Healthcare Exclusively for Women
Alexander Capelli M.D.

Phone-816-525-0061
Fax-816-875-1167

Thank you for making an appointment with our office. We greatly appreciate it. Please fill out all paper work completely and bring with you to your appointment. Also bring most current insurance card, driver's license or state ID and list of current medications you are taking and dosage.

Again thank you.

Your appointment is scheduled for:

Date: _____ Time: _____ New patient please arrive 15 min early

Appointment is at our:

Lee's Summit Office _____
1000 SW Blue Parkway
Lees Summit, MO 64063 (Across St. from Quicktrip at 3rd St. and Blue Pkwy)

If you are unable to keep you appointment please give the office a call, there will be a $50.00 Charge for no show/no call within 24 hours.

PATIENT INFORMATION SHEET

Patient Last Name, First MI

Home Phone/Cell Phone

Address

Work Phone

City/State/Zip code

Date of Birth:

Marital Status (M S W D) (Circle one)

E-Mail

Social Security#

Insurance of the Insured

Employer Name

Relation (Spouse, Parent) Work #

Employment Status (Active or Cobra)

If retired, is insurance thru retirement plan?

Insured Name (Spouse or Parent) DOB

Social Security#

Address (If different from above)

Emergency Contact Person Relationship Home # Work#

INSURANCE DATA:
(Copy of Card)

Primary Insurance Plan:

Secondary Insurance Plan:

Last Name, First MI

Social Security # DOB

Employer Phone#

X

Referring Dr. Name

X **PLEASE SIGN** RELEASE TO FILE CLAIM ON BACK:

SIGNATURE FOR AUTHORIZATION TO FILE INSURANCE AND PAYMENT AGREEMENT

HCFA 1500, Item 12

Patient's or Authorized person's Signature

I authorized the release of any medical or other information necessary to process this claim. I also request payment of Government benefits to the party who accepts assignment below.

HCFA 1500, Item 12

Insured's or Authorized Person's Signature

I authorized payment of medical benefits to the undersigned physicians or supplier for services described below.

Back of HCFA Form 1500 is available for any patient's review. Please request upon signing if you would like a copy.

I agree to pay deductibles and percentage Co-Pays after the insurance has paid. Services which are not covered or considered pre-existing by your insurance plan will be billed directly to the patient.

OFFICE Co-Pays are due at time of visit.

SignX_____Date_____

Signature valid for insurance filing 12 and 13, and acceptance of balance billing of non covered Services.

Billing and Charges for Medical Care

We are contracted to provide service for many insurance networks. The billing of medical care is quite complex. There are service, lab and medication codes which reflect the service that is provided to you.

I would be in your best interest to understand what insurance benefits are paid for by the insurance carrier you have. Most insurance have summary sheets or actual certificates of insurance that explains the benefits which are covered by the premiums you or the employer pays for. It is extremely important that we have the correct insurance information at each and every visit. Failure to notify us of any changes within 30 days of your visit may result in a denial of your insurance claim, at which time all charges would become your responsibility.

We collect office visit copays on the day of service.
Deductibles can be paid as you are seen if known.
Percent Coinsurance (10% to 50%) is determined after insurance has paid.

We preauthorize surgical services, obstetric care, and some medication as necessary.
We try to verify benefits prior to procedure, but the insurance companies do not guarantee payment.

You will receive statements after the insurance has been processed and usually paid.
Statement balances are usually 30 days or more after service has been provided.

We do expect full payment on the first statement after insurance is processed. If three statements are sent and no payment has been made, it will be sent to collection with a $10.00 charge processing fee.

Payment plan will be accepted for 3 months if you notify the office for approval.

We accept check and credit cards (VISA, AMERICAN EXPRESS, DISCOVER and MASTERCARD)
Cash will need to be brought to the office.

COMPLETING FMLA FORMS AND DISABILITY FORMS ARE NOT PART OF THE MEDICAL SERVICE AND INSURANCE CLAIMS PROCESS. THERE IS A $30 CHARGE FOR COMPLETION OF THESE FORMS WHICH WILL TAKE 2 WEEKS TO FILL OUT. IF NEEDED SOONER THAN THAT IT WILL BE $50.00 CHARGE.

NO SHOW TO APPOINTMENTS WILL BE A $50.00 CHARGE IF YOU DON'T CALL AND NOTIFY THE OFFICE WITHIN 24 HOURS IN ADVANCE.

I understand and accept the above payment terms.

_____ _____

Signature Date

HealthCare Exclusively for Women

1000 SW Blue Parkway

Lee's Summit, MO 64063

Phone (816)525-0061

Fax (816)875-1167

Notice of Privacy Practice's Acknowledgement

I, _____, acknowledge that I have received a copy of Healthcare Exclusively for Women Notice of Privacy Practices.

_____
Patient

_____
Parent/Personal Representative

_____
Relationship to Patient

_____
Date

Unable to obtain written acknowledgement due to:

_____
_____
_____

Copy of our Notice of Privacy Practices was give __ sent __ to:

_____

_____ _____
Employee Date

DATE:

PATIENT DATA BASE

CHART: Date of Birth:_____

Name:_____ Age:_____

Reason for visit:_____

_____

Current Medication:_____Dose:_____

_____Dose:_____

Allergies:_____

List Medical Problems:_____

List Prior Surgeries:_____

_____

PAST OBSTETRICAL HISTORY: Age at time of first period____Date of first day of last period:_____

Duration:_____ How often do you have a period?_____ Irregular? Yes_____No_____

Current method of birth control: Pill____ Condom_____ Sponge _____ Diaphragm _____

Tubial Ligation_____ Vasectomy_____Other_____ None_____

Pregnancies:

Date of Delivery	Sex	Weight	Vaginal or C-Section	Early, Late, or on Time	Problems

Family History: Diabetes_____ Cancer_____

Social History: Tobacco?_____yes/no Alcohol?_____yes/no Drugs?_____yes/no

Last Pap:_____ Last Mammogram:_____ Colonoscopy:_____

PCP:_____ Weight:_____ BP:_____ _Ht:_____ Pulse:_____

Pharmacy:_____ **Religion:**_____ Contact Lens/Glasses/Lasix/None

Preferred Method of Contact: No Preference/Printed Letter/Phone Call

DATE _____

NAME _____
LAST FIRST MIDDLE

ID# _____ HOSPITALOFDELIVERY _____

NEWBORN'SPHYSICIAN _____ REFERREDBY _____

FINALEDD _____ PRIMARYPROVIDER/GROUP _____

BIRTHDATE	AGE	RACE	MARITALSTATUS S M W D SEP	ADDRESS
OCCUPATION			EDUCATION (LASTGRADECOMPLETED)	ZIP PHONE (H) (O)
☐ HOMEMAKER				INSURANCECARRIER/MEDICAID#
☐ OUTSIDEWORK				
☐ STUDENT TypeofWork				
HUSBAND/FATHEROFBABY			PHONE	EMERGENCYCONTACT PHONE

TOTALPREG	FULLTERM	PREMATURE	AB.INDUCED	AB.SPONTANEOUS	MULTIPLEBIRTHS	ECTOPICS	LIVING

MENSTRUALHISTORY

LMP ☐ DEFINITE ☐ APPROXIMATE(MONTHKNOWN) MENESMONTHLY ☐ YES ☐ NO FREQUENCY:Q_____DAYS MENARCHE _____(AGEONSET)
☐ UNKNOWN ☐ NORMALAMOUNT/DURATION PRIORMENES_____DATE ONBCPATCONCEPT. ☐ YES ☐ NO hCG+ ____/____/____
☐ FINAL _____

PASTPREGNANCIES(LASTSIX) Planned or Unplanned

DATE MONTH/ YEAR	GA WEEKS	LENTGH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES	PLACEOF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/COMPLICATIONS

PASTMEDICALHISTORY

	ONeg +Pos	DETAILPOSITIVEREMARKS INCLUDEDATE&TREATMENT				ONeg +Pos	DETAILPOSITIVEREMARKS INCLUDEDATE&TREATMENT
1.DIABETES					16.D(Rh)SENSITIZED		
2.HYPERTENSION					17.PULMONARY(TB,ASTHMA)		
3.HEARTDISEASE					18.ALLERGIES(DRUGS)		
4.AUTOIMMUNEDISORDER					19.BREAST		
5.KIDNEYDISEASE/UTI					20.GYNSURGERY		
6.NEUROLOGIC/EPILEPSY							
7.PSYCHIATRIC							
8.HEPATITIS/LIVERDISEASE					21.OPERATION/HOSPITALIZATIONS (YEAR&REASON)		
9.VARICOSITIES/PHLEBITIS							
10.THYROIDDYSFUNCTION							
11.TRAUMA/DOMESTICVIOLENCE					22.ANESTHETICCOMPLICATIONS		
12.HISTORYOFBLOODTRANSFUS					23.HISTORYOFABNORMALPAP		
	AMT/DAY PREPREG	AMT/DAY PREPREG	#YEARS USE		24.UTERINEANOMALY/DES		
13.TOBACCO					25.INFERTILITY		
14.ALCOHOL					26.RELEVANTFAMILYHISTORY		
15.STREETDRUGS					27.OTHER		

COMMENTS: Religion: Blood Transfusion: Medications:

Last Pap: Pain: Nausea: PCP:

ACOG ANTEPARTUM RECORD (FORM A)

SYMPTOMSSINCELMP

Patient Name:
DOB:

	YES	NO		YES	NO
1.PATIENT'SAGE(35OROLDER)			12.MENTALRETARDATION/AUTISM		
2.THALASSEMIA(ITALIAN,GREEK,MEDITERRANEAN,ORASIAN BACKGROUND)MCV<80			IFYES,WASPERSONTREATEDFORFRAGILEX?		
3.NEURALTUBEDEFECT (MENINGOMYELOCELE,SPINABIFIDA,ORANENCEPHALY)			13.OTHERINHERITEDGENETICORCHROMOSOMALDISORDER		
4.CONGENITALHEARTDEFECT			14.MATERNALMETABOLICDISORDER(EG.INSULINDEPENDENT DIABETES,PKU)		
5.DOWNSYNDROME			15.PATIENTORBABY'SFATHERHADACHILDWITHBIRTHDEFECTS NOTLISTEDABOVE		
6.TAY-SACHS(EG.JEWISH,CAJUN,FRENCH-CANADIAN			16.RECURRENTPREGNANCYLOSS,ORASTILLBIRTH		
7.SICKLECELLDISEASEORTRAIT(AFRICAN)			17.MEDICATIONS/STREETDRUGS/ALCOHOLSINCELASTMENSTRUAL PERIOD		
8.HEMOPHILIA			IFYES,AGENT(S)		
9.MUSCULARDYSTROPHY			18.ANYOTHER		
10.CYSTICFIBROSIS					
11.HUNTINGTONCHOREA					

COMMENTS/COUNSELING No Genetic Disorders on Either Side of Family — Yes — No

INFECTIONHISTORY	YES	NO		YES	NO
1.HIGHRISKHEPATITISB/IMMUNIZED?			4.RASHORVIRALILLNESSSINCELASTMENSTRUALPERIOD		
2.LIVEWITHSOMEONEWITHTBOREXPOSEDTOTB			5.HISTORYOFSTD.GC.CHLAMYDIAHPV.SYPHILIS		
3.PATIENTORPARTNERHASHISTORYOFGENITALHERPES			6.OTHER(SEECOMMENTS		

COMMENTS Do you have cats in the house? No Yes If yes do they go outside? No Yes

INTERVIEWER'SSIGNATURE _____

INITIALPHYSICALEXAMINATION Pulse ____

DATE ____ / ____ / ____ PREPREGNANCYWEIGHT _____ HEIGHT _____ BP _____

1.HEENT	☐ NORMAL	☐ ABNORMAL	12.VULVA	☐ NORMAL	☐ ABNORMAL
2.FUNDI	☐ NORMAL	☐ ABNORMAL	13.VAGINA	☐ NORMAL	☐ ABNORMAL
3.TEETH	☐ NORMAL	☐ ABNORMAL	14.CERVIX	☐ NORMAL	☐ ABNORMAL
4.THYROID	☐ NORMAL	☐ ABNORMAL	15.UTERUSSIZE	☐ NORMAL	☐ ABNORMAL
5.BREASTS	☐ NORMAL	☐ ABNORMAL	16.ADNEXA	☐ NORMAL	☐ ABNORMAL
6.LUNGS	☐ NORMAL	☐ ABNORMAL	17.RECTUM	☐ NORMAL	☐ ABNORMAL
7.HEART	☐ NORMAL	☐ ABNORMAL	18.DIAGONALCONJUGATE	☐ NORMAL	☐ ABNORMAL
8.ABDOMEN	☐ NORMAL	☐ ABNORMAL	19.SPINES	☐ NORMAL	☐ ABNORMAL
9.EXTREMITIES	☐ NORMAL	☐ ABNORMAL	20.SACRUM	☐ NORMAL	☐ ABNORMAL
10.SKIN	☐ NORMAL	☐ ABNORMAL	21.SUBPUBICARCH	☐ NORMAL	☐ ABNORMAL
11.LYMPHNODE	☐ NORMAL	☐ ABNORMAL	22.GYNECODPELVICTYPE	☐ NORMAL	☐ ABNORMAL

COMMENTS (Numberandexplainabnormals) _____

EXAMBY _____

ULTRASOUNDS FOR PREGNANCY

ULTRASOUNDS ARE BILLED SEPARATLY FROM THE GLOBAL MATERNITY FEE THAT WE CHARGE AT THE END OF YOUR PREGNANCY. IF YOU HAVE A DEDUCTIBLE, THE FIRST OFFICE VISIT AND ULTRASOUND WILL BE APPLIED TO THAT DEDUCTIBLE AND YOU WILL BE RESPONSIBLE FOR THE ADJUSTED AMOUNT. YOUR NEXT ULTRASOUND MAY ALSO BE APPLIED TO THE DEDUCTIBLE IF YOU HAVE A DEDUCTIBLE OVER $250.00. A STATEMENT WILL BE SENT AFTER YOUR INSURANCE COMPANY PAYS AND THE AMOUNT YOU OWE WILL NEED TO BE PAID BEFORE YOUR NEXT ULTRASOUND VISIT.

PLEASE MAKE SURE YOU UNDERSTAND YOUR MATERNITY BENEFITS BY CALLING YOUR INSURANCE COMPANY.

SOME INSURANCE COMPANYS CHARGE A COPAY PER DAY FOR INPATIENT HOSPITAL STAYS. THESE COPAYS CAN BE AS MUCH AS $200.00 PER DAY THAT YOU WOULD PAY TO THE HOSPITAL.

BY CALLING YOUR INSURANCE COMPANY AND GETTING A BETTER UNDERSTANDING OF YOUR MATERNITY BENEFITS, YOU WILL BE PREPARED WHEN YOU RECEIVE STATEMENTS IN THE MAIL.

OUR GOAL IS TO MAKE YOUR PREGNANCY AS STRESS FREE AS POSSIBLE, FINANCIAL CONCERNS CAN OVERLY STRESS A PREGNANT WOMEN AND CAUSE HEALTH ISSUES.

FMLA OR SHORT TERM DISABILTIY

FOR VAGINAL DELIVERY WE ARE ONLY ALLOWED TO PUT 6 WEEKS AND FOR C-SECTIONS IT IS 8 WEEKS ON THE FMLA PAPERS OR SHORT TERM DISABILITY. IF YOUR JOB GIVES YOU MORE WEEKS THAT WE ALLOW THAN THAT IS SOMETHING YOU HAVE TO TALK TO YOUR JOB ABOUT. THIS IS THE MANDATORY WEEKS BY LAW THAT WE ARE ALLOWED TO GIVE YOU AND NOTHING MORE. SORRY FOR ANY INCONVENIENCE ABOUT THIS MATTER.

I HAVE READ THE ABOVE STATEMENT AND HAVE RECEIVED A COPY OF THIS FORM:

SIGNATURE DATE

CONSENT FOR THE HIV BLOOD TEST

I have been informed that my blood will be tested in order to detect whether or not it contains antibodies to the human immunodeficiency virus (HIV) which is the causative agent in the acquired immune deficiency syndrome (AIDS). I understand that the test is performed by drawing blood and processing the resulting specimen utilizing ELISA and Western Blot laboratory tests. The combination of these two tests reduces the possibility of the false positive (indicates presence of HIV when it is not present) to a very small fraction per ten thousand (10,000) tests processed.

I have been informed that the ELISA test also fails to detect anti-HIV in rare instances and for a period of time immediately after infection with the virus.

I have been informed that if I have questions regarding the nature of the blood test, its expected benefits, its risks, and alternative tests, I may ask those questions before I decide to consent to the blood test.

I understand that positive test results must be reported to the Missouri Department of Health and the confirmed HIV antibody test results will be made available beyond that only in summary or statistical form so that individual cannot be identified.

By my signature below, I acknowledge that I have been given all the information I have requested concerning the blood test and the release of results. Therefore I acknowledge that I have given consent for the performance of a blood test to detect antibodies to HIV.

DATE:_____,20_____

XX_____
Signature of Patient or Guardian

_____
Printed Name

_____
Witness

_____
Signature of Physician

Brittany Esmeralda Maria
Printed Name

_____
Printed Name
Alexander Capelli, M. D.

CONSENT FOR THE HIV BLOOD TEST

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR HEALTHY FAMILIES AND YOUTH

ACKNOWLEDGEMENT OF COUNSELING

My health care provider has discussed with me the effects of the following on my health and the health of my unborn child:

- ☐ ALCOHOL (BEER, WINE, WINE COOLERS, LIQUOR)
- ☐ TOBACCO (INCLUDING SECOND HAND SMOKE)
- ☐ PRESCRIPTION DRUGS (WITHOUT DOCTOR ADVICE)
- ☐ OVER THE COUNTER MEDICATION (WITHOUT DOCTOR OR PHARMACIST ADVICE)
- ☐ STREET DRUGS SUCH AS: CRACK/COCAINE, MARIJUANA, BARBITURATES, AMPHETAMINES, ETC.

My health care provider has given me literature on:

☐ ALCOHOL ☐ TOBACCO ☐ DRUGS

I understand this information and have been given the opportunity to ask questions concerning substance use in pregnancy.

I have been given these toll-free numbers for more information:

- MISSOURI DEPARTMENT OF MENTAL HEALTH, Division of Alcohol and Drug Abuse – Referral to a treatment center, pregnant women given priority for treatment. 800-575-7480.
- TEL-LINK – Missouri's information and referral telephone line for maternal, child, and family health services. 800-TEL-LINK or 800-835-5465.
- OTIS (Organization of Teratology Information Specialists) – A toll-free line that provides information about the effects of exposure during pregnancy to substances or maternal diseases that may influence the development of an unborn baby. 866-626-OTIS or 866-626-6847.
- MISSOURI TOBACCO QUITLINE – A free smoking cessation coaching quitline and self-help materials. 800-QUIT-NOW or 800-784-8669.
- NATIONAL DOMESTIC VIOLENCE HOTLINE – A 24-hour referral hotline for women in domestic violence environments. 800-799-SAFE or 800-799-7233. TTY: 800-787-3224.
- NATIONAL SEXUAL ASSAULT HOTLINE – A 24-hour referral hotline for victims, including friends and family members of the victim, who have experienced some form of sexual assault or rape. 800-656-HOPE or 800-656-4673.

CLIENT SIGNATURE	DATE
PROVIDER SIGNATURE	DATE

Billing and Charges for Medical Care

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_____ _____

Signature Date