



**New Patient Intake Form**

Please complete this brief history to assist me in providing you with the best care possible.

This form will be added to your medical record.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zipcode: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ E-mail address: \_\_\_\_\_  
 Pharmacy name: \_\_\_\_\_  
 Address/phone#: \_\_\_\_\_

How did you hear about us?

- Friend: \_\_\_\_\_  Referral: \_\_\_\_\_  Google  
 insurance  social media

Reason for Visit: \_\_\_\_\_

**ALLERGIES**

Are you allergic to any medications?  No  Yes (Please specify the medication and reaction):

**MEDICAL HISTORY (either now or in the past/detail below with year of diagnosis and treatment given)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Inflammatory bowel disease        | Psychiatric diagnosis                     |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> Lupus                             | <input type="checkbox"/> Anxiety          |
| <input type="checkbox"/> Cardiac disease                  | <input type="checkbox"/> Osteoporosis/Osteopenia           | <input type="checkbox"/> Depression       |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Stroke                            | <input type="checkbox"/> Bipolar disorder |
| <input type="checkbox"/> Hypertension/high blood pressure | <input type="checkbox"/> Thrombotic disorder (blood clots) | <input type="checkbox"/> Other: _____     |
| <input type="checkbox"/> Hyperlipidemia/cholesterol       | <input type="checkbox"/> Thyroid disease (low/high)        | _____                                     |
| <input type="checkbox"/> Irritable bowel syndrome         | <input type="checkbox"/> Reflux (GERD)                     |   |

**CURRENT MEDICATIONS (include vitamins, herbs, and other supplements)**

NAME OF MEDICATION	DOSAGE	HOW OFTEN

**SURGICAL HISTORY**

NAME OF PROCEDURE	DATE OF PROCEDURE	REASON FOR PROCEDURE

**SOCIAL HISTORY**

Do you exercise? If so what do you do \_\_\_\_\_

Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How many packs a day? \_\_\_\_\_ If you quit, when was this? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How many drinks per week? \_\_\_\_\_ Any other drugs? \_\_\_\_\_

**PHYSICIAN:**

Medical/Primary Care Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Other Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

**Please check all that apply to you or if you are interested in any of the following:**

- Wrinkles/fine lines
- Acne/Rosacea
- Keloids/Excessive Scarring
- Hair removal
- Weight management
- Hormone therapy
- Hair regeneration
- Botox
- Body sculpting
- Help with Sleep
- Sun Sensitivity
- Easy Bruising
- Auto Immune
- Body aches
- Chemical peels
- Dermaplaning
- Detoxification
- Emsculpt Neo
- Energy boosting treatments
- Facial rejuvenation
- Filler Treatments
- Frequent Urination support
- Urination at night
- Joint pain
- Leaking when coughing
- Light therapy
- Medical Weight loss
- Brain Fog
- Micro-needling RF
- Nutrition guidance
- Postpartum Support
- Scar reduction
- Stretch mark management
- Stress management
- Sun Damage Repair
- Vaginal rejuvenation
- Vitamin Deficiency
- Breast concerns
- Gut Health support
- Hot Flashe
- Low Libido
- Sexual Vitality
- Vaginal dryness
- Vaginal Pain
- Labiaplasty
- Liposuction
- Face heaviness
- Skin laxity



**HIPAA Patient Consent**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the HHealth Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Horizons OB-GYN & Aesthetics (Dr. Manny Herrera, Katie Herrera, APRN) to use and disclose my protected health information to carry out:

- Treatment (Including direct and indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (i.e. my insurance company); the day to day healthcare operations of our practice.

I have also been informed of and given the right to review and secure a copy of our Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that the office reserves the right to change the terms of this notice from time to time and that patients may contact us at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that these requested restrictions. However, if Horizons OB-GYN & Aesthetics (Dr. Manny Herrera, Katie Herrera, APRN) does agree in writing, then he or she is bound to comply with this restriction.

I understand that I may revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

May we phone, email, or send a text to you to confirm appointments? YES \_\_\_ NO \_\_\_

May we leave a message on your answering machine at home or on your cell phone with lab results? YES \_\_\_ NO \_\_\_

Is there another individual you would like to release medical records, financial information and treatment plans to?

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone# \_\_\_\_\_ Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone # \_\_\_\_\_

If you want certain information excluded from being released please list below:

HIV/STD results \_\_\_\_\_ Other: \_\_\_\_\_

Signed this date: \_\_\_\_\_

Patient Name Printed: \_\_\_\_\_

Signature of Patient/Guardian: \_\_\_\_\_



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DR. MANNY HERRERA, OBGYN

KATIE HERRERA, APRN, CNM

**PELVIC EXAM CONSENT FORM**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

- **CONSENT:** I, the above listed Patient or as the legally authorized person for the Patient, hereby consent to receiving pelvic examinations being performed by my physician or other health care practitioner.
- **NATURE OF PELVIC EXAMINATIONS:** For the purposes of this Consent Form, a “pelvic examination” means the series of tasks that comprise an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, external pelvic tissue, or organs using any combination of modalities, which may include, but need not be limited to, the health care provider’s gloved hand or instrumentation.
- **VALIDITY OF CONSENT:** The Patient, or the Patient’s legal authorized person, acknowledges that this consent will remain valid from the date the Patient, or the Patient’s legally authorized person, dated this Consent Form below, unless otherwise revoked in writing by the Patient, or the Patient’s legal authorized person.

**I CONSENT TO RECEIVE PELVIC EXAMINATIONS AS DESCRIBED ABOVE, AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.**

\_\_\_\_\_  
Patient’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legally Authorized Person Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Legally Authorized Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Printed Name

\_\_\_\_\_  
Date



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## Annual Exam Responsibility Acknowledgement

**Annual well-woman exams** are a vital part of your health. Please be aware that the following services are covered per insurance guidelines:

- Pelvic Exam/pap smear
- Breast exam/mammogram order(s)
- Birth control/routine fills

Acute concerns and/or chronic conditions **ARE NOT** routinely covered during your annual exam. Examples include but are not limited to:

- Menopausal symptoms
- Bioidentical HRT
- Pelvic pain
- UTI symptoms
- Yeast/BV

These issues may be addressed during your annual, time permitting, however, due to the additional diagnosis codes, you may be subject to an additional copayment and/or deductible as outlined by your insurance policy. If you do not want to address any issues during your annual visit, we are happy to provide you with a prompt follow-up appointment.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_/\_\_\_/\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient's Signature Acknowledging the above

\_\_\_/\_\_\_/\_\_\_  
Today's Date



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### Patient Financial Responsibility Form/ Self-Pay Waiver

Thank you for choosing Horizons OBGYN for your medical needs, we are committed to providing you the highest quality healthcare. We ask that you read, make the appropriate selection, and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities: The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.

PLEASE CHECK ONE BELOW:

Check here if you agree to the self-pay rate for services rendered, at time of service.

Check here if you elect to use available medical insurance for visit coverage. Self-pay rates will not apply after date of service.

- We will bill your insurance for you; however, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles, and non-covered items are due after your insurance(s) have responded.
- Patients may incur, and are responsible for payment of additional charges, if applicable.

By my signature below, I hereby authorize assignment of financial benefits directly to Horizons OBGYN for services rendered. I understand that I am financially responsible for charges not covered by this assignment.

I also accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, attorney fees and/ or court costs, if such be necessary.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient/ Guardian Signature: \_\_\_\_\_

**MRS Checklist - BEFORE HRT**

Place an "X" for EACH symptom you are currently experiencing. Please mark only ONE box.

For symptoms that do not apply, please mark NONE.

	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1. <b>Hot flashes, sweating</b> (episodes of sweating)	<input type="checkbox"/>				
2. <b>Heart discomfort</b> (unusual awareness of heart beat, heart skipping, heart racing, tightness)	<input type="checkbox"/>				
3. <b>Sleep problems</b> (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	<input type="checkbox"/>				
4. <b>Depressive mood</b> (feeling down, sad, on the verge of tears, lack of drive, mood swings)	<input type="checkbox"/>				
5. <b>Irritability</b> (feeling nervous, inner tension, feeling aggressive)	<input type="checkbox"/>				
6. <b>Anxiety</b> (inner restlessness, feeling panicky)	<input type="checkbox"/>				
7. <b>Physical and mental exhaustion</b> (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	<input type="checkbox"/>				
8. <b>Sexual problems</b> (change in sexual desire, in sexual activity and satisfaction)	<input type="checkbox"/>				
9. <b>Bladder problems</b> (difficulty in urinating, increased need to urinate, bladder incontinence)	<input type="checkbox"/>				
10. <b>Dryness of vagina</b> (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	<input type="checkbox"/>				
11. <b>Joint and muscular discomfort</b> (pain in the joints, rheumatoid complaints)	<input type="checkbox"/>				

Please share any additional comments about your symptoms you would like to address.

Do you have cold hands and feet?  Yes  No

Do you have daily bowel movements?  Yes  No

Do you have gas, bloating or abdominal pain after eating?  Yes  No

Please select your WEEKLY Activity Level based on this criteria - Physical activity that accelerates heart rate Breathlessness

0-1 day per week (Low)  2-3 days per week (Average)  More than 3 days per week (High)

Please list any prior hormone therapy? \_\_\_\_\_

FOR OFFICE USE ONLY

CHART ID: \_\_\_\_\_ DOB: \_\_\_\_\_ APPT DATE: \_\_\_\_\_



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### Appointment Cancellation & Form Completion Fees

We feel our patient's time is valuable and our team effort. We ask that if you must change an appointment, **please give us at least 24 hours' notice**. This courtesy makes it possible to give your reserved time to another patient who is in need of receiving care in a timely manner.

Failure to give insufficient notice to keep scheduled appointment or not to show for scheduled appointment will result in a **non-refundable \$50 fee being charged**. This charge is in accordance with our office appointment and cancellation policy for all of our patients and it is to be paid before any new appointments can be scheduled. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

Please also note that a **\$25 fee applies for the completion of any medical paperwork**, including, but not limited to forms for work, school forms, insurance, or other administrative needs. This fee helps cover the time and care our team dedicates to completing your documents accurately and promptly. We appreciate your understanding and cooperation.

The patient, parent or legal guardian is responsible for the payment of this fee.

Printed Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**Consent to Treat Form**

1. I \_\_\_\_\_ (patient name) give permission for Horizons OBGYN to give me medical treatment
2. I allow Horizons OBGYN to file for insurance benefits to pay for the care I receive.

I understand that

- Horizons OBGYN will have to send my medical record information to my insurance company
- I must pay my share of the costs
- I must pay for the cost of these services if my insurance does not pay, or I do not have insurance

I understand

- I have the right to refuse any procedure or treatment
- I have the right to discuss all medical treatments with my clinician

\_\_\_\_\_  
Patients Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature (under 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name