PATIENT INFORMATION

PLEASE FILL OUT FORM COMPLETELY

Last Name:	**First Name:**			**Middle Name:**	
Address (NO PO BOX):		**City:**		**State:**	**Zip Code:**
Home #:	**Cell #:**	**Work #:**		**Legal Gender:** ☐ Male ☐ Female	
Social Security #:	**DOB:**	**Race:**	**Ethnicity:**	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Employer:		**Employer Address:**			
Email Address:		**How did you hear about us? If a patient referred you, please provide name:**			
Referring Physician:		**Primary Care Physician & Phone:**			
Pharmacy Name & Location:		**Pharmacy Phone Number:**			

INSURANCE INFORMATION
(PLEASE COMPLETE ALL SECTIONS)

Name of Primary Insurance:		**Name of Secondary Insurance:**	
Subscriber Name:	**Relationship to Patient:**	**Subscriber Name:**	**Relationship to Patient:**
ID #:	**Group #:**	**ID #:**	**Group #:**
Subscriber DOB:	**Subscriber Social Security #:**	**Subscriber DOB:**	**Subscriber Social Security #:**

EMERGENCY CONTACT INFORMATION

Last Name:	**First Name:**		**Relationship To Patient:**	
Address:	**City:**		**State:**	**Zip Code:**
Home #:	**Cell #:**	**Work #:**		

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.

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.

Signature of Responsible Party:	**Date:**

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 **20** 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 **$25.00**. Cancellations of less than 7 days of procedures or surgeries are subject to a fee of **$150.00**. For Urodynamic Testing, if a 48-hour notice of cancellation/rescheduling is not provided, you will be subject to a **$100.00** fee. Please be advised that chronic missed appointments may result in dismissal from our practice. After 3 appointments are missed, without a call to cancel prior to the time of the appointment, you will be dismissed from the 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 **$15.00** will be charged for the completion of each form, or the writing of letters. *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 **$5.00** 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 all services.

Payment for Services for Patients without Insurance: You will be responsible for payment by cash 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 accept 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.

COPAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.

_____

Patient Signature **Patient Printed Name** **Date**

PRIVACY PRACTICES

1. **Purpose:** We understand that medical information about you and your health is personal and we are committed to protecting that information. We create a record of the care and services you receive at Women's Health and Surgery Center to provide you with quality care and to comply with certain legal requirements. This Notice of Privacy Practices describes how we may use and disclose medical information about you, including demographic information that may identify you and your related health care services, to carry out your treatment, obtain payment for our services, perform the daily health care operations of the practice and for the purposes that are permitted or required by law. This notice also describes your rights to access and control your medical information. We are required to abide by the terms of this Notice of Privacy Practices.
2. **Written Acknowledgement:** You will be asked to sign a written statement acknowledging that you have received a copy of this notice. The acknowledgement only serves to create a record that you have received a copy of the notice.
3. **Changes to this Notice:** We may change the terms of our Notice at any time. The new Notice will be effective for all medical information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised copy, you may call our office and request that a revised copy by sent to you in the mail or you may ask for one at the time of your next appointment.
4. **How We May Use and Disclose Medical Information about You:** The following categories describe the different ways Women's Health and Surgery Center may use and disclose your medical information and a few examples of what we mean. These examples are not meant to describe every circumstance, but to give you an idea of the types of uses and disclosures that may be made by our office. Other uses and disclosures of your medical information that are not listed or described below will be made only with your written authorization. You may revoke this authorization, at any time, in writing, but it will not apply to any actions we have already taken.
    - **For your treatment:** We may use and disclose your medical information to provide medical treatment to you or to assist another health care provider in providing medical treatment to you. For example, a nurse obtains treatment information about you and documents it in your medical records and the physician has access to that information. If you require an x-ray to be taken, the x-ray technician also has access to your medical information. In addition, your medical information may be provided to a physician to whom you have been referred or are otherwise seeing to ensure that the physician has the necessary information to diagnose or treat you.
    - **To obtain payment for our services:** We may use and disclose your medical information to obtain payment for your health care bills or to assist another health care provider in obtaining payment for its health care bills. For example, we may submit requests for payment to your health insurance company for the medical services that you received. We may also disclose your medical information as required by your health insurance plan before it approves or pays for the health care services we recommend for you.
    - **For our health care operations:** We may use and disclose your medical information to support our daily operations. For example, we may disclose your medical information to medical school students who see patients at our office. We may also use the medical information to determine where we can make improvements in the services and care we offer.
    - **For the health care operations of other health care providers:** We may use and disclose your medical information to assist another health care provider treating you with that provider's quality improvement activities, evaluation of the health care professionals or for fraud and abuse detection or compliance. For example, we may disclose your medical information to another physician to assist in his efforts to make sure he is complying with all rules related to operating a medical practice.
    - **For appointment reminders:** We may use and disclose your medical information to contact you to remind you of your appointment, by mail or by telephone. Our message will include the name of our practice or the name of our physician as well as the date and time for your appointment or a reminder that an appointment needs to be scheduled.
    - **To provide you with treatment alternatives:** We may use and disclose your medical information to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, we may contact several home health agencies or physical therapy providers to discuss the services they provide when we have a patient who needs these services.
    - **To our business associates:** We will share your medical information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your medical information, we will have a written agreement that contains terms that will protect the privacy of your medical information. For example, Women's Health and Surgery Center may hire a billing company to submit claims to your health care insurer. Your medical information will be disclosed to this billing company, but a written agreement between our office and the billing company will prohibit the billing company from using your medical information in any way other than what we allow.
    - **Others Involved in Your Health care:** Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your medical information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose your medical information to notify a family member or any other person who is responsible for your care of location and general health condition. Finally, we may use or disclose your medical information to an authorized public or private entity to assist in (1) disaster relief efforts and (2) to coordinate uses and disclosures to family or other individuals involved in your health care.
    - **As required by law:** We may use and disclose your medical information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
    - **For public health activities:** We may disclose your medical information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your medical information, if directed by the public health authority, to any other government agency that is collaborating with the public health authority
    - **As required by the Food and Drug Administration:** We may disclose your medical information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, or to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.
    - **For communicable disease exposure:** We may disclose your medical information, if authorized by law. To a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
    - **To your employer:** We may disclose your medical information concerning a work-related injury or illness to your employer if you are covered under your employer's policy to conduct an evaluation relating to medical surveillance of the work place or to evaluate whether you have a work-related injury, in accordance with the law.

- **For abuse or neglect:** We may disclose your medical information to a public health authority that is authorized by law to receive reports of child or adult abuse or neglect. In addition, we may disclose your medical information if we believe that you have been a victim of abuse, neglect or domestic violence as may be required or permitted by Virginia and/or federal law.
- **For health oversight:** We may disclose your medical information to a health oversight agency for activities authorized by law. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs (such as Medicare or Medicaid), other government regulatory programs and civil rights laws.
- **In legal proceeding:** We may disclose your medical information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena or other lawful request.
- **For law enforcement:** We may disclose your medical information, so long as all legal requirements are met, for law enforcement purposes. Examples of these law enforcement purposes include: (1) responses to information requests for purposes of identification and location of a person; (2) responses to information requests pertaining to victims of a crime; (3) reporting suspicion that death has occurred as a result of criminal conduct; (4) reporting evidence of criminal conduct that occurs on the premises of the practice; and (5) reporting a medical emergency where it is likely that a crime has occurred.
- **To coroners, to funeral directors, and for organ donation:** We may disclose your medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose medical information to a funeral director to carry out its duties. We may disclose such information in reasonable anticipation of death. Your medical information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.
- **For research:** We may disclose your medical information to researchers when their research has been established as required by federal and state law.
- **Due to criminal activity:** Consistent with applicable federal and state laws, we may disclose your medical information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose your medical information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- **For military activity and national security:** When the appropriate conditions apply, we may use or disclose medical information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purposes of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your medical information to authorized federal officials for conducting national security and intelligence activities, including for to provision of protective services to the President or others legally authorized.
- **For workers' compensation:** Your medical information may be disclosed as authorized to comply with workers' compensation laws and other similar legally established programs.
- **Regarding inmates:** We may use or disclose your medical information if you are an inmate of a correctional facility and your physician created or received your medical information in the course of providing care to you.
- **For required uses and disclosures:** Under the law, we must make disclosures to you and, when required, to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act and its regulations.

5. **Your Rights:** Following is a statement of your rights with respect to your medical information and a brief description of how you may exercise these rights.

   You have the right to inspect and copy your medical information. You may inspect and obtain a copy of your medical information that we maintain. The information may contain medical and billing records and any other records that we use for making decisions about you. However, under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled and related to a civil, criminal, or administrative action; and medical information that is subject to laws that prohibit access to medical information in certain circumstances. We may deny your request to inspect your medical information. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical records.

   You have the right to request a restriction of your medical information. This means you may ask us not to use or disclose any part of your medical information for the purposes of treatment, payment or health care operations. You may also request that any part of your medical information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request. If we agree to the requested restriction, we may not sure or disclose your medical information in violation of that restriction unless it is needed to provide emergency treatment or unless we otherwise notify you that we can no longer honor your request. With this in mind, please discuss any restriction you wish to request with your physician. Please request all restrictions in writing to our Privacy Officer.

   You have the right to request that we accommodate you in communicating confidential medical information. We will accommodate reasonable requests, but we may condition this accommodation by asking you for information as to how payment will be handled or other information necessary to honor your request. Please make this request in writing to our Privacy Officer.

   You may have the right to ask us to amend your medical information. You may request an amendment of your medical information as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a disagreement with us and we may respond in writing to you. Please contact our Privacy Officer if you have questions about amending your medical record.

   You have the right to receive an accounting of certain disclosures we have made, if any, of your medical information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made pursuant to your authorization (permission), made directly to you, to family members or friends involved in your care, or for appointment notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain expectations, restrictions and limitations.

   You have the right to obtain a paper copy of this notice from us. If you would like a paper copy of this notice, please request one from our Privacy Officer or request one when you are in our offices.

6. **Complaints:** You may complain to us if you believe your privacy rights have been violated by us. To file a complaint, please contact our Privacy Officer who will be happy to assist you. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. If you do not wish to file a complaint with us, you may contact the Secretary of Health and Human Services.
7. **Privacy Contact:** If you have any questions about this Notice or require additional information, please contact our Privacy Officer Stephanie Rainville. Our Privacy Officer is available during normal business hours to discuss your privacy questions, concerns or complaints.
8. **Effective Date:** This revised notice was published and becomes effective on September 20, 2012.

CONFIDENTIALITY AGREEMENT

As a patient I understand my medical information is **Confidential** and it is the policy of Women's Health and Surgery Center not to release any sensitive information to anyone other than myself, **unless written** authorization has been given. Therefore, in an effort to let the Doctors, Nurses or their designee better communicate my confidential medical information to me or my designated relative/friend.

Please fill in below information if you are authorizing Women's Health and Surgery Center to leave any confidential information with.

I am hereby authorizing the release of personal confidential information to the following person(s):

Name	Relationship	Phone Number
Name	Relationship	Phone Number

☐ I decline for Women's Health and Surgery to leave confidential information with any person other than myself.

May we call your place of employment?

Yes or **No**_____
Phone Number

Is it ok to leave you a detailed voicemail concerning your appointments or results?

Yes or **No** _____
Phone Number

Patient Signature	**Printed Name**	**Date**

RECEIPT OF PRIVACY PRACTICES

Women's Health and Surgery Center reserves the right to modify the privacy practices outlined in the notice.

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

Patient Signature	Printed Name	Date

Date:_____ Patient's Name: _____

Reason for your visit_____

ALLERGIES:

Are you allergic to any medication ○Yes ○ No

Name of medication Reaction: *(rash, itching, shortness of breath, nausea, etc.)*

_____ _____

_____ _____

MEDICATIONS: (List any medications you are presently taking)

_____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PERSONAL SURGICAL HISTORY: (Check any surgical procedures you have undergone and list the date performed)

Appendectomy _____
Breast Biopsy Left/Right _____
Breast Reduction _____
Breast Augmentation (implants) _____
Colonoscopy (colon scope) _____
C-Section _____ (Indicate number)_____
D & C _____
Endometrial Ablation _____
Gall Bladder _____
Heart Surgery (type) _____
Hysterectomy Vaginal/Abdominal _____
LEEP/Conization _____
Removal of Ovaries _____
Sterilization _____
Tonsillectomy _____
Other _____

PERSONAL MEDICAL HISTORY: (Circle if applies)

Cancer (indicate type)
Breast
Cervical
Colon
Endometrial
Lung
Ovarian
Other _____

Cardiac (heart)
High Blood Pressure
High Cholesterol
Heart Attack
Mitral Valve Prolapse

Endocrinology
Diabetes Mellitus (during pregnancy)
Diabetes Mellitus (non-insulin dependent)
Diabetes (insulin dependent)
Thyroid Problems
Hypothyroidism
Hyperthyroidism
Osteoporosis
Osteopenia

Gastrointestinal
Crohn's Disease
Ulcerative Colitis
Gallbladder Disease
GERD (Reflux)
Irritable Bowel Syndrome (IBS)
Liver Disease
Hepatitis

Hematology
Anemia
Blood Clotting Disorder
Blood Transfusion
DVT (Deep Vein Thrombosis)
PE (Pulmonary Embolism/ Clot in Lung)
Sickle Cell Disease/Trait

Infectious Disease
Chicken Pox
Shingles
HIV
Tuberculosis/Positive PPD

Neurology
Alzheimer's/Dementia
Headache/Migraines
Numbness in Hands/Feet
Seizures/Epilepsy
Stroke

Psychiatric
ADD/ADHD
Anxiety
Bipolar Disease
Depression
Eating Disorder
Panic Attacks

Pulmonary
Asthma
COPD/Emphysema
Seasonal Allergies

Rheumatology
Arthritis
Autoimmune Disease
Fibromyalgia

Urology
Frequent Urinary Tract Infections
Hematuria (blood in urine)
Kidney Disease
Kidney Infection
Incontinence (bladder leakage)

Patient's Name: _____

SOCIAL HISTORY:

Tobacco use currently: Yes No How much per day: _____

Tobacco use in the past: Yes No If yes, when did you stop smoking: _____

Alcohol use: Yes No How much per day/week: _____

Drug use: Yes No Describe: _____

Occupation: _____ Education Level Completed: _____

Marital Status: Married Single Divorced Widowed Religious Affiliation: _____

GYN HISTORY:

Date of most recent Pap Smear: _____

Date of most recent Mammogram: _____

Date of most recent Bone Density: _____

History of: ***(Please circle all items that apply)***

Abnormal Pap Smear
Describe: _____
HPV/Genital Warts
Endometriosis
Fibroids

Ovarian Problems
PCOS
Infertility
Bacterial Vaginosis
Yeast Infections

Chlamydia
Gonorrhea
Trichomonas
Herpes Simplex
Syphilis

Are you sexually active? Yes No **Current birth control method**: _____

Age of first intercourse? _____ Number of lifetime sexual partners? _____

MENSTRUAL HISTORY:

Age started menstrual cycle: _____ Date of last menstrual period: _____

# of days of bleeding with your period: _____ # of days from start of one period to the start of the next period: _____

Flow is: mild moderate heavy

Menstrual Cramps: None Mild Moderate Severe Bleed between Periods: Yes No

FAMILY MEDICAL HISTORY: (Please indicate relationship: mother, father sister, brother, maternal/paternal grandmother, etc.)

Cancer (breast/ovarian/uterine/colon/pancreas/other)

Depression _____ High Blood Pressure _____ Stomach Ulcer _____

Diabetes _____ High Cholesterol _____ Stroke _____

Endometriosis _____ Irritable Bowel _____ Hypothyroidism _____

Fibroids _____ Osteopenia _____ Hyperthyroidism _____

Heart Attack _____ Osteoporosis _____ Ulcerative Colitis _____

Reproductive History

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

Pregnancy Summary:

Total Pregnancies:	**Total Full Term Pregnancies:**	**Total Premature Deliveries (before 37 weeks):**	**Total Elective Terminations (Abortions):**	**Total Spontaneous Terminations (Miscarriages):**	**Total Ectopic Pregnancies (Tubal):**	**Total Living Children:**

Date of Birth:	**Gestational age in Weeks:**	**Hours in Labor:**	**Birth Weight:**	**Sex**	**Delivery Type (vaginal or cesarean):**	**Early Labor:**	**Comments or Complications:**	**Delivery Location:**
						Yes/No		
						Yes/No		
						Yes/No		
						Yes/No		
						Yes/No		
						Yes/No		
						Yes/No		
						Yes/No		