REGISTRATION FORM

PATIENT INFORMATION

Last Name | Legal First Name | MI | Preferred Name

SS# _____ Date of Birth: _____ Age: _____

____ Single ____ Married ____ Widowed ____ Divorced Patient Employed By: _____

Address: _____ Work Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Work Phone: (___) _____

Cell: (___) _____ Referring Physician: _____

Email: _____ Pharmacy: _____

Spouse Name: _____ Pharmacy Location: _____

Phone: (___) _____

INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Name of Insured: _____	Name of Insured: _____
Insured DOB: _____	Insured DOB: _____
Policy ID#: _____	Policy ID#: _____
Group #: _____	Group #: _____
Insured SS#: _____	Insured SS#: _____
Employer Name: _____	Employer Name: _____

GUARANTOR / RESPONSIBLE PARTY

Name: _____ Relationship to Patient: _____

Billing Address: _____

SS#: _____ DOB: _____

Work Phone: (___) _____ Cell Phone: (___) _____

Employer: _____

AUTHORIZATIONS

**************PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST**************

- I hereby authorize and request the medical treatment necessary for the care of the above named patient.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow the fax transmittal of my medical records, if necessary.
- I acknowledge full financial responsibility for services rendered by Women's Health Care. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I understand that I am responsible for any un-met deductibles
  and co-insurances fees.
- I understand that insurance companies have agreements with certain laboratories for lab work and that it is my responsibility to know which laboratory my insurance authorizes and to inform the staff of Women's Health Care as to which laboratory my insurance covers.
- I further authorize and request that insurance payments be made directly to Women's Health Care.

I have read and fully understand the above consent for treatment, release of medical information, financial responsibility and insurance authorization.

_____ _____ _____

Patient / Parent or Guardian (Please Print) | Patient / Parent or Guardian Signature | Date

Medical Information

Patient Name: _____ **Email:** _____

Address: _____ **Phone:** _____

DOB: _____ **Height:** _____ **Weight:** _____ **Religion:** _____ **Race:** _____

Insurance: _____ **Policy #** _____

Primary Care Physician: _____

Pharmacy *(name and location):* _____

ALLERGIES *(Medication, foods, etc):* _____

Current Medications: _____

_____

Birth control (circle one): Nexplanon Pills Condoms IUD Depo Provera Other None

Name of birth control: _____ **Start date:** _____

Prescribed or placed by *(doctor's name):* _____

Smoking: *Ever smoked?* Y N *Presently smoke?* Y N *Packs per day?* _____ *How long?* _____
Drinking: *Past history?* Y N *Presently drink?* Y N *How much?* _____
Recreational Drug use: *Past History* Y N *Type:* _____

Medical conditions *(high blood pressure, diabetes, asthma, etc):* _____

_____

Surgeries _____

_____

Last pap: _____ History of abnormal pap: _____ History of STDs: _____
Last mammogram: _____ Bone Density: _____ Colonoscopy: _____

Obstetrical History

Total # of pregnancies -- # of **full-term pregnancies** _____ # of **preterm** deliveries _____
# of miscarriages _____ # of abortions _____ # of living children _____ Vag or C/S _____

Menstrual history: Age of first period: _____ 1st day of last period: _____

Family history *(cancer, high blood pressure, diabetes, etc):* Example: Mother - Breast cancer

_____

_____

Signature _____ **Date** _____

NOTICE OF PRIVACY POLICIES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Introduction

At WOMENS HEALTH CARE, P.C., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 8, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit WOMEN'S HEALTH CARE, P.C., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

Although your health record is the physical property of WOMEN'S HEALTH CARE, P.C., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

WOMEN'S HEALTH CARE, P.C. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, KATHY FOX at (478) 922-9136.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below.

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you when necessary.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information tht identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples may include but are not limited to medical students, outside laboratory company employees, medical record software and IT support personnel. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, your location, and general condition.

Communication With Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose, information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Director: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund-Raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and we are potentially endangering one or more patients, workers or the public.

Patient Signature _____ Date: _____