



Welcome! We are pleased that you have chosen our office for your care. We will give you the best possible care and hope that you will feel secure and comfortable with the treatment that you receive. The enclosed booklet will give you a better understanding of how we work so that we can establish a more successful patient-physician relationship. You can expect to be treated professionally and courteously at all times.

If you find that you cannot keep your appointment, we would appreciate your calling our office as much ahead of time as possible. In the same respect, if for some reason, your doctor is delayed or unable to be in the office at the time of your appointment, we will do our best to notify you.

ALL NEW PATIENTS ARE EXPECTED TO PAY THEIR BILL ON THEIR FIRST VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH OUR OFFICE. The only exception would be if we are a provider in your insurance plan; you will then be responsible for your co-pay and deductible amounts. We do accept Medicare assignment. PLEASE BRING YOUR INSURANCE IDENTIFICATION CARDS WITH YOU.

Enclosed you will find a patient registration form. Would you please complete the form and bring it with you the day of your appointment and please give the form to the secretary at the front desk after registering.

If you have any questions, please feel free to call our office and we will be glad to assist you.

We look forward to meeting you and participating in your care.



Notifications and Releases

We want to make your experience with every aspect of our service meet or exceed your expectations. If you have any questions or concerns, suggestions for improvement in our services, or any comments, please do not hesitate to speak with any of our staff or physicians. Listed below are several notices that outline certain responsibilities of ours, and yours. Please read them carefully and sign where indicated that you have read each statement.

General Consent for Treatment

We look forward to treating you as a patient, however, we need your permission for our physicians to exam you, provide treatments, and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks and benefits of those invasive treatments will be explained to you. When you agree to proceed with an invasive treatment, you will be asked to sign a more detailed consent.

I give general consent to be treated.

Patient /Guardian _____ Date _____

Financial Policy/Assignment of Benefits

As a courtesy to our patients, the practice accepts assignment from most commercial insurance programs and Medicare. We will file your primary insurance claim for you. Once the primary insurance has paid, we will also file your secondary insurance, if you have provided us with that information. However, insurance is a contract between you and your insurance company. Therefore, we ask that you acknowledge your responsibility for the payment of our services. If the insurance denies coverage, disallows a service, or otherwise does not pay the claim, you are still responsible for the fees. In addition, if the fees for our services are not paid, we may turn the account to a collection agency. If an account is turned for collection, their fees, attorney's fees and court cost will be added to the account balance. Also, your insurance company may ask us to provide information concerning your treatment before they will pay for the services

I acknowledge it is my responsibility to ensure payment of fees for services provided by the practice and authorize the practice to release any medical information, if necessary, to my insurance company.

Patient/Guarantor _____ Date _____

Privacy Policy

New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. We only share your medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will keep your record as long as you are a patient of the practice and seven years after your last visit.

I acknowledge that I have been informed about the privacy of my medical record, and the practice's Privacy Policy has been made available to me.

Patient _____ Date _____



Breast Cancer Risk Survey

Patient Sticker Here Date:

While you are waiting to see the physician, we ask that you complete the survey below. It will help us to assess your risk for developing breast cancer. Thank you.

1. YOUR RACE: CAUCASIAN OR NON-BLACK _____ BLACK _____
2. YOUR AGE: _____
3. AGE YOU WERE AT YOUR FIRST MENSTRUAL PERIOD: _____
4. AGE YOU WERE WHEN YOUR FIRST CHILD WAS BORN: _____
5. NUMBER OF FAMILY MEMBERS WITH BREAST CANCER: _____
(such as: mother, sister(s), daughter(s))
6. NUMBER OF PREVIOUS BREAST BIOPSIES: _____
7. WAS BIOPSY ATYPICAL HYPERPLASIA? YES _____ NO _____

Thank you for completing this survey. Your doctor will discuss the results with you.

Patient sticker here

Age: _____ Marital Status: _____

To help us better serve you, please answer the following questions:

Who is your primary care or medical doctor? _____

We're currently sending electronic Rx(s). Where would you like your Rx sent *today*? _____

At what age did you start your period? _____ First day of last period? _____

How many times have you been pregnant? _____ Have you had the HPV vaccine? _____

What is your birth control method? _____ Do you take extra calcium? _____

Do you exercise? _____ Are you on any special diet? (vegetarian, weight watchers, etc) _____

Are your immunizations up to date? _____ Do you wear seat belts? _____

Do you smoke? _____ # packs per day _____

Do you do self breast exams? _____ When was your last mammogram? _____

How often do you douche? _____ How often do you drink alcoholic beverages? _____

Do you take non-prescribed drugs or have a history of drug abuse? _____

Have you ever had a bone density test? _____ when? _____ where? _____

Do you or anyone in your family have a history of blood clots? _____

Are you sexual with anyone? _____ male ___ female ___ both male/female ___ never sexual ___

How many sexual partners have you had in your lifetime? _____

Have you experienced any undiagnosed or unexplained vaginal itching, irritation or pain? _____

What Gynecologic problems (if any) do you have today? _____

List all drug allergies: _____

Are you allergic to LATEX? _____

List all current medications, including dosages:

List all surgeries:

Since your last visit:

List any new family history of:

Osteoporosis _____

Cancer (Breast, Ovarian or Colon) _____

Diabetes _____

Heart problems _____

High Blood Pressure _____

Patient's Signature _____

Today's Date _____

WE APOLOGIZE FOR ANY WAIT YOU MAY EXPERIENCE IN OUR OFFICE. WE CONSIDER YOU A VERY IMPORTANT PART OF OUR DAY AND WE DO NOT WANT YOU TO FEEL RUSHED DURING YOUR VISIT WITH US. THANK YOU FOR YOUR HELP AND YOUR PATIENCE. WE WILL BE WITH YOU AS SOON AS POSSIBLE.



Privacy Restriction

Patient Name: _____ Acct#: _____

Social Security #; _____ D.O.B.; _____

As your healthcare provider, I want you to understand that everything you tell me is confidential. New federal regulations require physician practices to keep your medical information private. Our practice *has* always guarded the privacy of our patients We only share your medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will not discuss your condition with anyone else (i.e., parents/guardian/spouse) without your approval in writing.

I understand the above statement AND ... (check one box below):

I want my medical information to remain confidential. I realize that if insurance is billed for all services provided, there is a chance that an insurance company may release information to the guarantor paying for my medical insurance.

I do not mind that my medical information is shared with the following: *

Name Address City, State, Zip Phone #

Name Address City, State, Zip Phone #

Name Address City, State, Zip Phone #

Name Address City, State, Zip Phone #

Patient Signature Date

NOTICE: *If you are in need of Emergency Treatment, and restricted health information (above) is needed to provide such treatment, we are allowed to use the restricted health information (above) to provide treatment to you:* _____

W. I. S. H.

In the last 12 months have you had any of the following:

		How	Current
	<u>Circle</u>	<u>Many</u>	<u>Treatment</u>
Yeast infections?	Yes/No	1 2 3 4 +	_____
Urinary tract infections?	Yes/No	1 2 3 4 +	
Vaginal or anal itching?	Yes/No	1 2 3 4 +	_____
Unusual/unexplained rashes, cuts or scratches in genital area?	Yes/No	1 2 3 4 +	_____
Pimples on your buttocks or lower back?	Yes/No	1 2 3 4 +	_____

Women's Institute for Specialized Health, PLLC

Date _____

2009

Doctor _____

PATIENT INFORMATION

Patient Name _____ first _____ Middle initial _____ Last _____ Email _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____ Cell #/Pager # _____

Date of Birth _____ Age _____ Social Security No. _____

Employer's Name and Address _____ Position: _____

Please Circle Marital Status: Married Single Divorced Widow

Husband's Name _____ Social Security No. _____

Employer's Name and Address _____ Work Phone # _____

Student Status ___ No ___ Full time ___ Part Time Do You Have A Living Will Or Power Of Attorney? Yes No

If under 18 years of age or full-time student please give name of person responsible for payment.

Primary Care Physician (PCP) _____

Referring Physician _____

PRIMARY INSURANCE INFORMATION

Policyholder _____ SS# _____ Relationship to Patient _____

Date of Birth _____ Employer _____

Insurance Company Name _____

Street Address _____ City _____ State _____ Zip _____

Group Name or Number _____ Insured's ID # _____

SECONDARY INSURANCE INFORMATION

Policyholder _____ Relationship to Patient _____

Date of Birth _____ Employer _____

Insurance Company Name _____

Street Address _____ City _____ State _____ Zip _____

Group Name or Number _____ Insured's ID # _____

Contact Person (Not in your household)

Name _____ last _____ First _____ Middle Initial _____

Street Address _____ City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Relationship to Patient _____

I authorize the release of medical information to the insurance company and payment of benefits to Women's institute for Specialized Health, PLLC. I agree to be responsible for my account and any collection fees incurred in obtaining payment.

Signed _____

Date _____