JOANNE HERRMAN, M.D., P.C.

Diplomate, American Board of Obstetrics and Gynecology

8324 Professional Hill Drive
Fairfax, Va. 22031

703 573-5600
703 573-5665 Fax

Dear Patient:

Thank you for taking time to read this letter and to complete the enclosed forms and questionnaire. I understand that the questionnaire deals with some very personal and sensitive topics, however, it is important that you answer all the questions honestly and thoroughly. Any information you give will be held in the strictest confidence. Along with your general medical health and specific gynecological condition, the questionnaire will enable me to better understand you as a whole person.

We do not participate with every insurance company. You should contact your insurance company to be absolutely sure of your coverage and payment responsibility. Your insurance co-payment is due at the time of service, before you are seen. **If we do not participate with your insurance company, you are responsible for all office charges at the time of your visit.** As a courtesy, we will file your insurance. **We do not participate with Medicaid. If you have Medicaid insurance, you are responsible for payment in full at the time of your visit. Since we do not participate with Medicaid, you cannot file for Medicaid benefits.**

We ask that you arrive 10 minutes before your appointment, as we make every effort to stay on schedule. **Please make sure all paperwork is complete before your appointment.** If it is not, your appointment may be rescheduled to another day. Please bring with you the completed paperwork, your insurance card, a photo I.D., and any records we may need. **Please do not mail them to us**.

****Due to Asthma and Allergy problems, please do not wear perfume or fragrances on the day of your appointment or we may be unable to treat you**.

We thank you in advance for making baby-sitting arrangements for your children.

We look forward to meeting you and making your visit a pleasant one.

Sincerely,

Dr. Herrman and Staff

* THERE IS AN AUTOMATIC **$50 FEE** BILLED TO THE PATIENT FOR ANY APPOINTMENTS CANCELLED WITHOUT **24 BUSINESS HOURS NOTICE.** *

* YOU **MUST** BRING YOUR INSURANCE CARD WITH YOU UNLESS YOU PLAN TO PAY IN FULL BY CASH, CHECK OR CREDIT CARD. *

The Healthcare Industry is experiencing a dramatic increase in the cost of malpractice insurance in the state of Virginia. At the same time, reimbursement from insurance companies continues to decline. We now find it necessary to institute several changes in our office policies. We appreciate your cooperation and understanding while we endeavor to provide you with the best possible medical care.

Arrival Time: Please arrive **10 minutes before your appointment time in order to complete the paperwork necessary for your visit.** This will help us keep to the scheduled appointment times. Updating paperwork is required for every visit to the office.

Prescription Fee: $10. If for any reason your prescription for medication, mammograms, sonograms, bone density scans, etc., needs to be re-written there will be a **$10 charge** for a replacement to be called or faxed to a pharmacy, radiologist, or mailed to you. As an alternative, you may make an appointment to see Dr. Herrman at which time she will rewrite your prescription. **If you use a mail-in prescription plan, let Dr. Herrman know this at the time of your visit**. Please be sure to send the prescription to the insurance company as soon as possible. It can take up to 4 weeks to receive your prescription. If you are more than one month past your annual exam date, you can receive a one-month refill only of **any** prescription. **Please allow 48 hours for all refills**.

Late Policy: If you are more than 15 minutes late for your appointment, we will make every effort to fit you into the schedule. Otherwise, we will have to reschedule your appointment and a missed appointment fee may be incurred.

Missed Appointment: $25. Missed appointments are appointments cancelled with less than 24 hours notice. Abusive missed appointments may result in your dismissal as a patient. Missed procedure appointments will incur a **$50 (Fifty dollar)** charge.

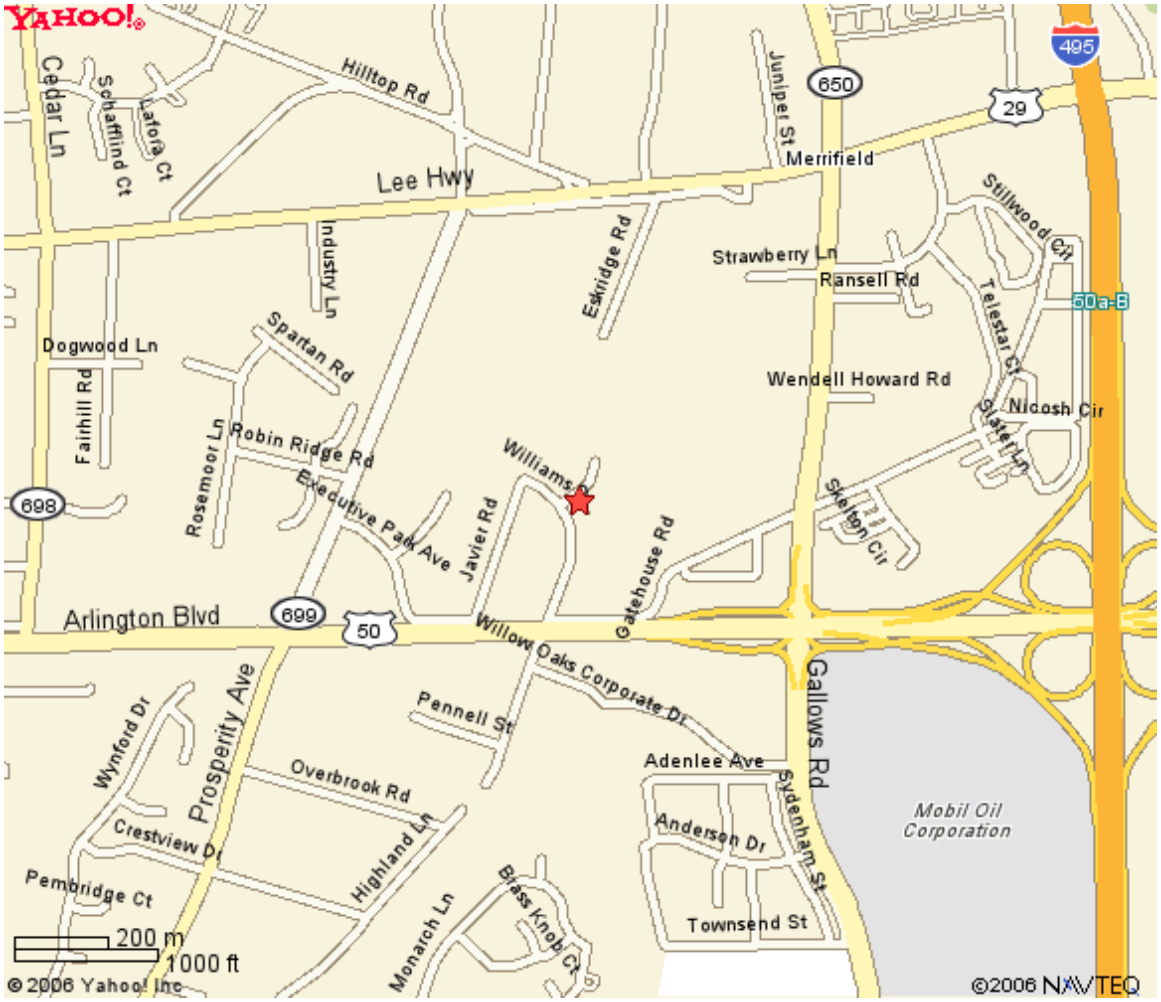
Medical Records: To obtain copies of your medical records you must sign a Medical Release form. There is a **$10** office fee, plus **$0.50/page.** If we mail the records, there is a **$5** certified mail fee. These fees, set forth by Virginia State law, must be paid in full before your request can be processed. Please allow two weeks for processing.

Forms, letters, reports: The fee for completion of these items is based upon the complexity of the form and the time required in its preparation. All fees must be paid in full before the forms can be returned to you. Please allow at least one week for processing.

Outstanding Bills: There will be a $5 charge per payment period for balances not paid within 30 days.

****In deference to our staff and patients who have Asthma or Allergies, we ask that you do not wear perfumes or fragrances on the day of your appointment otherwise we may be unable to treat you**.

Directions to Dr. Joanne Herrman's Office
8324 Professional Hill Drive
Fairfax, VA 22031



From Tyson's Corner and points North: Via the Capital Beltway 495 S to Arlington Blvd (Rte 50). Exit toward West/Fairfax. Continue on Arlington Blvd 0.4 mi. Turn Right on Williams Drive 0.2 mi. Turn Right on Professional Hill Drive.

From Springfield and points South: Via the Capital Beltway 495 N to Arlington Blvd (Route 50) Exit West/Fairfax. Continue on Arlington Blvd 0.7 mi. Turn Right on Williams Drive 0.2 mi. Turn Right on Professional Hill Drive.

Via Route 66 from the West: Exit Nutley Street Exit 62 toward Fairfax. Continue on Nutley St 0.8 mi (crossing Lee Hwy) to Arlington Blvd (Rte 50). Turn Left onto Arlington Blvd and proceed 1.5 mi. Turn Left on Williams Dr. Turn Right on Professional Hill Drive.

Via Route 66 from the East: Via the Capitol Beltway 495 S to Arlington Blvd (Route 50). Exit toward West/Fairfax. Continue on Arlington Blvd. 0.4 mi. Turn Right on Williams Drive 0.2 mi. Turn Right on Professional Hill Drive.

Patient Information

Last Name	First Name	Middle Initial
Street Address	City	State Zip Code
Home Telephone Nr.	Cell Phone Number	Emergency Contact Name/Telephone
Date of Birth / /	Social Security Nr.	Single/Married/Divorced/Widowed Partnered
Employer	Address	Work Phone
E-Mail Address:	Ethnicity: Race: Language:	May we E-mail you appointment reminders? Yes ☐ No ☐

PRIMARY INSURANCE INFORMATION

Insurance Company	Office Co-Pay	Insurance Telephone Nr.
Member ID	Group Number	
Insured's Last Name (***If NOT SELF***)	First Name	Middle Initial
Street Address	City	State Code Zip
Home Telephone Nr.	Social Security Nr.	Date of Birth / /
Relationship	Employer	Employer's Telephone Nr.
Employer's Address	City	State Zip Code

SECONDARY INSURANCE

Insurance Company	Policy Number	Group Number
Insured's Last Name ***(If NOT SELF)***	First Name	Middle Initial
Telephone	Social Security Nr.	Date of Birth
Relationship	Employer	Employer's Address
City	State Zip Code	Employer's Telephone Nr.

PATIENT AUTHORTIZATION

I authorize my insurance benefits to be paid directly to the physician, and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payer, health maintenance organization, insurer or other health benefit plan. This consent applies to Joanne Herrman, M.D. P.C.

I agree to promptly pay for services rendered to me or to the patient above. If I fail to meet my financial commitment to Joanne Herrman, M.D., P.C. and it becomes necessary to take action to collect my account I agree to pay all costs and Expenses incurred in the collection of my account, including attorney and collection fees.

I further agree to pay for any missed appointments for which I did not notify the medical office within 24 business hours.

I authorize Joanne Herrman, M.D., P.C. to test my blood for hepatitis and/or the AIDS virus, if in their opinion, an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

Signature_____ Date_____

How did you hear about our Medical Center? _____

JOANNE HERRMAN, M.D., P.C.

8324 Professional Hill Drive
Fairfax, VA 22031
PH 703 573-5600 FAX 703 576-5665

Today's Date _____ Reason for visit today _____

Name_____ Age_____ Date of Birth _____
Address_____ City, State, Zip _____
Occupation_____ Marital Status _____
If married age of husband _____ Number of years married_____

MEDICAL HISTORY

Please list any allergies or sensitivities you have _____

Please mark (X) any of the following illnesses you have or had and indicate year when started

ILLNESS	HAD	YEAR	STILL HAVE	ILLNESS	HAD	YEAR	STILL HAVE
High Blood Pressure	_____	_____	_____	Psychiatric Condition	_____	_____	_____
Heart Disease/Rheumatic Fever	_____	_____	_____	Liver Disease/Hepatitis	_____	_____	_____
High Cholesterol	_____	_____	_____	Mononucleosis	_____	_____	_____
Stroke	_____	_____	_____	Gallbladder Disease	_____	_____	_____
Phlebitis/Clots in Veins	_____	_____	_____	Thyroid Disease	_____	_____	_____
Varicose Veins	_____	_____	_____	Diabetes	_____	_____	_____
Blood Disorder/Anemia/Sickle Cell	_____	_____	_____	Cancer (Type)	_____	_____	_____
Bleeding Tendencies	_____	_____	_____	Lung Problems/ TB	_____	_____	_____
Frequent Headaches	_____	_____	_____	Asthma	_____	_____	_____
Vision Problems (not corrected)	_____	_____	_____	Breast Lumps/Discharge	_____	_____	_____
Glaucoma	_____	_____	_____	Arthritis	_____	_____	_____
Diagnosed Migraines	_____	_____	_____	Orthopedic/ Bone Disorder	_____	_____	_____
Epilepsy/Convulsions	_____	_____	_____	Kidney/Bladder Problems	_____	_____	_____
Colitis/Irritable Bowel	_____	_____	_____	Heart Valve Problems	_____	_____	_____
Stomach, Duodenal Ulcer	_____	_____	_____	Other_____	_____	_____	_____

Do you smoke cigarettes? Yes No Have you ever smoked? Yes No
How many per day? _____ For how many years?_____ Quit when? _____
What is your average alcohol consumption (beer, wine or liquor)? _____ drinks per day week month
Have you ever had a problem with alcohol? Yes No
Do you use any "recreational" drugs (cocaine, marijuana)? Yes No Any drug use in the past? Yes No
How much coffee, tea or cola do you drink? _____ cups/glasses a day
How would you describe your diet? _____
Do you feel you have an eating disorder (anorexia, induced vomiting)? Yes No
How much do you exercise? _____

Please list all the times you have been hospitalized, operated on, or seriously injured, *excluding* dental surgery and normal childbirth:

Year	Location	Operation/Illness/Injury

List all medications you are taking on regular basis (prescription and non-prescription) and dose if known:

_____
_____
_____
_____
_____

FAMILY HISTORY Indicate who of your blood relatives (parents, grandparents, siblings) have or had nay of the following problems:

_____ Heart Attack/Coronary Artery Disease	_____ Uterine Cancer	_____ Birth Defects
_____ Diabetes	_____ Cancer (Describe)_____	_____ Psychiatric Condition
_____ Stroke	_____ Endometriosis	_____ Alcoholism/Drug Dependence
_____ High Blood Pressure	_____ Fibriod Uterus	_____ Other (Describe)_____
_____ Breast Cancer	_____ Blood Disorders	

SEE NEXT PAGE

OBSTETRIC HISTORY

Please list all pregnancies you have had and the type of delivery (C-section, vaginal birth, miscarriage with or without D&C, induced abortion and type). Also include any complications (diabetes, high blood pressure, hemorrhage, infection, stillbirth).

Date	Duration of Pregnancy	Type of Delivery	Complications

GYNECOLOGIC HISTORY

Age when menstrual periods began _____. Date last menstrual period started _____. Year of Menopause _____.
Periods come every ____ days; lasting ____ days. Amount of flow: Light Moderate Heavy # of pads/tampons on heaviest day _____
Menstrual cramps: None Mild Severe Do you bleed between periods? Yes No
Specify if periods are abnormal:
_____
_____
_____

Is this your first pelvic exam? Yes No Date of last pelvic exam _____ Date of last Pap smear_____
Have you ever had an abnormal Pap Smear? Yes No Year _____
Any treatment?_____

Circle if you have ever had: Herpe Chlamydia Syphilis Gonorrhea Veneral Warts Pelvic Inflammatory Disease (infection of uterus/tubes)
Are you presently sexually active (having sexual relations)? Yes No
Age you first had sex _____ Number of sexual partners (total) _____
Do you have bleeding after sex? Yes No
Do you feel your sex life is satisfactory? Yes No
Have you ever been raped or sexually abused? Yes No
Do you have any questions concerning sexuality?
_____
_____

Have you had your tubes tied (tubal ligation)? Yes No When? _____
If you are currently using birth control, what method?
_____
Name of pill _____
How long have you used this method?_____
Any problems?_____

Check other methods you have used: Pills Sponge Foam Condoms Diaphragm IUD Withdrawal Rhythm/Natural Family Planning Partner Sterile
Describe any problems you may have had with the methods:_____
Are you presently trying to conceive? Yes No Do you want to have children in the future? Yes No Undecided
Did your mother take DES (estrogen therapy) when she was pregnant with you? Yes No Don't Know
If you douche, how often?_____
Do you have an abnormal discharge from the vagina? Yes No
Do you have itching of the vagina or vulva? Yes No
Do you have difficulty holding your urine at any time, particularly when you strain or cough? Yes No Is this a problem? Yes No
Do you have hot flashes? Yes No
Have you ever taken Estrogen or other hormones? Yes No
Check if you have a problem with: Breast Lumps Breast Tenderness Nipple Discharge
Date of last mammogram if you have ever had one _____
Have you had any gynecological diseases or conditions (fibroids, endometriosis, infertility, cancer, etc.) evaluated and treated? Yes No
If yes, please specify:
_____

TELEPHONE CONFIDENTIALITY PREFERENCES

From time to time, our office may contact you regarding test results. To help expedite this process, please indicate below your preferences for contacting you.

Name:_____

Please CIRCLE one of your numbers below to indicate which is your PRIMARY NUMBER:

Home _____

Cell _____

Work _____

Please choose one of the following options:

_____Please DO NOT leave detailed messages for me, only call-back instructions.

_____Detailed messages may be left for me at (circle one) Home Cell Work.

Signed _____

Date _____