Women's
Integrated Healthcare, P.A.

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

Waiver of Financial Responsibility for Annual/Well Woman Exam

Today's Date: ____/____/____

Your Annual/Well Woman Exam includes a comprehensive preventative examination and management of an individual. This includes a gender and age specific history, examination, counseling, risk reduction, and the ordering of specific laboratory and diagnostic procedures.

Any other symptoms, complaints, or health concerns that require additional evaluation and counseling are not covered by your insurance. If you choose to address these issues at this visit, there will be an additional charge for which you may be billed by your insurance provider.

Please be aware that most insurance companies limit coverage of "wellness" labs. Typically, the only labs that will be covered by your insurance company are a complete blood count (CBC), a complete metabolic panel (CMP), and a lipid panel to check cholesterol. Pap test and HPV testing will be determined by your physician and will be in accordance of ACOG guidelines.

Urine analyses, vaginal cultures, thyroid testing, hormone testing, vitamin D testing, STD testing, etc. would normally go towards your deductible or could possibly not be covered if drawn during a preventative care visit. We do not know your laboratory benefits and we cannot change diagnosis codes for coverage of these tests.

Any additional lab testing recommended by the physician or requested by the patient may incur separate charges that will be the responsibility of the patient. We apologize for any inconvenience that this may cause.

By signing, I understand that I am financially responsible for any lab work ordered during my annual/well woman exam.

_____
Patient Printed Name

_____ _____
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

Women's
Integrated Healthcare, P.A.

ANNUAL QUESTIONNAIRE

Patient Name:

Date of Birth: | Age:

Primary Care Physician

PAST MEDICAL HISTORY

1.	Seizures, Stroke, Phlebitis, Blood Clots	☐ Yes	☐ No
2.	Depression, Emotional Problems	☐ Yes	☐ No
3.	Thyroid Disease, Goiter	☐ Yes	☐ No
4.	Heart Problems, Murmur, Rheumatic Fever	☐ Yes	☐ No
5.	Chest Pain, Difficulty Breathing, Asthma	☐ Yes	☐ No
6.	High Blood Pressure	☐ Yes	☐ No
7.	Anemia (Low Iron)	☐ Yes	☐ No
8.	Breast Lump, Nipple Discharge	☐ Yes	☐ No
9.	Diabetes	☐ Yes	☐ No
10.	Gastrointestinal Disease	☐ Yes	☐ No
11.	Do you perform self-breast exams?	☐ Yes	☐ No
12	Have you ever had a mammogram?	☐ Yes	☐ No
13.	Bladder, Kidney Infections	☐ Yes	☐ No
14.	Do you ever "lose" urine when coughing/laughing/sneezing?	☐ Yes	☐ No
15.	Cancer? Type_____	☐ Yes	☐ No
16.	Allergies to medication? If yes, list:_____	☐ Yes	☐ No
17.	Any other medical problems or concerns? _____	☐ Yes	☐ No
18.	Have you ever received any medical care within the last year? If yes, what? _____	☐ Yes	☐ No
19.	Are you currently taking any medications? If yes, what? _____	☐ Yes	☐ No
20.	Any past surgical procedures? If yes, please list below:	☐ Yes	☐ No

Date	Procedure	Hospital

PAST GYN HISTORY

21.	Frequent Vaginal Infections	☐ Yes	☐ No
22.	Unusual Vaginal Discharge, Odor, Itching	☐ Yes	☐ No
23.	Gonorrhea, Chlamydia, HIV, Syphilis	☐ Yes	☐ No
24.	Herpes, HPV	☐ Yes	☐ No
25.	Infection in Tubes, Ovaries, Uterus	☐ Yes	☐ No
26.	Pain or Bleeding with Intercourse	☐ Yes	☐ No
27.	Missed or Unusual Periods in the Last Year	☐ Yes	☐ No
28.	Severe Menstrual Cramps	☐ Yes	☐ No

29.	Ovarian Cyst	□ Yes	□ No
30.	Uterine Growths (Fibroids, Polyps)	□ Yes	□ No
31.	Abnormal Pap Smears	□ Yes	□ No
32.	If yes, what type of treatment have you had for an abnormal pap smear? □Cryro (Freezing of the Cervix) □LEEP (Loop Electrical Excision Procedure □Other	□ Yes	□ No

REPRODUCTIVE HISTORY

33.	How old were you when you first started getting your period? _____
34.	How many days do your periods last? _____
35.	Do you have a period every month? _____
36.	How would you describe your flow? □ Heavy □ Medium □ Light
37.	Are your cramps: □ Mild □ Moderate □ Severe □ None
38.	Do you ever miss work and/or school because of heavy bleeding/cramping? How many days during your period? _____
39.	What was the first day of your last menstrual period? _____

PREGNANCY HISTORY

40.	Do you think you might be pregnant? □ Yes □ No
41.	Have you ever been pregnant? □ Yes □ No *If yes, please complete the following pregnancy history:*

42.

Age of First Pregnancy	Total Number of Pregnancies	Number of Births	Number of Births Living Now	Number of Still Births	Miscarriages	Induced Abortions

43.	Have you had an ectopic (tubal) pregnancy?	□ Yes	□ No	
44.	Have you ever had a C-Section?	□ Yes	□ No	
45.	Have you ever had a vaginal birth after C-Section?	□ Yes	□ No	
46.	Were you diagnosed with gestational diabetes with any of your pregnancies?	□ Yes	□ No	

47.

Month/Year of Delivery	Baby's Weight	Month/Year of Delivery	Baby's Weight
a.		e.	
b.		f.	
c.		g.	
d.		h.	

SEXUAL HISTORY

(May Answer "N/A" if this section is "Not Applicable" to you.)

48.	Are you currently sexually active?	□ Yes	□ No
49.	Age at first Intercourse? _____		
50.	How many sexual partners have you had to date? _____		
51.	Does your partner use a condom? □ Every time □ Sometimes □ Never		
52.	Do you feel comfortable discussing "safe sex" with your partner(s)? □ Yes □ No		
53.	Do you have any questions/concerns about your sexuality? □ Yes □ No If yes, what? _____		

CONTRACEPTIVE HISTORY

54.	What method of birth control have you used? (Please Check) □ Pills □ Condoms □ Depo Provera □ Nexplanon/Implant □ Diaphragm □ IUD □ Withdrawal □ Natural Family Planning □ Sterilization □ Foam/Gel □ Abstinence
55.	Are you using a method(s) of birth control now? □ Yes □ No

	If yes, what kind(s)? _____			
56.	Have you had any problems? _____			
57.	What method would you like to consider using in the future? _____			
58.	Do you plan to have children within the next year? □ Yes □ No If yes, ask your physician about pre-conceptual concerns.			
SOCIAL HISTORY				
59.	Have you ever been battered, injured, slapped?		□ Yes	□ No
60.	Have you had all of your immunizations?		□ Yes	□ No
61.	Have you ever been tested for HIV?		□ Yes	□ No
62.	Do you use street drugs?		□ Yes	□ No
63.	Do you smoke?		□ Yes	□ No
64.	Do you realize that smoking and birth control pills can cause blood clots, heart attack, and cardio vascular disease?		□ Yes	□ No
65.	Do you drink alcohol? If yes, how much? _____		□ Yes	□ No
66.	Do you have any tattoos or body piercings?		□ Yes	□ No
FAMILY HISTORY				
67.	Have your parents, siblings, or grandparents had any of the following?			Who
	Heart Attack Under Age 50	□ Yes	□ No	
	High Blood Pressure	□ Yes	□ No	
	Breast Cancer	□ Yes	□ No	
	Uterine Cancer	□ Yes	□ No	
	Colon Cancer	□ Yes	□ No	
	Ovarian Cancer	□ Yes	□ No	
	Diabetes	□ Yes	□ No	
	Genetic Problems/Birth Defects	□ Yes	□ No	
	Stroke	□ Yes	□ No	
	Alzheimer's	□ Yes	□ No	
	Osteoporosis	□ Yes	□ No	
	Blood Clots	□ Yes	□ No	

PHARMACY INFORMATION	
Name of Pharmacy	
Address	
City, State, Zip	
Phone Number	

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

_____

Printed Patient Name

_____ _____

Patient Signature/Parent of Minor Signature Date