MID-ATLANTIC WOMEN'S CARE, PLC

PATIENT REGISTRATION

Patient Name: _____
Patient Sex: _____
Patient DOB: _____ Age: _____
Patient SSN: _____ - _____ - _____
Address: _____
City: _____ State: ____ Zip: _____
Race: _____
Ethnicity: Not Hispanic or Latino **Language:** _____

Home Phone: **(_____) _____- _____**
Cell Phone: **(_____) _____- _____**
Work Phone: (_____) _____- _____
Email: _____
Marital Status: _____
Preferred Method of Contact: Home / Work / Mobile
Primary Care Provider: _____
_____

EMERGENCY CONTACT

Emergency Contact:_____ _____
Phone:_____
Relation:_____

PATIENT'S EMPLOYMENT

Name of Employer:_____
Phone: (_____) _____- _____
Occupation: _____

PRIMARY INSURANCE INFORMATION

Insurance Plan Name: _____
ID/Certification No: _____
Policy/Group No: _____
Policy Holder: _____
Relationship to Policy Holder:_____

SECONDARY INSURANCE INFORMATION

Insurance Plan Name: _____
ID/Certification No: _____
Policy/Group No: _____
Policy Holder: _____
Relationship to Policy Holder: _____

GUARANTOR INFORMATION (to whom statements are sent)

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____
SSN: _____ - _____ - _____

Relationship to Patient: _____
Phone: (_____) _____- _____

Access Allowed to Patient Portal: _____ Yes _____ No

I authorize and consent to all examination and treatment necessary for the care of the patient named below and consent to any and all procedure incident to such treatment which are deemed necessary by the physicians, including but not limited to blood and urine tests, drug tests, and any other procedures or treatment. I agree to allow Mid-Atlantic Women's Care, PLC to obtain medication history. I authorize the release of all medical records to referring and family physicians, if applicable. I authorize the release of medical information to process my claims, and authorize Mid-Atlantic Women's Care, PLC direct receipt of insurance payment for services rendered. I allow fax transmittal of all my medical records, if necessary. I further acknowledge that I have been provided with a copy and/or given the opportunity to review the Notice of Privacy Practices of Mid-Atlantic Women's Care pursuant to the Federal regulations known as HIPAA privacy rules.

_____ _____
Signature of Patient or Responsible Party Date

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	☐	☐	Urinary Tract Inf	☐	☐
Deep Vein Thrombosis	☐	☐	Migraines	☐	☐	Vascular Disease	☐	☐
Endometriosis	☐	☐	Osteoporosis	☐	☐	Other_____		
Fibromyalgia	☐	☐	Ovarian Cancer	☐	☐			

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 **S** ☐ type of employment _____

MID-ATLANTIC WOMEN'S CARE, PLC

Last Name: _____

First Name: _____

Date of Birth: _____

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	dizziness	numbness	headache
	sadness	anxiety	mood swings	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	blood in stool	constipation	pain in abdomen
	indigestion	hemorrhoids	bloating	nausea/vomiting
Urologic:	urgency	painful urination	blood in urine	frequent urination
	loss of urine	>2 nighttime voiding	incomplete emptying	wearing pads
Gynecological:	period heavy	late periods	painful periods	irregular periods
	pelvic pain	prolonged periods	painful intercourse	vaginal discharge
	bleeding after intercourse	bleeding between periods	genital itching	vaginal dryness
	genital lump			
	vaginal odor			

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: _____

MID-ATLANTIC WOMEN'S CARE, PLC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents or others to call and discuss medical information, request prescriptions, appointment information, medical records, test results, or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information release to family members you must sign this form. Signing this form will only give information to family members indicated below.

☐ I, _____ (DOB _____), authorize Mid-Atlantic Women's Care, PLC to release my personal health information to the following individuals:

	NAME	RELATIONSHIP
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

☐ I would like all of my medical information pertaining to my care to remain confidential. (I do understand if another physician who is participating in my care needs information relevant to my care, this information may be provided without a written consent.)

I understand any changes I wish to make regarding the confidentiality of my personal health information must be made by completing a new form, in person.

_____ _____
Signature of Patient Date

_____
Printed Name

* The Privacy Act of 1977 was designed to protect private information such as medical and financial information. The Privacy Rule was updated in 2003 and is now called Protected Health Information. PHI is any information about health status, provision of health care, or payment of health care that can be linked to an individual. This includes any part of a patient's medical record or payment history.

MID-ATLANTIC WOMEN'S CARE

AUTHORIZATION FOR TREATMENT
I authorize treatment by Mid-Atlantic Women's Care and/or affiliated medical staff member(s) on behalf of myself and/or my minor children.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES
By signing below, I am acknowledging that I have been provided with a copy of Mid-Atlantic Women's care Privacy Notice, pursuant to the Federal regulations known as the HIPAA Privacy Rule.

NOTIFICATION OF EXPOSURE POLICY
The possibility exists (during treatment) for health care workers to become directly exposed to my blood or bodily fluids. In the event of such an exposure, State law requires a sample of my blood to be tested for infectious diseases.

PRIVACY
I agree that all telephone numbers provided by me including land line and wireless may be subject to receiving telephone calls and voice messages from Mid-Atlantic Women's Care by a live operator and/or an automated dialer using a pre-recorded artificial voice. Mid-Atlantic Women's care does not sell or otherwise distribute patient phone numbers or email addresses to any third party. By providing my email address and signing this acknowledgement. I am giving Mid-Atlantic Women's Care the ability to send me email updates on important general women's healthcare topics, practice news and information. I understand that I have the ability to opt out of these emails at any time by putting that request in writing or opting out of the email at the footer of the document. By providing my email address, I also give permission for the practice to create a portal account on my electronic health record, where I may review lab and test results, obtain health information, update my medical history, and pay my bill.

Mid-Atlantic Women's Care has an electronic interface link with the Virginia Immunization Information System (VIIS), and with various pharmacy and insurance company linkages, for deposit into patient electronic medical records. We will periodically download prescription histories from patient claims data, and vaccine history information from the VIIS. Mid-Atlantic Women's Care will use this information in order to keep my medication lists and vaccine history current within my medical record and this information will not be disclosed to any third party without my consent, or as allowed by federal or state law. I understand that I have the option to opt out of these downloads by submitting my-opt out request in writing, and obtaining an acknowledgement from Mid-Atlantic Women's Care.

I understand that Mid-Atlantic Women's Care participates with the Virginia Prescription Monitoring Program. The program collects prescription data for Schedule II IV drugs into a central database which can then be used by limited authorized users to assist in deterring the illegitimate use of prescription drugs. The information collected in this program is maintained by the Department of Health Professions, and strict security and confidentiality measures are enforced. I understand that Mid-Atlantic Women's Care providers may query the database to assist in determining my treatment history with controlled substances.

HIPAA Interoperability
Mid-Atlantic Women's Care supports efforts by The Office of the National Coordinator for Health Information Technology (ONC) to advance the safe and secure exchange of electronic health information across care settings to improve health. Our electronic health record (EHR), Athenahealth, through their secure online platform allows patient health information to follow patients throughout their continuum of care. Timely exchange of clinical health information is critical to ensuring that providers have the best information possible when making decisions about patient care, minimizing repetition and errors, ensuring high quality transitions of care and lowering costs. For that reason, we will share an electronic summary of your visit with other care partners you may have visited. If you wish to opt out of electronic sharing of your health information among your care settings, please notify a staff member and submit this request to our staff in writing.

NO SHOW FEES

I understand that it is my responsibility to keep all scheduled appointments or to cancel appointments in a timely fashion. I understand that I will be charged $30 for any appointment that is not canceled at least 24 hours in advance.

RETURNED CHECKS

All checks received in the office will be processed electronically and direct debited from your account at the time it is presented. I understand that in the event my check is returned from my bank as unpaid for any reason, I will be responsible for a $50 returned check fee.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of all medical and / or charge information necessary for reimbursement from any third party or govern mental agency involved in the payment of my treatment including but not limited to Insurance Payers, Workers Compensation carriers, Medicare, Tricare and Medicaid. I direct and assign payment from any insurance coverage, workers compensation, governmental agency or disability benefits and assignment of proceeds from all settlements, judgments or verdicts in favor of the undersigned from the third party liability claims for injuries treated hereunder, in the amount equal to the full amount of all charges (including attorney's fees, collection agency fees, cost and interest) due hereunder is to be made directly to Mid-Atlantic Womens Care.

FINANCIAL RESPONSIBILITY STATEMENT/COLLECTION POLICY ACKNOWLEDGEMENT

I am responsible to Mid-Atlantic Womens Care for any charges not covered by my insurance, including but not limited to co-payments, deductibles and non-covered services. An estimate of benefits may be provided to me by this office upon request, but is not a guarantee of payment. Final determination of my claim/ claims will be made by my insurance company/third party payer once the claim/claims are received and processed under the terms of my contract with my insurance company or third-party payer. It is my responsibility to understand the conditions, limitations and benefits of my policy prior to obtaining any service and I will be financially responsible for any unmet deductibles, coinsurances, copays or non-covered services at the time of service. Any additional unanticipated balances will be due after my claim is filed and all balances will be due within 60 days of having the services rendered.

I understand that it is my responsibility to comply timely with all requirements, and supply all information and documents necessary to obtain payment of benefit by any third-party insurer. I understand I will be responsible for payment in full if my third-party payer has not paid my claim(s) to Mid-Atlantic Womens Care within three months of my claim being filed. If the account is not paid in full within 60 days of service, interest at the rate of 1% per month (12% APR, minimum charge $2.50 per month) will be assessed on the aged balance.

Any balance remaining on the account after any insurance pays will be due in full upon receipt of my first statement. Charges for non-covered services are due in full at the time of service. The undersigned agree(s) to pay all charges made by medical providers at their current rate. If payment is not made, I understand that Mid-Atlantic Womens Care may take action to collect its fees, up to and including legal action to include obtaining a judgement against me. I agree to pay all costs incurred by Mid-Atlantic Womens Care for collecting its fees, including but not limited to, an attorneys' fee of forty percent (40%) of the unpaid bill.

I acknowledge that I understand and agree to all the terms listed above.

Patient Name (please print) _____ Date of birth: _____

Patient/ Guarantor (signature) _____ Date: _____

Witness Name and Signature: _____ Date: _____

NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING, HEPATITIS B AND C CODE OF VIRGINIA ANNOTATED

32.1-45.1. Deemed consent to testing and release of test results related to infection with Human immunodeficiency virus and hepatitis B and C.

A. Whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may, according to the current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus, hepatitis B and C. Such patient shall also be deemed to have consented to the release of such test results to the person who was exposed.

B. Whenever any patient is directly exposed to body fluids of a health care provider, or of any person employed by or under the control of a health care provider, in a manner which may, according to the current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus, hepatitis B and C. Such patient shall also be deemed to have consented to the release of such test results to the patient who was exposed.

C. You would be informed before any of your blood would be tested for HIV antibodies, Hepatitis B and C. Pursuant to this provision, the testing would be explained and you would be given the opportunity to ask questions you might have.

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

Signature of Patient	Date
Patient's Printed Name	Witness
Patient's date of birth	

MID-ATLANTIC WOMEN'S CARE, PLC

Consent to Obtain Patient Medication

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR /EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and / or illness properly and in avoiding potential dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also over-the-counter-drugs, supplements, or herbal remedies that patients take on their own may not be included.

- ☐ **I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.**
- ☐ **I do <u>NOT</u> give permission to have my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.**

Signature of Patient or Responsible Party	Date
Patient Printed Name	Patient Date of Birth

By signing this consent form you are giving your healthcare provider permission to collect, and giving your pharmacy and your health insurer permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS / HIV and medicines used to treat mental health issues such as depression.

Pharmacy Name: _____

Location: _____