Name:_____Date:_____Marital Status:_____

Date of Birth:_____/_____/_____ Race:_____ Preferred Language:_____

Social Security No:_____-_____-_____

Address:_____City:_____State: _____Zip:_____

Home Phone:_____ Cell Phone:_____Email:_____

Patient's Employer:_____Phone : _____

Spouse's Employer:_____Phone :_____

Referring Physician:_____Phone:_____

Primary Care Physician:_____Phone:_____

Emergency Contact:_____Phone_____

Local Pharmacy_____Address (Cross Streets):_____Phone:_____

Is it OK to leave medical information on your answering machine or voicemail? ◯ ***YES*** ◯***NO***

You authorize us to share your Protected Health Information with the following person(s) (until you notify us otherwise):

Name:_____Relationship:_____DOB:_____/_____/_____

Name:_____Relationship:_____DOB:_____/_____/_____

Primary Insurance:_____

ID Number:_____ _Group Number_____

Policy Holder's Name:_____

DOB:____/_____/_____ Social Security No:____-___-___

Secondary Insurance:_____

ID Number:_____ _Group Number_____

Policy Holder's Name:_____

DOB:____/_____/_____ Social Security No:____-___-___

Please carefully read and sign both statements below:

It is understood that I, or we, will be responsible for all charges incurred on this account, to include all present and future services. I understand that regardless of the insurance coverage that I may have, I am responsible for paying all charges. In event of non-payment of charges for the services rendered, I agree to pay all costs of collection, including reasonable attorney's fees. I have read this agreement and do understand its provisions.

Patient or Responsible Party_____Date_____

I hereby authorize Women's Health Now to send me newsletters, bulletins, and other documents via email. I understand the Women's Health Now will not share my email address with any other person or agencies with my express written consent. This authorization will remain in effect until I revoke thi authorization.

Patient or Responsible Party_____Date_____

Patient Medical Information
Check in Sheet

Name_____ **DOB**_____ **Date** _____

Height: Feet_____ Inches_____

1. What is your reason for today's visit?
   _____
   _____

2. Are you allergic to any medications? ____
   If yes, please list and reaction:
   _____
   _____
   _____

3. What medications are you taking? Please list with dosages:
   _____
   _____
   _____
   _____
   _____

Contraception	***Bleeding***	***Paps***	***Breast Cancer***
What is your current form of birth control? _____ Condoms? Yes No	When was your last period? _____ Number of days between periods?_____	Date of your last pap _____ Normal Abnormal	Date of your last Mammogram _____ Normal Abnormal If abnormal, what?_____ _____
Sterilization: Male Female	Number of days of flow?_____	Have you ever had an abnormal pap? Yes No	Do you perform self-breast exams? Yes No
IUD: Yes No If yes, what type? _____	Heavy? Yes No	Treatment? Yes No	How often do you perform self-breast exams? Monthly Occasionally Never
Birth Control Pills: Yes No If yes, what type? _____	Are your periods regular? Yes No	If yes, type? Date: Leep_____ Colposcopy_____	Other?_____
Injection? Yes No If yes, what type? _____	Do you have pain with your periods? Yes No	Laser_____ Cryotherapy_____	***Smoke*** Do you smoke? Yes No If yes, how often? _____
Other?_____	Do you have bleeding in between your periods? Yes No	Other?_____	

4. Please mark any condition that you have or have had in the past:

Have you ever had:	Yes/Date Diagnosed		Yes/Date Diagnosed		Yes/Date Diagnosed
Epilepsy		Kidney Disease		Gonorrhea	
Heart Disease		Hepatitis		Chlamydia	
Heart Attack		Thyroid Disorder		Syphilis	
Heart Murmur		Bowel Disease		Genital Herpes	
Stroke		Arthritis or Lupus		HIV/AIDS	
Blood Disease		Depression		**Recurrent Urinary Tract Infections**	
Blood Clots		High Blood Pressure		**Bacterial Vaginosis (BV)**	
Anemia		Scarlet Fever		Scarlet Fever	
Diabetes		Chicken Pox		Syphilis	
Asthma		Rheumatic Fever		Trichomonas	
Migraine Headaches		Type of Cancer		Pelvic Inflammatory Disease (PID)	
Other		Breast Cancer		Human Papillomavirus (HPV)	

Pregnancy History

Total Pregnancies _____ Deliveries _____Miscarriages _____ Abortions _____

Year of Delivery	Vaginal, C-Section or Miscarriage, Abortions

Past Surgical History

Date of Surgery	Type of Surgery

Family History

1. Were you adopted? ☐Yes ☐No

No Family History ☐

Has any blood relative ever had any of the following?

Relationship to You	Maternal (Mom's Family)	Paternal (Dad's Family)	Age at Diagnosis	Disease Yes/No	Deceased Yes/NO
				Breast Cancer	
				Ovarian Cancer	
				Colon Cancer	
				Osteoporosis	
				Stroke	
				Heart Attack	
				Diabetes	
				Blood Clots	
				High Blood Pressure	
				Other	

WOMEN'S HEALTH NOW, P.L.L.C
Notice of Privacy Practice

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

Women's Health Now, P.L.L.C "Practice is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office; a record is made that describes the treatment and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present, or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information. Privacy Practices and examples of how your information may or disclosed.
The practice will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in prominent locations. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present, or future.

The practice may use individually health information for the following purpose without your authorization.

1. ***Treatment:*** We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as spouse, children, or parents.
2. ***Payment:*** We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting your over the phone or through the mail about balances to a collection agency.
3. ***Health Care Operations:*** We may use and disclose health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing, or to identify you by name when you visit the office.
4. ***Appointment Reminders:*** We may use and disclose your information to remind you of appointments. We may also mail you a reminder for a follow-up visit.
5. ***Treatment Options:*** We may use your health information to inform you of treatment options or other health-related services we offer that may be of interest to you.
6. ***Business Associates:*** We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as after-hour telephone answering, billing or quality assurance. Our Business Associates agree to protect the privacy of our information.

The practice may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases.
- For worker's compensation or similar programs as required by law.
- To authorities when we suggest abuse, neglect, or domestic violence.
- To health oversight agencies.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- To medical examiner, coroner, or funeral director.
- For facilitation of organ, eye, or tissue donation if you are an organ donor.
- For research purposes under strictly limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.

The practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. The practice may leave messages for you at home or work about your visits or test results. If you do not want us to do so, please inform our Privacy Officer in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you request your records to be released, the practice will provide you with an authorization form to complete and return to the address listed on it.

Your health records are the physical property of the practice. The information contained in it belongs to you. Below is a list of your rights regarding individually identifiable health information:
All requests related to these items must be made in writing to our privacy officer at the address listed below. We will provide you with appropriate forms to exercise these rights. We will notify you if your requests cannot be granted.

1. *Restitution on Use and Disclosure:* You have the right to request restitution on how we disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals or entities involved in your care as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. *Confidential Communications:* You have the right to request we communicate with you particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. *Access:* You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointment for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances we may deny your records to inspect and/or copy records. You may request a review of the denial.
4. *Records Amendment:* You have the right to request amendments to your health records created by and for this Practice if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request you have the right to provide a statement of disagreement.
5. *Accounting of Disclosures:* You have the right to receive an accounting of disclosures. This means you may request a list of certain disclosures the practice has made of your records. Upon you request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. *Copy of Notice:* You have the right to request that we provide you with a paper copy of this notice of Privacy Practice.

If you have questions about this notice, please contact Practice Privacy Officer at Women's Health Now, P.L.L.C practice location in Queen Creek, Arizona. If you feel your privacy rights have been violated you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

I have received a copy of this office's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, and protected.

_____ _____

Printed Patients Name | Name/Relationship if signed by individual other than patient

_____ _____

Signature | Date

*******FOR OFFICE USE ONLY*******

Consent for Treatment and Insurance Authorization/Financial Responsibility

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy. The patient or authorized person agrees that the demographic information is correct and allows for the medical treatment as specified by physician or associate provider.

I hereby authorize Women's Health Now to furnish information to insurance carriers concerning my illness and treatment and I hereby assign the physician ALL insurance payments for medical services rendered to myself or my dependents. I understand that I am responsible for ANY unpaid amounts, and agree to pay service charges at the current rate, collection charges, and accounts that become 30 days overdue are subject to a 10% charge. Should balances not be paid within 60 days, there will be an additional $30 charge and you will be referred to a collection agency. There will be a $25 charge for returned checks and all future payments will be by credit, debit card, money order or cash. Patients with outstanding balances of 60 days overdue must make arrangements for payment prior to scheduling appointments.

Your insurance may or may NOT pay for well woman exams or routine preventative services.
Insurance: We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all the charges. We are legally obligated to assign procedure codes based on the service provided to you, whether it is a well woman exam or a visit to take care of problems, or both. If both kinds of services are provided during a single visit, then both services may be billed. We cannot change the coding later to cause insurance to pay for a non-covered service. Depending on your insurance coverage, you may be responsible for paying a copay for each service. Based on the kind on coverage you have, some or all of this cost may have to be billed to you. It is your responsibility to be familiar with your insurance benefits. You agree to contact your insurance provider if you need help understanding your benefits. You are responsible for notifying our office of all insurance changes including any secondary insurance. If you do not inform the office, you will be responsible for any remaining balances.

Office visits, consults, treatments and procedures with the physician are SEPARATE charges from any laboratory testing that is determined to be medically necessary or performed as a matter of course in the examination. Examples of these are blood tests, urinalysis, pap smears, cultures, biopsies, or any other test that involves taking bodily fluid or tissue specimen. These are sent to a laboratory with the resulting charges that are separate from Women's Health Now and it is possible based on your insurance or cash pay status that you may get a bill from the laboratory for which you agree to be responsible. Lab fees are additional fees billed out separately. You will inform the back office or phlebotomist if insurance requires use of a specific lab other than LabCorp or Sonora Quest.

I agree that for disability forms, FMLA forms, paperwork, etc., there is a $25 fee per set of forms.

Appointments: If I am unable to keep an appointment, procedure or ultrasound, a 24 hour notice is required or a $25 charge will be made for each missed appointment or $50 for each missed ultrasound. A $100 charge will be made for missed surgery appointments. Excessive abuse of scheduled appointments will result in discharge from the practice.

I have read and understand the Women's Health Now Consent and Financial Responsibility. If my account is sent to collections, I agree to pay the amount I owe plus the fees charged by the collection agency for costs of collections.

Signature of insured: _____ Date: _____

Print Name: _____