THE GROUP FOR WOMEN
PATIENT INFORMATION SHEET

TGFW ACCOUNT #:______________________ **DATE:**__________

NAME:______________________________ Preferred Name:______________
Last First Middle Initial

DOB:__________ FEMALE ☐ MALE ☐ S.S.N:______________ MARITAL STATUS: M ☐ S ☐ W ☐ D ☐

RACE: ☐ American Indian/Alaska Native ☐ Nat Hawaiian/Pacific Islander
☐ Asian ☐ Other Race
☐ Black/African American ☐ White

ETHNICITY: ☐ Hispanic or Latino
☐ Not Hispanic or Latino

ADDRESS:______________________________ APT/UNIT#:__________

ZIP:__________ CITY:____________________ STATE:__________

HOME PHONE:______________ WORK PHONE:______________ CELL:______________

EMAIL: ______________________________

PREFERRED COMMUNICATION: ☐ Home ☐ Work ☐ Cell ☐ Mail

PHARMACY NAME:______________________________ PHONE #:______________

ADDRESS:____________________ CITY:__________ STATE:__________ ZIP:__________

EMERGENCY CONTACT INFORMATION:

NAME:______________________________ RELATIONSHIP:______________
Last First Middle Initial

ADDRESS:______________________________ DATE OF BIRTH:______________

EMPLOYER:______________________________

HOME PHONE:______________ WORK PHONE:______________ CELL:______________

FINANCIAL RESPONSIBLE PARTY (If other than the patient)

NAME: ______________________________ RELATIONSHIP:______________
Last First Middle Initial

ADDRESS: ______________________________ DATE OF BIRTH: ______________

HOME PHONE: ______________ CELL: ______________ WORK: ______________

PRIMARY INSURANCE:______________________

POLICYHOLDER'S NAME:______________________________ SSN:______________

DOB:______________ RELATIONSHIP:______________

SECONDARY INSURANCE:______________________

POLICYHOLDER'S NAME:______________________________ SSN:______________

DOB:______________ RELATIONSHIP:______________

PRIMARY CARE PHYSICIAN (The doctor you see regularly)

FAMILY PHYSICIAN:______________________________ OFFICE PHONE:______________

ADDRESS:____
Street City State Zip

REFERRAL PHYSICIAN: (If you are being referred by a Doctor other than your PCP)

PHYSICIAN:______________________________ OFFICE PHONE:______________

ADDRESS:____
Street City State Zip

AUTHORIZATION FOR TREATMENT / ACCIDENTAL EXPOSURE / FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

1) – I hereby apply for treatment by the health care providers at The Group For Women. Such treatments may include ultrasounds, biopsies, and such other procedures as they deem necessary. I further understand that it is my responsibility to be familiar with the Notice of Privacy Practices (NPP) which spells out how my Protected Health Information may be used. This NPP is available for review and the Written Acknowledgment Form will be kept in your record. If health care workers accidentally expose themselves to my body fluids, I agree to have my blood tested for any infectious disease that can be transmitted by exposure to blood and/or body fluids.

By signing below you acknowledge reading and complying by the above statements.

Signature of Patient/Guarantor:______________________________ **Date:**____________

Printed Full Name:______________________________

Witness:______________________________ **Date:**____________

2) – Notice of Deemed Consent to HIV Blood Testing: A law was enacted in Virginia in 1989 which authorized health care providers to test their patients for HIV antibodies when the health care provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies pursuant to this provision, and the testing would be explained to you and you would be given the opportunity to ask any questions you might have.

I have read and understand the above "Notice of Deemed Consent to HIV Blood Testing".

Signature of Patient/Guarantor:______________________________ **Date:**____________

Printed Full Name:______________________________

Witness:______________________________ **Date:**____________

3) –Financial Policy: I understand that my insurance policy is a contract between me and my insurance carrier and those co-payments and deductibles that have not been satisfied are the responsibility of the patient/guardian and **payment is expected at the time services are rendered.** For **Self Pay,** a standardized payment formula will be used for office visits and procedures conducted in the office. A minimum of **$150** is expected prior to seeing the doctor. A pre-established standard deduction will be applied by The Group For Women to the office visit / procedure charge. For self-pay patients when surgery is required, a 50% down payment is expected at a minimum one week prior to the elective surgery date. The remainder of the payments will be expected within 30 days, unless other payment arrangements are made. In the event of default, I agree to pay the balance and all reasonable costs of collections, including agency and/or attorney fees, up to **37%** of the total amount due if turned over to collections. I acknowledge that this form is being signed in either Norfolk, VA, or Chesapeake, VA, and that services are being performed in either Norfolk, VA, or Chesapeake, VA and should a suit become necessary to collect on this account that court filings will be in either Norfolk, VA or Chesapeake, VA.

By signing below you acknowledge reading and complying by the above statement.

Signature of Patient/Guarantor:______________________________ **Date:**____________

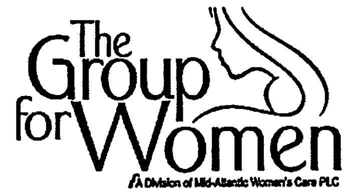
Printed Full Name:______________________________

Witness:______________________________ **Date:**____________

Last Name: ______________________________

First Name: ______________________________

Birthdate: ______________________________



The Group for Women Office Policy

Thank you for choosing The Group for Women. We are committed to providing you the best service we can.

FINANCIAL: Unless valid insurance is presented, you are responsible for payment in full at the time of your visit. Your co-payment, deductibles, and/or your co-insurance cost are to be paid at the time service is rendered. Any remaining balance after your insurance has paid is also your responsibility. Your services may require a referral or authorization prior to being rendered. If required, you are responsible for securing that referral authorization. Some medical services may not be covered by your insurance. You are responsible for payment of any services your insurance company does not cover for any reason. Please be aware that some visits performed by our nursing staff, without seeing a physician, are considered an office visit and fees will be generated accordingly.

MESSAGES: As a service to our patients, we may send you appointment reminders and possibly other important messages. By providing your email address and/or phone number(s), you consent to receive messages by such means.

PRESCRIPTION REFILLS: We ask that all refill requests be processed through your pharmacy. Your pharmacy can still request a refill even if you have no refills remaining. Please request your routine refill requests at least 48 hours in advance.

FORMS: To ensure we are able to meet your needs please submit any request for any forms completion at least 10 days in advance. There is a $15 charge for standard Disability forms to be paid at the time the form is completed and prior to the form being released via fax, in person or mail.

MEDICAL RECORDS: We are happy to provide you with a copy of your medical records upon completion of a Medical Records Release form in compliance with the HIPAA privacy regulations. At your request we will generally send your records directly to your requested provider without fee. If you would like a physical copy of your records a copying fee will apply. Our fee for coping is regulated by the state of Virginia and in part is based on the number of copies. You may request an estimate of the fee in advance.

NO-SHOW, LATE ARRIVALS AND CANCELLATION POLICY: Should you arrive late for an appointment, please be aware that you may be required to reschedule or you may have to wait to be seen between or after the other patients who have arrived at their scheduled time.

Appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. At least 24 hours advance notice is required if you are not able to keep your appointment. Patients will not be charged for an office visit if cancellation is made 24 hours prior.

In the event an appointment is missed (no show) a fee of $25.00 may be billed. We reserve the right to terminate the patient-doctor relationship if you miss multiple appointments.

We reserve an extended amount of time for ultrasounds and procedures. Therefore a fee of $25.00 will be charged for each missed ultrasound and procedure appointment.

FEEDBACK: We appreciate you choosing The Group for Women to care for you. Your satisfaction is very important to us. If at any time you have questions, issue, or concern we want to answer your questions and address any concern you may have. Please contact us at 757-466-6350 so that we may do so. If you believe your concern remains inadequately addressed after discussing them with us you agree to provide The Group for Women a written copy of your unresolved concern.

We reserve the right to modify these policies without providing direct notification.

My signature below indicates that I have read, understand and agree to the terms of these policies.

______________________________ X ______________________________

Patient or Responsible Party printed name | **Patient or Responsible Party Signature**

Date ______/______/______

Last Name: ______________________________

First Name: ______________________________

Date of Birth: ______________________________

Privacy Options

- ☐ I want **NO ONE** to receive my Personal Health Information except for myself.
- ☐ I request the following person(s) **BE ALLOWED** access to my Personal Health Information:

______________________ ______________________

______________________ ______________________

______________________ ______________________

Please Sign

Patient's Name (Print Last, First)	**Patient's Signature**	**Date**

If you are signing on behalf of the patient, please complete this section:

Representative's Name (Print)	*Representative's Signature*	*Date*

Reason Patient Cannot Sign

*** Office Use Only ***

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgement and the reason you could not obtain it:

____

____

____

The Group For Women

Name____________________ Age________ Date________
Social Security #__________ Referred by__________ Primary Care Physician__________
Reason for Today's Visit____________________

Last Menstrual Period ______/______/______ Contraception__________
Last Pap Smear________ □ normal □ other__________ yes/no history of abnl Pap smear, year________
Last Mammogram__________ Results__________
Bone Densitometry__________ □ normal □ other__________ Colonoscopy: □ no □ yes; year______
Menstrual History: cycle length__________ duration__________ flow □ min □ mod □ heavy □ clots
Cramps □ none □ mild □ mod □ severe other:__________
Obstetrical History: How many pregnancies__________ Living children__________
Vaginal__________ C/Sections__________ Miscarriage__________ Elective Terminations__________

MEDICAL HISTORY □ No changes since last visit (established patients only)
Do you or any family members have a history of any of the following:

	Yourself	Family		Yourself	Family		Yourself	Family
Anemia	□	□	GERD	□	□	Rheum. Arthritis	□	□
Arthritis	□	□	Heart Disease	□	□	Seizures	□	□
Asthma	□	□	Hepatitis	□	□	Sexually Transmitted Diseases	□	□
Breast Cancer	□	□	HIV	□	□	Stroke	□	□
Cancer ________	□	□	High Blood Pressure	□	□	Thyroid	□	□
Colon Disease	□	□	Hypercholesterolemia	□	□	Tuberculosis	□	□
Depression	□	□	Irritable Bowel Syndrome	□	□	Ulcers	□	□
Diabetes	□	□	Kidney Disease	□	□	Urinary Problems	□	□
Diverticulosis	□	□	Lung Disease	□	□			
Deep Vein Thrombosis	□	□	Migraines	□	□	Urinary Tract Inf	□	□
Endometriosis	□	□	Osteoporosis	□	□	Vascular Disease	□	□
Fibromyalgia	□	□	Ovarian Cancer	□	□	Other __________		

SURGICAL HISTORY □ No changes since last visit (established patients only)
□ Tubal Ligation _____ no _____ yes; year________ □ Dilation and Curettage for __________ year(s)________
□ Hysterectomy: type _____ vaginal _____ abdominal _____ laparoscopic _____ year __________
□ Ovaries Removed _____ both _____ right _____ left via □ laparoscopic □ laparotomy for __________ year ___
□ Cervix removed _____ yes _____ no □ Laparoscopy: year __________ findings __________
□ Appendectomy year__________ □ Cholecystectomy via □ laparoscopic; year ________ □ laparotomy; year _____
□ Tonsils & Adenoidectomy; year ________ □ Breast Reduction; year ________ □ Breast Augmentation; year _____
□ Other ____________________

Medications (use back of page for additional space if needed)

Medicine Name	Dosage	How many times a day?

Allergies to Medications (Please list medicine with symptoms) (use back of page for additional space if needed) Allergy to Latex □ Yes □ No

____
____
____

SOCIAL HISTORY

Do you smoke?	□ Yes	□ No	How much?__________	How long?__________
If no, did you previously?	□ Yes	□ No	How much?__________	How long?__________
Do you drink alcohol?	□ Yes	□ No	How much?__________	How long?__________
Do you use drugs?	□ Yes	□ No	How much?__________	How long?__________
Do you use caffeine?	□ Yes	□ No	How much?__________	
Do you wear glasses?	□ Yes	□ No	Contacts? □ Yes □ No Hearing aid? □ Yes □ No	Dentures? □ Yes □ No

Marital Status ____M____S____D____W____Sep □ type of employment__________

Name:
Chart:
Date:

Review of Systems:
Please circle symptoms that you are currently experiencing and have not addressed with another physician:

Constitutional:	weight loss	weight gain	fatigue	insomnia
Eyes:	double vision	vision change	dry eyes	
ENT/mouth:	nose bleeds	sore throat	dental problems	change in hearing
Cardiovascular:	chest pain	rapid heartbeat	palpitations	varicose veins
Respiratory:	wheezing	chronic cough	short of breath	coughing up blood
Musculoskeletal:	weakness	joint pain	stiff joints	back pain
Neuro/Psych:	fainting sadness	dizziness anxiety	numbness mood swings	headache crying spells
Endocrine:	excess thirst	hot flashes	night sweats	unwanted hair
Breast:	pain in breast	lump in breast	breast discharge	
Skin:	rash	hives		
Gastrointestinal:	diarrhea indigestion	blood in stool hemorrhoids	constipation bloating	pain in abdomen nausea/vomiting
Urologic:	urgency loss of urine	painful urination >2 nighttime voiding	blood in urine incomplete emptying	frequent urination wearing pads
Gynecological:	period heavy pelvic pain bleeding after intercourse genital lump vaginal odor	late periods prolonged periods bleeding between periods	painful periods painful intercourse genital itching	irregular periods vaginal discharge vaginal dryness

Are you a victim of domestic violence? YES NO

Your Signature ______________________________ Date ______________
Thank you for completing this form; this information is now required by your insurance.

M.D. Comments: ______________________________

Reviewed by: ______________