

WOMEN'S HEALTH AND SURGERY CENTER

YOUR HEALTH • YOUR BABY • YOUR LIFE

PATIENT INFORMATION (PLEASE PRINT)					
Last Name:		First Name:		Middle Name:	
Address (NO PO BOX):			City:	State:	Zip Code:
Home #:		Work #:		Cell #:	
Social Security #(<u>Required</u>):		DOB:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Employer:			Employer Address:		
Email Address:			How did you hear about us?		
Referring Physician:			Primary Care Physician:		
Pharmacy Name & Location:			Pharmacy Phone Number:		
INSURANCE INFORMATION					
Name of <u>Primary</u> Insurance:			Name of <u>Secondary</u> Insurance:		
Subscriber Name:		Relationship to Patient:		Subscriber Name:	
ID #:		Group #:		Relationship to Patient:	
Subscriber DOB:		Subscriber Social Security #:		ID #:	
Subscriber DOB:		Subscriber Social Security #:		Subscriber DOB:	
Subscriber Social Security #:		Subscriber Social Security #:		Subscriber Social Security #:	
EMERGENCY CONTACT INFORMATION					
Last Name:		First Name:		Relationship To Patient:	
Address:			City:	State:	Zip Code:
Home #:		Cell #:		Work #:	
<p>Assignment of Insurance Benefits: I hereby authorize payment to this practice for any benefits payable to me for healthcare services provided to the client/patient at this practice, to be paid directly to the practice. I understand that if health insurance information is provided, this in no way relieves me of financial responsibility for services rendered now or in the future at this practice.</p> <p>Guarantee of Payment: I understand that I am financially responsible for all amounts payable with regards to fees for healthcare services rendered now and in the future by this practice. In the event of non-payment by me of any amount due to this practice after 90 days, I agree that in addition to the original amount due, I am fully responsible to pay collection fees of 33% and 1/3% of the amount due, court costs and reasonable attorney's fees incurred by this practice if required to collect my debt owed.</p>					
Signature of Responsible Party:				Date:	

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MEDICAL INFORMATION

Patient Name:	DOB:	Age:
Reason for your visit today:	How long have you had this problem?	

MEDICAL HISTORY

First day of last period:	Do you have regular monthly periods? <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do your periods come?	Age at first period?
Periods are: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy	How many days does your period last?	Cramps are: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Drug Allergies:		Current Birth Control: Are you happy with this birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Age at first intercourse:	Number of partners(lifetime):	Sexual Preference: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual	
Have you had a new sexual partner since your last exam? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you desire testing for STD's? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Last Pap Smear: ___/___	Have you ever had an abnormal Pap? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please give year and any procedures:	
Last Mammogram: ___/___	Have you ever had an abnormal Mammogram? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please give year and any procedures:	
How many total pregnancies have you had:	How many did you deliver?	How did you deliver?	Number of miscarriages ____ Number of elective terminations _____

Hospitalizations/Surgeries(list all <u>except</u> for pregnancy):	Date of Surgery	
Do you currently: <input type="checkbox"/> Exercise regularly <input type="checkbox"/> Diet-What type?_____ <input type="checkbox"/> Drink alcohol-How much?_____ <input type="checkbox"/> Use recreational drugs? <input type="checkbox"/> Smoke cigarettes:____packs/day	Current Medications(please list ALL)/Herbal/Calcium Supplements:	Do you do monthly breast exams? <input type="checkbox"/> Yes <input type="checkbox"/> No

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MEDICAL HISTORY CONTINUED...

Name:	DOB:
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<p>Are you experiencing any of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Leak urine when you cough/laugh/sneeze <input type="checkbox"/> Unaware that you are leaking urine <input type="checkbox"/> Strong urge to urinate <input type="checkbox"/> Wear a pad because of urine leakage <input type="checkbox"/> Leaking after intercourse <input type="checkbox"/> Painful urination <input type="checkbox"/> Incomplete urination <input type="checkbox"/> Difficulty beginning to urinate <input type="checkbox"/> Slow urinary stream <input type="checkbox"/> Straining to pass urine <input type="checkbox"/> Irregular Periods <input type="checkbox"/> Pain with your menses <input type="checkbox"/> Pain with ovulation <input type="checkbox"/> Dissatisfied with sexual relations <input type="checkbox"/> Pain with intercourse <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Bleeding after intercourse <input type="checkbox"/> Bleeding from your rectum 	<p>Continued...</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Vaginal itching <input type="checkbox"/> Vaginal burning <input type="checkbox"/> Breast/Nipple discharge <input type="checkbox"/> Lump(s) in breast <input type="checkbox"/> Breast Pain <input type="checkbox"/> Bloody Urine <input type="checkbox"/> Incomplete urination <input type="checkbox"/> Hot flashes <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Night sweats <input type="checkbox"/> Feel anxious <input type="checkbox"/> Feel sad/depressed <input type="checkbox"/> The sight/sound/feel of running water causes you to leak urine <input type="checkbox"/> Feeling of pressure or bearing down <input type="checkbox"/> Bulging from your vagina <input type="checkbox"/> Unusual hair growth
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<p>Please check the box if <u>you</u> have had problems with the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Skin <input type="checkbox"/> Eyes/vision <input type="checkbox"/> Ears/hearing <input type="checkbox"/> Mouth/teeth <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer-What kind? _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Migraines <input type="checkbox"/> Seizures/Epilepsy 	<ul style="list-style-type: none"> <input type="checkbox"/> Psychiatric problems <input type="checkbox"/> Depression <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding problems <input type="checkbox"/> Blood transfusions <input type="checkbox"/> Hepatitis <input type="checkbox"/> Lung disease <input type="checkbox"/> Breast lump <input type="checkbox"/> Breast discharge <input type="checkbox"/> Breast surgery 	<ul style="list-style-type: none"> <input type="checkbox"/> Gall bladder disease <input type="checkbox"/> Stomach Ulcer <input type="checkbox"/> Black/Bloody stool <input type="checkbox"/> Kidney <input type="checkbox"/> Bladder infections <input type="checkbox"/> Gonorrhoea <input type="checkbox"/> Syphilis <input type="checkbox"/> PID <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Trichomonas <input type="checkbox"/> HPV <input type="checkbox"/> Chlamydia <input type="checkbox"/> Genital warts <input type="checkbox"/> Herpes 	<ul style="list-style-type: none"> <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Broken bones <input type="checkbox"/> Back pain <input type="checkbox"/> Joint problems <input type="checkbox"/> Arthritis <input type="checkbox"/> Vaginal infections <input type="checkbox"/> Pelvic tumor <input type="checkbox"/> Pelvic infections <input type="checkbox"/> Abnormal Paps <input type="checkbox"/> Endometriosis <input type="checkbox"/> Fibroids <input type="checkbox"/> Ovarian tumors <input type="checkbox"/> Breast biopsy
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<p>Incontinence Questionnaire: Please answer as accurately as possible.</p> <ol style="list-style-type: none"> 1. Do you leak urine when you cough, sneeze or laugh? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Do you ever have such an uncomfortably strong need to urinate that if you reach the toilet you will leak? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. If "yes" to #2 do you ever leak before you get to the toilet? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. How many times during the day do you urinate? _____ 5. How many times do you void during the night after going to bed? _____ 6. Have you wet the bed in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Do you develop an urgent need to urinate when you are nervous, under stress, or in a hurry? <input type="checkbox"/> Yes <input type="checkbox"/> No 	<ol style="list-style-type: none"> 8. Do you ever leak during or after sexual intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No 9. Do you find it necessary to wear a pad because of your leaking? <input type="checkbox"/> Yes <input type="checkbox"/> No 10. How many times do you leak during the day? _____ 11. Have you had bladder, urine, or kidney infections? <input type="checkbox"/> Yes <input type="checkbox"/> No 12. Are you troubled by pain or discomfort when you urinate? <input type="checkbox"/> Yes <input type="checkbox"/> No 13. Have you had blood in your urine? <input type="checkbox"/> Yes <input type="checkbox"/> No 14. Do you find it hard to begin urinating? <input type="checkbox"/> Yes <input type="checkbox"/> No 15. Do you have a slow urinary stream? <input type="checkbox"/> Yes <input type="checkbox"/> No 16. Do you have to strain to pass your urine? <input type="checkbox"/> Yes <input type="checkbox"/> No
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FAMILY HISTORY

Are you adopted? Yes No

Please check all that apply under the appropriate family member: **(For brother and sister please list which sibling or both)**

Disease	Self	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother/Sister	Other
Alcoholism									
Anemia									
Arthritis									
Asthma/Lung Problems									
Birth Defects									
Bleeding Problems									
Blood Clots									
Bloody Stools/Colon Polyp(s)									
Breast Cancer									
Cervical Cancer									
Colon Cancer									
Depression									
Diabetes									
Heart Disease									
High Cholesterol									
High Blood Pressure									
Kidney Disease/UTI's									
Liver Disease									
Loss of Urine									
Mental Illness									
Osteoporosis									
Ovarian Cancer									
Seizures									
Stomach Ulcers									
Stroke									
Thyroid Disease									
Tuberculosis									
Uterine Cancer									

Other(please explain):

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS REQUIRED BY FEDERAL LAW AND DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Once you sign our Patient Information consent form, we may use and disclose your medical information in order to treat you, obtain payment, and to operate the practice.

This Notice of Privacy Practices (“Notice”) describes the ways in which we may use and disclose your Protected Health Information (PHI) and how you can get access to this information. “Protected Health Information” is information about you that is contained in your medical and billing records maintained by this organization. It includes demographic information and information that relates to your present, past or future physical or mental health and related healthcare services.

If you have any questions about this Notice, please contact our Privacy Officer.

Uses and Disclosures of Protected Health Information: We may use and disclose your Protected Health Information for purposes of healthcare treatment, payment and healthcare operations as described below.

For Treatment: We may use and disclose your Protected Health Information to provide, coordinate or manage your healthcare and any related services. Examples of how we will disclose information for treatment may include sharing information about you with: referring physicians, your primary care physician, a specialist, hospitals, ambulatory care centers, pharmacies or home health agencies.

For Payment: Your Protected Health Information will be used and disclosed as required, so that we can bill and receive payment for the treatment and services you received from us. Examples of how we will disclose information for payment include: contacting your health plan to confirm your coverage or obtain precertification of a service, or we may provide information to any other healthcare provider who requests information necessary for them to collect payment.

For Healthcare Operations: We may use and disclose your Protected Health Information in performing business activities that we call “healthcare operations”. This includes internal operations, such as for general administrative activities and to monitor the quality of care you receive at our facility. Examples include: quality of care assessments, training of medical staff, assessing certain services that we may want to offer in the future, evaluating the performance of our employees, licensing, or conducting or arranging other business activities. Other examples include: leaving messages on your answering machine; leaving messages at your place of employment or sending our recall notices. We may use or disclose your Protected Health Information when making calls to remind you of your appointment. We will use a sign-in sheet at the receptionist’s desk where you will be asked to sign your name and the name of the provider you are seeing. We will also call you by name when you are in our waiting room.

Other Uses and Disclosures We May Make Without Your Written Authorization: Under the Health Insurance Portability and Accountability Act(HIPAA) Privacy Regulations, we may use and disclose your Protected Health Information in which you do not have to give authorization. These situations include: those Required by Law, Public Health Information in which you do not have to give authorization. These situations include: those Required by Law, Public Health Risk Issues as required by Law, Communicable Diseases, Health Oversight Activities, reporting Victims of Abuse, Neglect or Domestic Violence, Legal Proceedings, Law Enforcement, Coroners, Medical Examiners, Funeral Directors, Organ/Tissue Donation Organizations, Research; Criminal Activity and National Security, Inmates/Law Enforcement Custody, and Workers Compensation. **Any Other Use or Disclosure of Your Protected Health Information Requires Your Written Authorization:** Will be made only with your consent, authorization or opportunity to object unless required by law.

Your Rights Regarding Your Protected Health Information: You have the right to access your personal Protected Health Information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and Protected Health Information that is subject to law that prohibits access to Protected Health Information.

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You Have the Right to Request Restrictions: You have the right to request a restriction on the way we use or disclose your Protected Health Information for treatment, payment or healthcare operations. You may make this request in writing, at any time. If we do agree to the restriction, we will honor that restriction except in the event of an emergency and will only disclose the restricted information to the extent necessary for your emergency treatment.

You Have the Right to Request Confidential Communications: You have the right to request that we communicate with you concerning your health matters in a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number or a specific address. We will accommodate your reasonable requests, but may deny the request if you are unable to provide us with appropriate methods of contacting you.

You Have the Right to Request that We Amend your Protected Health Information: If we deny your request, we will give you a written notice, including the reasons for the denial. You can submit a written statement disagreeing with this denial. Your letter of disagreement will be attached to your medical record.

You Have the Right to Request an Accounting of Certain Disclosures of Your Protected Health Information.

You Have the Right to Obtain a Paper Copy of This Notice, even if you have agreed to receive this notice electronically. You may request a copy of this Notice at any time by contacting our office in writing or by phone.

You May Issue a Complaint to our Privacy Officer (listed on the first page) or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. We will not retaliate against you for filing a complaint.

We Reserve the Right to Change the Terms of This Notice of Privacy Practices and to make the new provisions effective for all Protected Health Information we already have about you as well as any Protected Health Information we create or receive in the future. If we make any changes, we will:

- a. Post the revised Notice in our office(s), which will contain the new effective date; and
- b. Make copies of the revised Notice available to you upon request (either at our offices or through the contact person listed on the Notice)

This Notice was published and effective 04/21/09

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The practices listed above reserves the right to modify the privacy practices outlined in the notice.

-I have received or have been offered a copy of the Notice of Privacy Practices for the practices listed above.

PRINTED NAME

SIGNATURE OF PATIENT/LEGAL GUARDIAN

DATE

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Policies and Procedures Agreement

Patient Information and Insurance Cards: Your personal information sheet and insurance card are an important part of your medical record. It is your responsibility to make sure that you update this information at each visit to keep your record current. As this may seem inconvenient, it is necessary to keep your insurance and contact information updated to insure you receive proper care.

Late Policy: Every effort is made to keep our physicians schedules on time; therefore if you are more than **15** minutes late, we will reschedule your appointment to the next available with a physician in the office; however, there is no guarantee that you will be seen immediately or by the originally scheduled physician. If all the physicians' schedules are full you will be asked to reschedule your appointment to a later date.

Missed/Cancelled Appointments, Procedures or Surgeries: Every effort is made to accommodate our patients request for appointment, procedure or surgery dates/times; therefore, it is important that **you** make every effort to keep your scheduled appointments. Cancellations of less than 24 hours for missed office appointments/ no-show appointments will be subject to a fee of **\$50.00**. Cancellations of less than 7 days of procedures or surgeries are subject to a fee of **\$150.00**. Please be advised that chronic missed appointments may result in dismissal from our practice.

Fee for Completion of Forms, Reports, and Letters: This is a non-insurance covered service which requires time from administrative and nursing staff as well as the doctors; therefore, a fee of **\$25.00** will be charged for the completion of forms or the writing of letters. Once the **\$25.00** fee is paid for the first form, each form thereafter will be **\$10.00** per form. *Forms include all forms, reports and letters.

Transferring of Records: All patients must sign a records release form to have their records copied or to send them to another provider or organization. Copies will be provided to the patient for a **\$10.00** administrative fee PLUS **\$0.50** per page up to 50 pages and **\$0.25** per page thereafter. There is no fee to transfer records directly to another provider or organization.

Payment for Services for Patients with Insurance: According to your health insurance plan you are responsible for paying your co-payment at the time of service. Co-pays that are not paid at the time of service will be billed with an additional **\$10.00** fee. This fee is necessary to cover administrative and supply costs when billing for co pays. If we participate as providers with your health plan we will bill your insurance company for your visit. If we are not contracted with your insurance company, you are responsible to pay for your visit after the services are rendered.

Women's Health and Surgery Center files your insurance as a courtesy. We ask that if your account remains unpaid after 45 days that you contact your insurance company for payment.

TRICARE INSURANCE: If you have **Tricare PRIME** you are required to have a referral from your PCM for services other than your annual(Pap, Breast Exam, and Birth Control).

Payment for Services for Patients without Insurance: You will be responsible for payment by cash, check or credit card on the day of service. On bills with extensive procedures and by approval of our billing department and office manager, you may set up a payment plan with our office.

Payments: Unless other arrangements are approved by the billing department and office manager in writing, the balance on your statement is due on the due date posted on your statement. If your account becomes past due, Women's Health and Surgery Center will take all necessary steps to collect this debt. If we have to refer your account to a collection agency or lawyer, you agree to pay all collection, lawyer and court fees incurred.

We do not except personal checks as payments. We accept Visa, Mastercard, Discover, or Cash. There is a **\$50.00** fee for any checks returned by your bank if you pay your balance by check.

PATIENT SIGNATURE _____

DATE _____

PRINTED NAME _____



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NEW PATIENT REPRODUCTIVE HISTORY

Patient Name: _____ **DOB:** _____ **Last Menstrual Period:** _____

Pregnancy Summary:

Total Pregnancies:	Total Full Term Pregnancies:	Total Premature Deliveries:	Total Elective Terminations:	Total Spontaneous Terminations (Miscarriages):	Total Ectopic Pregnancies:	Total Pregnancies with Multiples (twins, etc.):

Date of Birth:	Gestational Age in weeks:	Hours in labor:	Birth Weight:	Sex:	Delivery Type (Vaginal or Cesarean):	Anesthesia Received (i.e. Epidural):	Early Labor:	Comments or Complications:	Delivery Location:
							Yes / No		
							Yes / No		
							Yes / No		
							Yes / No		
							Yes / No		