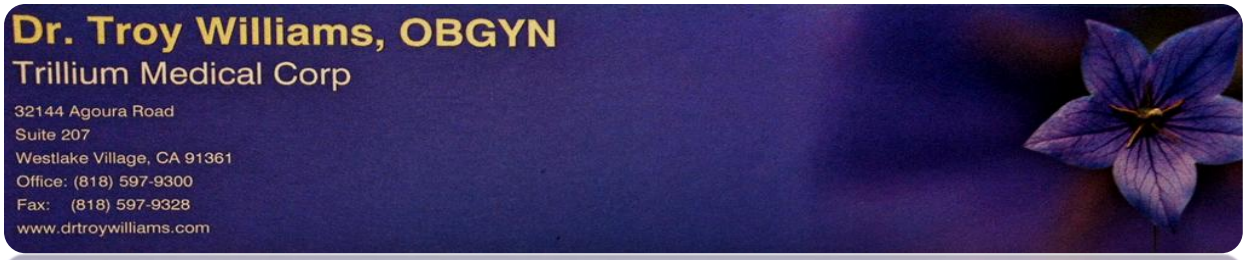


Patient:_____
First Middle Last

Home Phone:_____ Cell: _____

Email Address:_____

Address: _____

City:_____ State: _____ Zip:_____

Birth Date:_____ Social Security #:_____

Occupation:_____ Work #:_____

Spouse Name:_____ Spouse SSN:_____

Spouse Date of Birth:_____ Single:_____ Married:_____

Who to contact in case of
emergency:_____ Phone #:_____

Do you have medical insurance?: YES or NO

Who is responsible for this account?:_____ Relationship:_____

Name of Insurance Provider:_____ Policy #:_____

Name of Policy Holder:_____ Group #:_____

Medi-cal # or Presumptive Eligibility #:_____

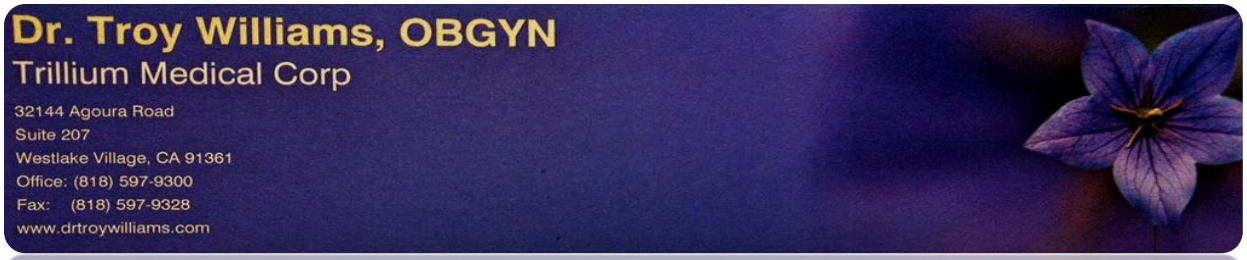
How were you referred to our practice? Please circle: Internet website, YHC Magazine,

Friend/ Relative, if so name:_____

Physician:_____ Other:_____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company as per the financial policy agreement.

Signature:_____ Print:_____ Date: _____



Patient Name and Date of Birth: _____

History and Physical Exam

Purpose of Today's visit: _____

Last Menstrual Period: _____ Length of Cycle: _____

Current Problems (head to toe): _____

_____

_____

Past Medical Diseases, please circle:

Asthma, Allergies, Cholesterol, Cancer, Diabetes, Heart Disease, High Blood Pressure, Thyroid Disease, Back Pain, Leakage of Urine, Weight Gain, Frequent Urinary Tract Infections, Varicose Veins

Past Pregnancies: _____ Deliveries: _____ Type: _____ Epidural: _____

Complications: _____

GYN History, please circle:

Heavy Bleeding, Painful Periods, Breast Mass, Mood Swings, Pelvic Pain, STDs, Fibroids, Ovarian Cysts, Endometriosis, Prolapsed Uterus/ Vagina, Loose Vaginal Wall/ Skin, Hormone Replacement, Painful Intercourse

Last Pap Smear: _____ Abnormal Pap Smear: _____

Past Surgeries: _____

Medications: _____

Allergies to Medications: _____

Cigarettes/ Day: _____ Alcoholic Drinks/ Day: _____ Drug Use: _____

Family History: Mother: _____ Father: _____

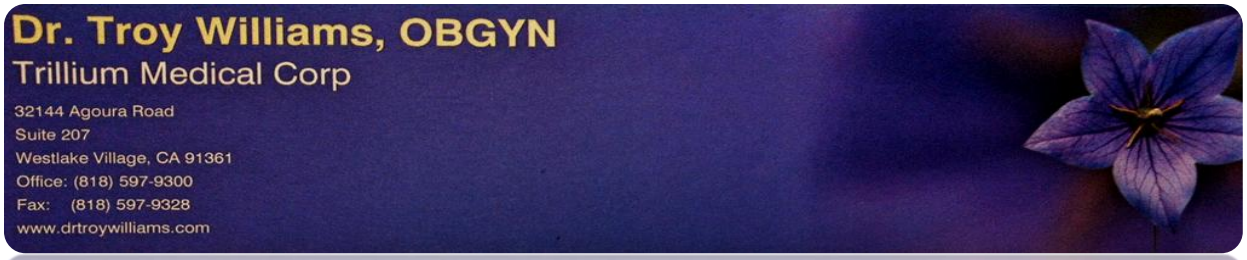
Brothers/ Sisters: _____ Grandparents: _____

BP: _____ RR: _____ P: _____ WT: _____ HT: _____ BMI: _____

Exam: _____

_____

_____



Authorization for Medical Treatment

I, _____ (Patient Name), hereby authorize Dr. Troy Williams, associates and assistants as designated by Dr. Troy Williams, to perform evaluation and treatment of my medical condition. I further require and authorize Dr. Troy Williams, associates and assistants to perform additional procedures as they may deem necessary on an emergent basis.

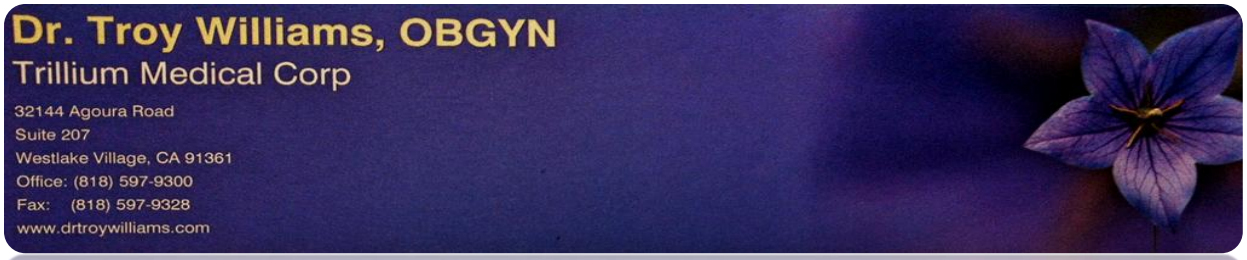
I understand that elective minor surgical procedures may be consented verbally or by contract.

Dr. Troy Williams can release to my insurance company any medical information necessary to process my insurance claim. I hereby assign benefits from my insurance company to be payable directly to Dr. Troy Williams/ Trillium Corporation.

I recognize that the practice of medicine is not an exact science, and Dr. Troy Williams does not guarantee the results of treatment.

Signed:_____ Date:_____

Printed Name:_____ Telephone #:_____



Financial Policy

Thank you for choosing our office. The following is our financial policy:

All patients will provide accurate and complete personal and insurance information.

All applicable co-pays, coinsurance, deductibles, and personal balances (current and prior) are due at the time of service.

Payment can be made by cash, check, Visa, Mastercard, or American Express.

Insurance: Dr. Troy Williams/ Trillium Corporation participates in plans administered by Blue Cross, Blue Shield, Aetna, Cigna, Health Net, and PacifiCare PPO Plans.

Financial Difficulties: It is your responsibility to disclose any concerns that you might have regarding payment of your bill prior to seeing the doctor. We will make every effort to assist patients who bring this to our attention BEFORE services are provided.

Missed Appointments: All appointments not cancelled at least 24 hours in advance, will result in a $25.00 charge for the first incident and $50 charge thereafter. Patients with a pattern of cancelling or missing appointments will be seen on a walk-in basis only.

Medical Records: Electronic Medical Record transmission to other treating providers will provided free of charge. Paper copies can be supplied within 48 hours of request at a fee of $40 per chart copy.

Forms: Completion of forms not directly related to patient care is not routinely covered by clinical visit fees or insurance. Because these take a significant amount of physician time, we find it necessary to charge a fee. Examples include but are not limited to Jury Duty Excuse, Family Leave Act Application, certain disability forms, accident reports, and certain DMV forms.

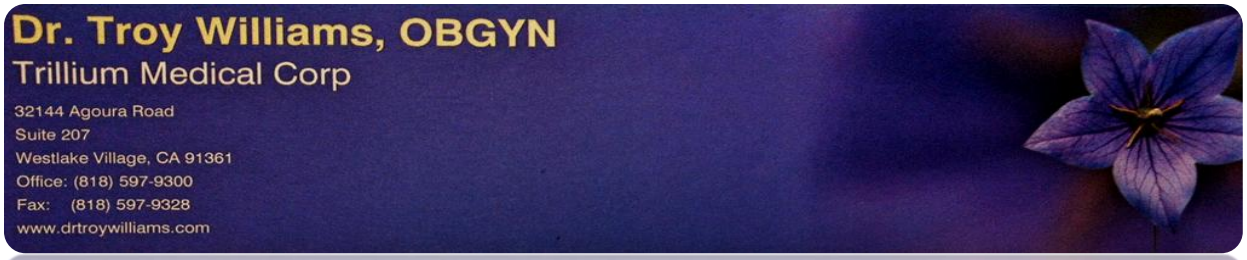
Past Due Accounts: Within 30 days of treatment, any additional payment not made at the time of service is expected in full. All accounts will be assessed interest charges at the rate of $30/ month on all unpaid balances greater than 30 days following the DATE OF SERVICE and the remaining balance may be sent to collections. We submit claims to your insurance company as a courtesy to all of our patients. If your insurance carrier requires additional information from you in order to process your claim and you do not provide it, you will be responsible for full payment of all services immediately.

Assignment of Benefits: I hereby authorize my insurance benefits to be paid directly to Dr. Troy Williams/ Trillium Corporation. I hereby instruct and direct my insurance company to pay by check made payable to Dr. Troy Williams/ Trillium Corporation. I understand that I am fully responsible for payments which my insurance company/ managed care company will not cover if they say that an office visit, procedure, or pathology, etc.., is “not medically necessary”, “pre-existing”, etc….or related to deductibles, co-pays, co-insurances, or for any other reason they may give for non-payment. I also understand that what my carrier considers “not medically necessary” may, on the contrary, be considered medically necessary by this office. Therefore, I agree to hold Dr. Troy Williams/ Trillium Corporation harmless for any medical decision made by my insurance/ managed care carrier which may in any way compromise my best care and result in medical damage, loss or death.

I authorize Dr. Troy Williams/ Trillium Corporation to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

I have read, understand and agree to the above financial policy.

Date:_____ **Signature:**_____ **Print:**_____



HIPPA Notice of Privacy Practices

Acknowledgement Letter

I hereby acknowledge that I have had access to a copy of this medical practice's Notice of Privacy Practices.

I further acknowledge that I have had the right to review this medical practice's Notice of Privacy Practices prior to signing this acknowledgement letter.

Additionally, I acknowledge that a copy of the current Notice of Privacy Practices will be available at the front desk upon request.

Print Patient Name:_____

Signature:_____ Date:_____