Women's
Integrated Healthcare, P.A.

PREGNANCY QUESTIONNAIRE

Name: _____ Date of Birth: _____

Is there a phone number where we can leave confidential messages such as test results/special instructions for today's visit as well as for future visits? If yes, phone number: _____ (mobile/home)

Marital Status: ☐ Single ☐ Partnered/Married ☐ Divorced ☐ Widowed ☐ Other
If you have a partner/spouse, what is his or her name? _____
Emergency Contact: _____ Phone Number: _____
Pediatrician's name: _____ Phone Number: _____

PAST OR CURRENT MEDICAL PROBLEMS					
(Please Check)	Yes	No	(Please Check)	Yes	No
Diabetes	☐	☐	Lung Problems, Asthma, Tuberculosis	☐	☐
High Blood Pressure	☐	☐	Breast Problems	☐	☐
Heart Disease	☐	☐	Rheumatoid Arthritis, Lupus	☐	☐
Autoimmune Disease	☐	☐	Urinary Incontinence	☐	☐
Kidney or Bladder Disease	☐	☐	Uterine Abnormalities	☐	☐
Neurologic Problem, Seizures	☐	☐	Migraines	☐	☐
Psychiatric Problems	☐	☐	Anxiety, Panic Attacks	☐	☐
Depression, Postpartum Depression	☐	☐	Herpes	☐	☐
Hepatitis, Liver Disease	☐	☐	Anemia, Blood Disorder	☐	☐
Trauma, Violence	☐	☐	Infertility	☐	☐
Thyroid Disorder	☐	☐	Allergies, Hay Fever, Chronic Sinusitis	☐	☐
Blood Transfusion	☐	☐	Sexually Transmitted Diseases	☐	☐
Chicken Pox	☐	☐	Abnormal Pap	☐	☐
Varicose Veins, Blood Clots in Veins	☐	☐	HIV	☐	☐

Other: _____

Details of positive responses_____
_____

MENSTRUAL HISTORY

Age at onset of mensus: _____ Cycle: _____ days (start to start) Usual duration: _____days
Flow: ☐ Light ☐ Medium ☐ Heavy Pain or Cramps? ☐ Yes ☐ No
LMP: _____ ☐ Definite ☐ Approximate (Month Known) ☐ Unknown

OBSTETRIC HISTORY

DATE (MONTH/YEAR)	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX (M/F)	TYPE OF DELIVERY	ANES	PLACE OF DELIVERY	PRETERM LABOR (YES/NO)	COMMENTS/ COMPLICATIONS

INFECTION HISTORY

1. High Risk Hepatitis B Immunized?	☐ Yes	☐ No	4. Chlamydia/ or Gonorrhea?	☐ Yes	☐ No
2. Live with someone with TB or exposed to TB?	☐ Yes	☐ No	5. Patient or partner with Syphilis?	☐ Yes	☐ No
3. Patient or partner has history of genital herpes?	☐ Yes	☐ No	6. Patient or partner with AIDS/HIV?	☐ Yes	☐ No

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PRENATAL GENETIC SCREENING/TERATOLOGY COUNSELING *Includes Patient, Baby's Father, or anyone in either family with any one of the following disorders:*		
1. Will you be 35 years old or older when the baby is due?	□ Yes	□ No
2. Thalassemia?	□ Yes	□ No
3. Neural Tube Defect, Spina Bifida (Open Spine), Anencephaly?	□ Yes	□ No
4. Congenital Heart Defect?	□ Yes	□ No
5. Down Syndrome?	□ Yes	□ No
6. Tay-Sachs?	□ Yes	□ No
7. Canavan Disease?	□ Yes	□ No
8. Sickle Cell Disease or Trait?	□ Yes	□ No
9. Hemophilia or Blood Disorder?	□ Yes	□ No
10. Muscular Dystrophy?	□ Yes	□ No
11. Cystic Fibrosis?	□ Yes	□ No
12. Huntington's Chorea?	□ Yes	□ No
13. Mental Retardation/Autism? If yes, was the person tested for Fragile X? □ Yes □ No	□ Yes	□ No
14. Other Inherited Genetic or Chromosomal Disorder?	□ Yes	□ No
15. Maternal Metabolic Disorder (eg. Type 1 Diabetes, PKU)?	□ Yes	□ No
16. Patient or Baby's Father had a child with birth defects not listed above?	□ Yes	□ No
17. Recurrent Pregnancy Loss or a Stillbirth?	□ Yes	□ No
18. Medications/Street Drugs/Alcohol since last menstrual period? If yes, Agent(s)? _____	□ Yes	□ No
19. Any Other? _____	□ Yes	□ No

To the best of my knowledge, this information is complete and accurate.

_____

Printed Patient Name

_____

Patient Signature Date

Thank you for selecting our healthcare team! We will strive to provide you with the best possible health care.
To help us meet all your healthcare needs, please fill out this form completely. Please print all information.

PATIENT REGISTRATION INFORMATION

Date: | **Soc. Sec. #:** | **Date of Birth:**

Name: | **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Other**

Address:

City, State, Zip:

Employer: | **Occupation:**

Employment Status: ☐ **Full-Time** ☐ **Part-Time** ☐ **Retired** ☐ **Self-Employed** ☐ **Unemployed** ☐ **Full-Time Student**

Phone: ( ) | **E-Mail Address:**

PRIMARY INSURANCE INFORMATION

Subscriber's Name:

Relationship to the Patient: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other (specify)**

Subscriber's Date of Birth:

Subscriber's Social Security:

Employer:

Member ID/Policy: | **Group #:**

Insurance Company:

Insurance Company Address: | **City, State, Zip:**

Insurance Company Phone:

PHARMACY INFORMATION

Primary Pharmacy Name:

Pharmacy Phone Number:

Pharmacy Address: | **City, State, Zip:**

Secondary Pharmacy Name:

Pharmacy Phone Number:

Pharmacy Address: | **City, State, Zip:**

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: | **Relationship:**

Emergency Contact Phone Number: ( )

AUTHORIZATION AND RELEASE

- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.
- I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.
- I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Patient Signature or Parent of Minor | Date

Women's Integrated Healthcare, P.A.
Financial Policy

Thank you for choosing our practice. We want to make every experience you have with us a positive one. Over the past few years, the practice of medicine has become more complicated for our physicians and patients alike, due to managed care rules and regulations.

Because of the growing complexity of the insurance business, we feel we can no longer assume that patients fully understand the relationship between the insurance company, the doctor, and themselves. In an effort to clarify this relationship, we have developed a set of guidelines regarding financial responsibility. If you have any questions, please speak with our insurance department. Please **check each box** of the following and sign at the end.

- ☐ ***You must present your insurance card prior to or at the time of your visit:*** If we do not receive your insurance card before you see the doctor, that visit becomes fee for service, and full payment is expected at that time.
- ☐ ***Co-Payments, Deductibles and Co-Insurance:*** A co-payment is a set dollar amount you owe for each office visit. Some insurance plans are subject to a deductible and co-insurance. You will be asked to pay your co-payment, deductible and co-insurance amount at the time of service if your deductible has not been met. We will verify if your deductible has been met with your insurance company prior to your visit. Co-insurance is the amount required by some insurance plans over and above the deductible amount.
- ☐ ***Laboratory and Pathology Fees:*** Many times it is necessary to obtain tissue or perform labs test to confirm a diagnosis or to determine a course of treatment. If any tissue is removed for a pathology examination or if a laboratory test (blood work, culture, etc.) is done in our office, the actual test is usually carried out by someone else. **THIS MEANS YOU WILL RECEIVE A SEPARATE BILL FROM ANOTHER DOCTOR, PATHOLOGIST, OR LAB FOR THESE TESTS.** We will attempt to use a service who files directly with your insurance carrier. Some plans do not specify a particular lab to use. It is also not uncommon for insurance carriers to change laboratory or pathology services several times in one year and not notify us immediately. Therefore, you are ultimately responsible for any bill you may receive from the laboratory or pathology service used. If you receive a bill from the lab, please contact that lab directly to resolve any billing concerns. If the lab will not file your claim for you directly, please attempt to file the claim yourself and pay the lab directly for the services.
- ☐ ***Forms of Payment:*** For your convenience, we accept cash, personal checks, MasterCard, Visa, Discover, and American Express.
- ☐ ***Returned Checks:*** All returned checks will result in a $30.00 NSF fee which will be applied to your account.
- ☐ ***Estimation of Services:*** We will be happy to give you an estimate of fees when this is possible. Please remember that we can only assure you of the estimated cost of a procedure on the day or the service when the doctor has determined the actual code being used. The estimate of our charges will not include work done by an outside lab or pathology service.
- ☐ ***Collection Efforts:*** We will make every effort to work with you to make payment arrangements should your bill become outstanding. If all efforts do not bring about a resolution of the account after several attempts, the account balance will be turned over to collections.
- ☐ ***No Show/Same Day Cancellation Fee:*** We will charge a fee of $25 for a no-show/same day cancellation fee.

I have read and understand the above completely and agree to comply with the financial polices of this office. My signature authorizes this office to file my claims and assigns to this office all rights, title and interest to my medical reimbursement benefits under my insurance policy. I understand that my signature also allows this office to release information regarding my visit to my insurance carrier**. I understand that I am responsible for my bills in the event the insurance company denies any claims.**

_____

Printed Patient Name

_____ _____

Signature of Patient (or Parent, if patient is a minor) Date

WOMEN'S INTEGRATED HEALTHCARE, P.A.
Cancellation and No Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to another patient.

Office appointments which are cancelled with less than 24 hours notification may be subject to a **$25.00 cancellation fee**.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as NO SHOW. Patients who Cancel/No-Show three (3) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (817-416-2229).

Please sign that you have read, understand, and agree to this Cancellation and No Show Policy.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

Women's Integrated Healthcare, P.A.
Prescription Policy

Women's Integrated Healthcare, P.A. is happy to help you with your health needs; which includes providing for needed medications for our patients. We do have certain guidelines for refilling the medications prescribed by our doctors.

- If you need a refill on your medication, we ask that you call your pharmacy and tell them which medication you need refilled and ask them to submit the request. (If you call us, we will direct you to the pharmacy.)
- We **do not** refill medications after business hours or on the weekends. Please make sure to contact your pharmacy before you run completely out of medication to allow ample time for the refill to be processed.
- **Please allow 24 to 72 hours to approve or deny and refill.** All refills are authorized by physicians, so we must have sufficient time to contact your physician for authorization.
- Our office has a "NO SHOW, NO MEDICATION" policy. Failure to show for your appointment will result in a denial for medication.

I have read and understand the above stated medication policy of Women's Integrated Healthcare, P.A.

_____ _____

Patient Signature Date

Women's Integrated Healthcare, P.A.

Consent for Release of Information

I, _____, authorize Women's Integrated Healthcare, P.A. to release my medical information, including lab results to the following person(s):

_____

Name-Print Date of Birth Relationship to Patient

_____

Name-Print Date of Birth Relationship to Patient

Expiration Date of Authorization
This authorization will remain effective unless revoked or terminated by the patient OR the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminated this authorization by submitting a written revocation to Women's Integrated Healthcare, P.A. You should contact the HIPAA Compliance Officer to terminate the authorization.

- ☐ I DO authorize for medical information to be left via voicemail or answering machine.
- ☐ I DO NOT authorize for medical information to be left via voicemail or answering machine.

Acknowledgement of Receipt

By my signature below, I acknowledge that I have received the Women's Integrated Healthcare, P.A. *Notice of Privacy Practices* on or prior to ANY service being provided to me by Women's Integrated Healthcare, P.A. following September 10, 2015.

_____
Patient's Initials-I have received the HIPAA booklet.

_____
Name of Patient (Please Print)

_____
Signature of Patient Today's Date

_____
Signature of Patient's Representative Today's Date