



JessICA MICELI

New Patient Pre-Appointment Checklist

- ___ Request Medical Records (Pap Smear Results, Pathology Results, Labs/Hormones, Spouse's Seminal Fluid Results, Office Notes, Operative Reports, etc.) be sent to The Gianna Center of the Gulf South so that they arrive prior to your scheduled appointment. The new patient packet includes an authorization form to complete and fax to the facility(s) that have the records.
- ___ Complete enclosed *Patient Information, Authorization for Treatment, Permission to Disclose Private Health Information (PHI), Payment Authorization and Informed Consent for Women's Health Care and Cancellation Policy* forms. **Submit them along with a copy of your insurance card (front and back)** to the Gianna Center of the Gulf South **before** scheduling your appointment.
- ___ Complete enclosed *Personal History Form* and submit it to the Gianna Center of the Gulf South **before** scheduling your appointment.
- ___ Review enclosed GYN Evaluation Information or Fertility Evaluation Information handout prior to appointment.
- ___ Arrive 15 minutes prior to your appointment time to check in.
- ___ Bring your picture ID and insurance card with you to your appointment.
- ___ Bring your CrMS Chart, if you are already Creighton FertilityCare™ charting (or other NFP chart)



Informed Consent for Women's Health Care

The providers at The Gianna Center of the Gulf South are pro-life healthcare providers. They are FertilityCare™ Practitioners and Medical Consultants for the Creighton Model FertilityCare™ System. The Medical Consultants practice NaProTECHNOLOGY®, which is an approach to women's reproductive health that uses hormones and treatments that cooperate with the women's cycle and are not contraceptive. Our providers do not prescribe or refer for any contraceptive agents for any reason. Such contraceptive agents would include birth control pills, patches, rings, or injections, intrauterine devices, barrier devices, or sterilization. Additionally, our healthcare providers do not perform abortion procedures, including "medically indicated" abortions. Diagnosing and treatment of gynecologic problems are offered to all female patients, but there are fertility specific treatments which are only offered to married couples in order to aid conception through an act of natural intercourse. They do not participate or refer for assisted reproductive technologies, such as intrauterine inseminations or in-vitro fertilization (IVF). By signing this consent you are agreeing to receive medical care from our providers and understand that contraceptive, abortive and assisted reproductive technology services and referrals are not available from our healthcare providers.

Gianna Center Cancellation/No Show/Late Policy

(Updated May 20, 2015)

It is a priority of the Gianna Center of the Gulf South to provide an excellent patient experience every time. This includes starting your visit on time and reserving 30 minutes to 1 hour for your first visit with the doctor. In order to assure this level of care for you and all of our patients, we maintain strict cancellation and late policies.

Your appointment is scheduled from: _____ - _____ on _____.

Traffic can be heavy at times. Please allow extra time for travel and completion of paperwork.

- We require additional notice of 1 business day if you will not be able to keep your appointment.
- If you give less than advanced notice of 1 business day of cancellation, you may be charged for your visit equivalent.
- If you arrive more than 10 minutes late, and you are not able to be seen that day, you may be charged for your visit equivalent.
- Your credit card will not be charged if you arrive on time for your scheduled appointment.
- Your information will be kept confidential and will not be shared with outside parties.

At the time of your first visit, you will be asked to sign a waiver acknowledging your awareness of this policy.

By signing below, you acknowledge that you understand the above policies of the Gianna Center of the Gulf South and any questions you have asked have been answered to your satisfaction.

Patient Name: Jessica Miceli (Please print)

Signature: Jessica Miceli Date: 3/9/17



Payment Authorization Form

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

- 1. All professional services rendered are charged to the patient and are due at the time of services rendered unless other arrangements have been made in advance with our practice financial counselor. Necessary forms will be completed to help expedite insurance carrier payments. However, YOU ARE responsible for all fees regardless of insurance coverage. *All unpaid balances due may be charged to the credit card on file on the 30th day following insurance payment unless other arrangements are made. Patient must verify at each visit that the credit card information on file is current and active.
2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
3. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
4. I agree to provide the above practice and/or its designated payment agent with my debit/credit card or ACH information.
5. I understand that my signature and payment information will be maintained on file digitally for future use by the practice. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.
6. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.
7. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or ACH account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
8. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.
9. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.
10. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

Jessica Miceli
Name as it Appears on Card/ACH Account

micelijessica@yahoo.com
Email Address

35143 Weiss Rd Walker LA 70785
Billing Address City State Zip Code

225-226-8489
Phone Number

AUTHORIZED SIGNATURE [Signature]

DATE 3/19/17

Personal History Form

Name: Jessica Miceli Date of Birth: 7/16/90

Referring Provider: _____ Last Menstrual Period: _____

Reason for Visit (i.e. fertility evaluation, annual exam, obstetrical, GYN issue, etc): _____

Medical Problems (i.e. endometriosis, hypothyroid, etc)	Year of Diagnosis
PCOS possible endometriosis	2008

Have you ever breastfed? Yes No Current breastfeeding? Yes No

Gynecologic History

Age at start of menses (menarche) 11 Age at menopause _____

Menstrual flow (i.e. light, heavy) Heavy Abnormal bleeding Sometimes

Frequency of menses (i.e. 26-28 days) 1 a month ^{not always the same} Duration of menses (i.e. 4 days) 4-7 days

Family Planning/Contraception history none

Current Family Planning Intent (Conceive, Avoid Conception) Avoid

STD history: Gonorrhea Chlamydia HSV/Herpes Syphilis HIV/AIDS HPV HSV/Herpes Trichomonas Other _____

What menstrual products do you use? (pads, tampons, liners, etc.) Pads

How often do you change your products in a day? 2-3 times

Do you have pain with menses? Yes (Pain scale rated 9/10) No

Do you have dyspareunia or pain with intercourse? Yes No not all the time

Do you have bleeding after intercourse or between periods? Yes No

Personal History Form

Ancestral Background

Please check if your parents are from the following ancestral backgrounds: African Mediterranean Asian
 Indian Jewish Latin American Native American French Canadian

Social History

Marital Status Single # of Marriages _____ Current Marriage Date Jan. 6 2018
 Occupation Draftsman Education Level Associates Religion/Spiritual Belief Catholic

Mark with a "C" if you currently or a "P" if you have previously experienced the following:

P Emotional Abuse _____ Physical Abuse _____ Sexual Abuse _____

Substance use- please list the type, amount, frequency, start date & last use

1. Tobacco products never current prior
 type/frequency: _____
2. Illicit drugs never current prior
 type/frequency: _____
3. Alcohol products never current prior
 type/frequency: Not frequent now never
4. Caffeine products never current prior
 type/frequency: Not frequent very little caffeine intake

Sexual History

Are you sexually active? Yes No (if no, you may skip the remaining questions in this section)

of lifetime sexual partners: 4 Have your sexual partners been male female both

Obstetrical History

Total # of pregnancies 0 # of ectopic pregnancies 0
 # of term (37 weeks or later) deliveries 0 # of preterm (20-36 weeks) deliveries 0
 # of miscarriages (before 20 weeks) 0 # of pregnancy terminations 0

Pregnancy & miscarries # (list all in order)	# of weeks at delivery	Vaginal vs C-Section	Date of Delivery	Gender of baby	Weight of baby	Complications
1						
2						
3						
4						
5						
6						

Name: Jessica Miceli Date of Birth: 7/16/90
 Revised 5/2015 Page 3 of 7



Permission to Disclose Private Health Information (PHI)

Patient Name: Jessica Miceli DOB: 7/16/90

By signing this paper below, I give permission to the person(s) listed in the table documented to receive Private Health Information or other authorization as listed in the comments section. I understand this form is legally binding and that I may revoke my authorization at any time by submitting by request to change, add, or terminate such permission in writing.

Date of Permission	Name of Individual	Comments/Instructions (i.e.; may pick up meds)	Parent/Guardian Initials	Date Permission Revoked	Parent/Guardian Initials	Telephone Number
3/9/17	Gloria or John griggs	any info				225 686 212 225 328 8838
3/9/17	David Woson	any info				386 383 1906
3/9/17	monica miceli Teresa miceli Paul miceli	any info				225 226 8489 985-445 6445 504-284-8484

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Identifier/Password: HERSHEYS

Signature of Patient or Legal Guardian [Signature] Date 3/9/17 Time _____

Printed Name of Patient or Legal Guardian Jessica Miceli Relationship (if not self) _____



GYN Evaluation

Please save for future reference

Overview

This handout is intended to give you an overview of what you may expect during a gynecologic evaluation through this office. Our providers take a primarily fertility sparing approach to gynecology. Our goal is to find out what is wrong, and to correct it to the best of our abilities.

Old Records

If you have not already done so, please arrange to have a copy of any old records relating to your situation sent to our office. This requires a written release of information form sent to your doctor, giving him/her your permission to send your records, and there is one included in your new patient packet. Pertinent records include prior pap smear results, pathology findings from prior surgeries, prior operative reports, lab results (especially hormone panels), radiology reports (such as ultrasounds), and office visits.

Charting

You may or may not already be charting your gynecologic cycles using the Creighton Model FertilityCare™ System (CrMS). If not, then these classes will be recommended to you. To identify an instructor near you, go to www.fertilitycare.org or call our office for help.

CrMS is based on the charting of your cervical mucus sign only- it does not involve charting your temperatures. CrMS can be very helpful in the overall evaluation of gynecologic problems because of a new reproductive and gynecologic science called NaProTECHNOLOGY®. It is through this new technology that your provider can treat your cycle in a natural and cooperative way. Many of the tests done in your evaluation are more useful if done at specific times during your cycle, and these days may be properly timed based on your charting. Knowledge of the cervical mucus sign can be extremely helpful in understanding and treating gynecologic problems.

Hormone series

Depending on your symptoms, a hormonal evaluation may be ordered. This may include a series of tests to see the pattern of your estradiol and progesterone levels. If so, you will receive the appropriate laboratory requisition(s) to take to your local lab. These tests may be drawn locally. However, some orders may require that you go to particular labs to have the test done. If you cannot use these particular labs, then you may need to have your blood drawn and then have it sent to the National Hormone Lab in Omaha, NE to be run. Drawing all of the blood tests could take about one month and obtaining the results could take another month, depending on where the tests are sent. It is important that these tests are run at one of the above locations, as there is a lot of variation in hormone testing results from laboratory to laboratory. Basing recommendations for treatment on lab work done at other facilities is not advised, as the labs may not be calibrated to our graphs. The hormone series will identify if hormonal abnormalities are playing a part in your medical problems.



GYN Evaluation

Ultrasounds

An ultrasound may be recommended in order to evaluate your reproductive organs for abnormalities. Sometimes this can be accomplished using an abdominal transducer, but often, it may also involve the use of a vaginal probe.

Medications

Medications are often prescribed as part of the treatment regimen. It is important to take these on the days and times as ordered. If you need refills on your medications, please call your pharmacy and request a refill. If no refills are available, they will contact us for approval. Some of the medications prescribed are compounded, so identifying a compounding pharmacy near you may be necessary.

Follow-up Appointments

Follow-up appointments with your physician are recommended at least every 12 months. Recently, pap smear guidelines have adjusted the interval to at least 3 years apart when cervical cancer screening results are normal. However, it is still recommended to have an annual breast and pelvic examination as part of your routine health maintenance.

Insurance issues and Payment

We offer the service of attempting to obtain pre-authorization for surgery. This does not guarantee your insurance will cover your expenses. Other procedures are your responsibility to research, but we can be of some assistance if needed. If you are having difficulty with your insurance company providing benefits, please contact us, and we will try to assist you. It is your responsibility to pay any portion of the bill not covered by insurance.

Questions for your provider

Any questions regarding your medical treatment should be directed to a nurse. If you are not connected directly with the nurse, please leave a message. These are reviewed throughout the day and answered within 2 business days with prioritization given to medically urgent or time-sensitive issues. If the nurse is unable to answer your questions/concerns without your provider's input, she will convey these to your provider and return your call with the information that was provided. If you call early in the day, you will most likely get a call back the same day. If you call mid/late day, it may be the next day before you hear a response. At times, the nurse may be waiting to talk with your provider in order to have the information that is needed to respond to your inquiry.

It is strongly encouraged that you set up a secure online patient portal where you may send/receive messages, receive secure test results, request appointments, and request prescription refills, if needed. Do



GYN Evaluation

An *oophorectomy* is the removal of an ovary, while a *cystectomy* is the removal of a cyst (usually ovarian in nature). A *salpingectomy* is the removal of a fallopian tube. A *hysterectomy* is the removal of the uterus (with or without the cervix). These procedures can be done vaginally, laparoscopically- with or without robotic assistance, or via laparotomy (with a larger abdominal incision).

Post-Operative Visit

You will have a physical exam visit with your surgeon about 2-6 weeks after your surgery to ensure you are healing well. If you are from out of state, it may be possible to do your post-operative evaluation long-distance. Feel free to inquire if you are a candidate for this.



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MICELI, JESSICA
Plan ID 91285665

Sex: F
DOB: 07/16/90
Effective: 07/01/16

Plan code 355/855

Primary care provider (PCP):
CALDWELL, SUSAN P. MD
WOMANS NEW LIFE CENTER
3032 RIDGELAKE DR STE 100
METAIRIE LA 70002

PCP phone number:
504-496-0214

RxBIN: **600428**
RxPCN: **06030000**

PERFORM[®]



P O Box 83580 Baton Rouge, LA 70884
www.amerhealthcaritasla.com

Always carry your AmeriHealth Caritas Louisiana card. You'll need it to get your benefits. Go to your AmeriHealth Caritas Louisiana primary care practitioner (PCP) for medical care.

Emergency rooms. Go to an emergency room near you when you believe your medical condition may be an emergency. If you get emergency care, please notify your PCP.

Out-of-area care. Report out-of-area care to AmeriHealth Caritas Louisiana and your PCP within 48 hours.

Non-emergency medical transport (NEMT). For transportation services, call 1-888-913-0364.

Member Services and filing grievances or appeals
1-888-756-0004 or TTY 1-866-428-7588

Provider Services and prior authorization
1-888-922-0007

Report Medicaid fraud
1-800-488-2317

To speak with a nurse anytime
1-888-632-0009

24-hour Mental Health and Substance Use Crisis Line
1-844-211-0971

Pharmacy Member Services
1-866-452-1040 or TTY 1-855-294-7047

Pharmacy Provider Services
1-800-684-5501

AmeriHealth Caritas Louisiana Claims Processing
P.O. Box 7323, London, KY 40322