JM

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of services unless other arrangements have been made in advance with our practice financial counselor. Necessary form will be completed to help expedite insurance carrier payments. However, YOU ARE responsible for all fees regardless of insurance coverage.

JM

Assignment of Benefits

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorized and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to the practice for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

JM

Authorization to Release Information

I hereby authorize the physician/practice participating in my care to release either verbally or in writing, any medical information which may be needed to assist in my continued care plan or be needed to process claims for medical insurance benefits relative to my care. I understand that my treatment provider(s) will access my prior medical records to aid in treatment. I authorize the physician/practice to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from the physician/practice on behalf of myself and/or my dependents, and understanding that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is considered as valid as the original.

JM

Notice of Privacy Practices

I acknowledge that I have read and received copies of the Authorization for Treatment, Patient's Rights and Responsibilities and the Notice of Privacy Practice, and authorize release of medical information to third parties.

JM

Cancellation/No Show/Late Policy

We reserve the right to charge a Cancellation/No Show/Late fee (up to \$100 depending on scheduled exam) if you do not provide 1 business day notice to cancel, do not show or arrive more than 10 minutes late for you scheduled appointment.

JM

Miscellaneous Services

If we need to reach you regarding an appointment or test results, we will make every effort to reach you personally. If we cannot reach you personally, we will only leave a message asking you to return our call during normal business hours.

JM Please initial if we have permission to leave a message on an answering machine or with a family member.

JM Please initial if we are able to contact you for appointment reminders via email or text.

Our office will never discuss your medical information with a family member unless you have authorized us to do so. If you would like to provide permission to speak to a family member, please initial in space provided on the respective line and provide the name of the authorized person where applicable.

Spouse: David Wogan

Parent: Jahn or Gloria griggs Monica miceli Theresa Miceli Paul miceli

Children: _____

Siblings: _____

Other: _____

Jessica Miceli
Patient/Responsible Party Signature

1/3/17
Date

Witness

Date



AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Jessica Miceli 7/16/90 225-226-8489
(Patient's Full Legal Name) (DOB) (Day Phone #)
Address: P.O. Box 2773 City: Slidell State: LA Zip: 70458
150 Bebble Beach Dr.

I, Authorize: Hope Womens Clinic
(Name of Organization to Disclose Information)

To Disclose the Following Information: _____ Date(s) of Service: _____

- Entire record
- Abstract of record
- Immunization record
- ED record
- X-rays or imaging report
- Laboratory results
- Operative report
- Discharge summary
- Other: _____
- Other: _____
- Other: _____

Person/Facility to Receive Information: The Gianna Center of the Gulf South / 985-466-1919 / Fax to 985-467-4752
71380 Hwy 21, Suite 101, Covington, LA 70433

Disclosure Format (Paper is default if not marked):
 US Mail Electronic format: CD/DVD Radiology Film/CD Fax to: (985) 467-4752
 eDelivery by Healthport (for Virginia patient's only) – email address: _____

Purpose of Disclosure:
 Physician Insurance Legal Other: _____
 Disability Determination Personal Worker's Compensation _____

Authorization to Release Information:

1. I understand that I am giving my permission to disclose confidential health care records, unless indicated below, relating to, if applicable, sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Special Instructions: [Signature]

- 2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the organization above disclosing the information.
- 3. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the facility. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 6 months from the date of signature.
- 4. I understand that I will be given a copy of this authorization form, after signing. I understand that copying charges will be applied, according to the hospital policy.

Signature of Patient or Legal Representative [Signature] 3/19/17
Date

If signed by legal representative, relationship to patient: _____

Department Use Only

Processed by: _____ Identity verified Signature verified



Dear New Patient,

Welcome to the Gianna Center of the Gulf South! We are excited that you have chosen us to participate in your healthcare. Our practice is a pro-life, natural family planning only women's health center devoted to maintaining your health and helping you heal physically, emotionally, and spiritually while treating you with dignity. Our practice attends to women from adolescence through post-menopausal status. It is our goal to empower you in taking care of your health. We take pride in using hormones that match the exact structure of the hormones your body makes (some call these bioidentical hormones), if you are in need of supplementation. We also encourage the use of natural family planning methods such as Creighton Model FertilityCare™ System (CrMS) to track your gynecologic health.

Please complete ASAP the included documents prior to your first appointment. You can mail the documents to 71380 Hwy-21 Suite 101, Covington, Louisiana 70433, fax it to 985-467-4752, or scan them into an electronic format and email it to info@giannagulfsouth.org. Your appointment will be scheduled once documents are received and processed.

We dedicate two 1 hour appointments to our New Fertility patients, and these appointments are in high demand, so we want to be able to help you and others in an efficient manner. Please help us to be available to all of our patients by giving us as much advanced notice as possible if you need to cancel or reschedule.

We strongly encourage you to thoroughly read the Fertility Evaluation handout prior to your appointment, as this will help facilitate your understanding of the process and allow you to be able to ask questions during the appointment. One suggestion is to avoid using "infertility" in any of your paperwork and substitute **'fertility evaluation' or 'fertility discussion'** instead. Our practice never uses the diagnosis of infertility, so we encourage you to eliminate it from your vocabulary, too!

Once you become an established patient with the Gianna Center, you will have questions concerning your summary of care. Please be educated regarding the following communication procedures that will need to occur in order to obtain resolutions to your questions:

- The patient portal is for brief non-urgent messages and will be addressed within two business days.
- Longer dialogue or urgent issues are best addressed with a nurse phone call or a nurse visit.
- The office is open Monday through Thursday from 8:30 am to 5:00 pm, and we are closed on Fridays. If you have to reach Dr. Hemphill after hours she can be reached via the answering service at (985) 796-6170. The answering service phone number is also available by dialing (985) 466-1919 and press 7.
- Non-urgent concerns for which Dr Hemphill is paged are subject to a telephone fee.

Thank you for your cooperation and understanding, and welcome to our family!
~Staff and Providers of the Gianna Center of the Gulf South