Patient Registration Form

PATIENTS INFORMATION

NAME (Last, First, MI)	BIRTH DATE	AGE	MARITAL STATUS

STREET ADDRESS	CITY/STATE	ZIP CODE

HOME PHONE	MOBILE PHONE	WORK PHONE

SSN	DRIVER'S LICENSE	E-MAIL (can we email you? Yes No)

RACE (required by insurance)	ETHNICITY (required by insurance)	PREFERRED LANGUAGE	PERSON/PLACE REFERRING YOU TO US

EMPLOYER	OCCUPATION	EMPLOYER ADDRESS

EMERGENCY CONTACT AND RELATIONSHIP	EMERGENCY CONTACT PHONE

PRIMARY CARE PHYSICIAN (Full Name, Phone Number, Fax)	PHARMACY (Name, Phone Number, Fax)

PRIMARY INSURANCE CARDHOLDER (if different from above)

NAME	RELATIONSHIP	BIRTH DATE	SSN

STREET ADDRESS	CITY/STATE	ZIP	HOME PHONE

EMPLOYER	EMPLOYER ADDRESS	WORK PHONE

INSURANCE INFORMATION

INSURANCE COMPANY	MEMBER ID# AND GROUP #	INSURANCE PHONE

RELEASE

☐ I would like for Modern Women's Care to leave messages providing test/procedure information or results on my voice mail/ answering machine only at the following telephone number(s):

☐ It's okay for Modern Women's Care to leave messages providing test/procedure information or results with the following person/people:

☐ I do not wish for Modern Women's Care to leave messages providing test/procedure information or results on my voice

Signature:_____ **Date:**_____**Relationship (if other than patient):** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

Our **Notice of Privacy Practices** describes in greater detail how your health information may be used and disclosed, and how you can access your information.

I would like a copy of the Notice of Privacy Practices **I do not want a copy of the Notice of Privacy Practices**

Sign:_____ **Date:**_____**Relationship (if other than patient):** _____

Health Questionnaire

Your answers on this form will help your health care provider understand your medical concerns and conditions better.
If something does not apply to you please write down either: no, never, or N/A.

Name:_____ Age:_____ Date:_____

Last Menstrual Period:_____Hysterectomy? ❒ Y ❒ N Marital Status: _____

Past Medical History (check all that apply)

❒ Anemia or Blood Disorder ❒ Birth Defects or Inherited Diseases ❒ Breast Cancer ❒Breast Problem

❒ Cancer ❒ Convulsions or Fainting ❒ Depression/Anxiety ❒ Diabetes ❒ Digestive Problems ❒ Ear Problems

❒ Eye Problems ❒ GI Problems ❒ HIV ❒ Heart Condition ❒ Hepatitis ❒ High Blood Pressure

❒ High Cholesterol ❒ Jaundice ❒ Kidney or Bladder Problems ❒ Lung Disorder or Asthma ❒Migraines

❒ Nose or Throat Problems❒ Ovarian Cancer ❒ Thyroid Problems ❒ Varicosities

❒Other (including any hospitalizations): _____

_____

Surgeries (List operations and dates)

_____ _____ _____

_____ _____ _____

Social History

Do you use tobacco? ❒ Not anymore (year stopped_____) ❒No ❒ Yes (packs/day__ year started____) Do you drink alcohol? ❒ No ❒ Yes (frequency: ❒ Occasionally ❒ < 3 times a week ❒ > 3 times a week) Do you currently use recreational drugs? ❒ No ❒ Yes

Current Drugs, Medications, and Vitamins

_____ _____ _____ _____

_____ _____ _____ _____

Allergies (List all drugs and/or medications you are allergic to, also list your reaction)

_____ _____ _____ _____

Family History

Mother

Living? Yes No (age of death_____, cause of death_____)

List health problems: _____

Father

Living? Yes No (age of death_____, cause of death_____)

List health problems: _____

Siblings (please indicate if brother or sister, their age, and health problems)

_____

_____

Children (please indicate if son or daughter, their age, and health problems)

_____

_____

Family History Continued: **Who?** (state if maternal and/or paternal side)

Breast Cancer? ☐ **Yes** ☐ **No** _____

Ovarian Cancer? ☐ **Yes** ☐ **No** _____

Colon Cancer? ☐ **Yes** ☐ **No** _____

Uterine Cancer? ☐ **Yes** ☐ **No** _____

Other: _____

Menstrual History

How old were you when you first got your period? (approximately)_____ Duration of periods (days): _____

How many days between periods?_____ Do you get your period every month? ☐ **Yes** ☐ **No**

Flow: ☐ **Light** ☐ **Medium** ☐ **Heavy** Menstrual Cramps: ☐ **Yes** ☐**No** Clots: ☐ **Yes** ☐**No**

If post-menopausal, age at menopause?_____Menopausal Symptoms: _____

Use of Hormone Replacement Therapy: ☐ **Yes** ☐ **No** How long on HRT?_____

Last Mammogram:_____Last Bone Density:_____Last Colonoscopy: _____

Pregnancies (include miscarriages and abortions)

Date	# of Fetuses	GA Weeks @ Delivery	Birth Weight	Sex	Delivery Type	Complications

Pap Smear

Date of last pap:_____Results: ☐ **Normal** ☐ **Abnormal** Any history of abnormal pap smears: ☐**Y** ☐**N**

Method of birth control **(including condoms)**_____ If pills, Name _____

Review of Systems (check all that apply)

☐ Vaginal Itching or Discharge ☐ Rectal Itching ☐ Loss of Urine Involuntarily ☐ Hot Flashes ☐ Abdominal Pain
☐Sexual Problems ☐Bleeding Between Periods ☐ Chest Pain/Palpitations ☐ Changes in Bowel Movement
☐ Extreme Menstrual Pain ☐ Breast Lump or Nipple Discharge ☐ Painful Intercourse

I authorize Modern Women's Healthcare to download my medication history? ☐ **Yes** ☐ **No**

List Below Any Problems You Wish To Discuss With The Doctor

_____

_____

Name _____

Date _____ Physician _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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Modern Women's Care

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Obstetrics, Gynecology, & Infertility

PATIENT FINANCIAL POLICY / ASSIGNMENT OF BENEFITS

Insurance Coverage

The patient or her legal guardian is ultimately responsible for all services incurred. Modern Women's Care will bill participating insurance plans if the patient provides the required insurance information and signs an Assignment of Benefits statement. All information given regarding the ability to pay, third party insurance, employment, etc., will be subject to verification. Patients with insurance policies that cover only portion of the services must pay the difference between the charges and anticipated insurance payment at the time the services are incurred.

Insurance claims are subject to eligibility, coverage and plan provisions which are determined by my insurance carrier. In some cases, certain services, supplies or medical care may be denied if found to be considered experimental, investigational or unproven by my carrier. I understand that I will be financially responsible for any denied or non-payable services rendered.

X_____
Initial

Non-covered Services/ Non-participating Insurance Plans/ Uninsured Patients

All charges for services covered by non-participating insurance plans and/or for non-covered procedures or provided to uninsured patients are required to be paid in full prior to the services being incurred.

X_____
Initial

Payment Methods

The following payment methods are accepted: cash, check, money order, credit cards and payment arrangements. Returned checks will be handled in accordance with Patient Financial Services Department NSF check procedures. A $35.00 bank fee will be assessed for each returned check.

In-House Payment Collection

All patient balances must be paid within 30 days of receiving the statement. Patients with unpaid delinquent accounts over 90 days old will be referred to outside collection and will be denied future services. If future services are requested, all services will be considered on a Fee for Service basis and payment in full will be required prior to time of service.

X_____
Initial

Referral for Outside Collection

Accounts that cannot be collected by Modern Women's Care will be referred to a collection agency, magistrate or attorney for further collection action in accordance with established guidelines as deemed appropriate by the Fair Debt Collection Practices Act. Any fess assessed will be the responsibility of the debtor.

X_____
Initial

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Obstetrics, Gynecology, & Infertility

PATIENT FINANCIAL POLICY / ASSIGNMENT OF BENEFITS (CONTINUED)

Refunds

Overpayments will be refunded to the appropriate party after review of the account. Any outstanding accounts receivable balance of $5.00 or under will be adjusted to zero. Any credits of $0.01 to $5.00 will not be refunded.

Assignment of Benefits

I authorize Modern Women's Care to release the requested and necessary information to my insurance company to complete my claim. I hereby authorize my insurance company to pay all my medical benefits directly to Modern Women's Care. X_____
Initial

Cancellation Policy

24-hour advance notice is required for cancellation or rescheduling of appointments. NO SHOW will result in a $25.00 charge on first occurrence and $50.00 for any preceding occurrence. X_____
Initial

"I have read, understand and agree to the above financial policy and assignment of benefits. I understand that charges not covered by my insurance company, as well as applicable copayment, co-insurance and deductibles are my responsibility."

_____ _____
Print Patient Name Date

_____
Signature

Modern Women's Care
Obstetrics, Gynecology, & Infertility

PATIENT PARTNERSHIP PLAN

Dear Patient,
Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings
I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, personal and family history. I understand I will need to complete these recommended health screenings (mammograms, immunizations, pap smears, etc.). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screening.

Keep Follow-up Appointments and Reschedule Missed Appointments
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan
I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs or tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____

Patient Signature Date

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.