PATIENT REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

Patient's Legal Name: (Last)_____ (First)_____ (Middle)_____

Preferred Full Name (If different from above): _____ Date of Birth (MM/DD/YYYY): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ (Cellular): _____ (Work): _____

Email Address: _____

Gender Identity:

___ Male ___ Female ___ Transgender Male to Female ___Transgender Female to Male ___ Choose not to disclose

___ Additional category not listed: _____

Race:

___ Black/African American ___ White/Caucasian ___ Asian ___ American Indian ___ Hawaiian/Pacific Islander ___ Hispanic

___ Choose not to disclose ___ Other not listed: _____

Preferred Language:

___ English ___ Spanish ___ Other not listed: _____

How did you hear about Women's Wellness Clinic? _____

How do you prefer to be contacted? Phone call Text E-mail (circle one)

RESPONSIBLE PARTY INFORMATION (IF NOT SELF) (Information used for patient balance statements)

Responsible Party: ___ Guarantor ___ Self Check here if address/telephone is the same as patient ___

Responsible party name: (Last) _____ (First) _____ (Middle) _____

Date of Birth (MM/DD/YYYY): _____

Gender Identity:

___ Male ___ Female ___ Transgender Male to Female ___Transgender Female to Male ___ Choose not to disclose

___ Additional category not listed: _____

Responsible Party Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ (Cellular): _____ (Work): _____

INSURANCE INFORMATION: Please provide your insurance card(s) (primary, secondary, etc.) to the front desk at check in.

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: (Last) _____ (First) _____ (Middle) _____

Emergency contact relationship to patient: _____ Check here if guardian: ___ Guardian

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ (Cellular): _____ (Work): _____

Do you have a living will? ___ Yes ___ No

Medical Power of Attorney? ___ Yes ___ No

Advance Directive? ___ Yes ___ No

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT:

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that:

1. You intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended
2. You consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____ Date: _____

Printed name of patient or personal representative: _____

Relationship to patient: _____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

FINANCIAL AGREEMENT

- I acknowledge, that as a courtesy, Women's Wellness Clinic may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges that have not been paid in full including, but not limited to any co-payment, co-insurance, and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

THIRD PARTY COLLECTION

- I acknowledge that Women's Wellness Clinic may use the services of a third-party business associate or affiliated entity as an extended business office for medical account billing and servicing

ASSIGNMENT OF BENEFITS

- I hereby assign to Women's Wellness Clinic any insurance or other third-party benefits available for health care services provided to me.
- I understand that Women's Wellness Clinic has the right to refuse or accept assignment of such benefits.
- I understand that if these benefits are not assigned to Women's Wellness Clinic, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon request.

MEDICARE PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS

- I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct.
- I request payment of authorized benefits to be made on my behalf to Women's Wellness Clinic by the Medicare or Medicaid program.

CONSENT TO TELEPHONE CALLS FOR FINANCIAL COMMUNICATIONS

- I agree that, in order for Women's Wellness Clinic or Extended Business Office Servicers and collection agents to service my account or to collect any amounts I may owe, I expressly agree and consent that Women's Wellness Clinic or Extended Business Office Servicers and collection agents may contact me by any telephone number that has been provided, or obtained from the telephone number(s) that we have on file, without limitation, regarding services rendered, or my related financial obligations. Methods of contact may include using pre-recorded or artificial voice messages and/or use of an automatic dialing device, as applicable.

A PHOTOCOPY OF THIS CONSENT SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

Patient/Patient Representative Signature: _____ Date (MM/DD/YYYY): _____

If you are not the patient, please identify your relationship to the patient below by placing a circle around the choices below:

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify): _____

FINANCIAL AND LATE/NO SHOW POLICY

In an effort to provide effective and efficient treatment to all of our patients, it is the policy of this office that all appointment cancellations are made at least 24 hours prior to your scheduled appointment time.

If an appointment is not cancelled or patient fails to show up for appointment, Women's Wellness Clinic reserves the right to charge patient a $25 fee per occurrence. As this fee is not billed to any insurance company, the patient accepts full responsibility to pay this fee.

Patient insurance Copays, in addition to any outstanding patient balance, are due at the time of appointment.

If you have any questions about this policy, please talk to us before signing.

Patient's Name: _____

Patient's/Guardian's Signature: _____

Date: _____

PATIENT HIPPA ACKNOWLEDGEMENT AND CONSENT FORM

Women's Wellness Clinic			
Patient Last Name (Printed)	Patient First Name (Printed)	Middle Initial	Date of Birth (MM/DD/YYYY)

NOTICE OF PRIVACY PRACTICE/CLINIC

___ (Patient/Representative Initials) I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have any questions or any complaints. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHO MAY BE CONTACTED? (LIST BELOW)

I give permission for my Protected Health Information to be disclosed for the purpose of communicating results, findings, and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1.			
2.			
3.			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification MUST be written.

COMMUNICATIONS ABOUT MY HEALTHCARE

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

CONSENT FOR PHOTOGRAPHING OR OTHER RECORDING FOR SECURITY AND/OR HEALTH CARE OPERATIONS

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes, and/or the practice's/clinic's health care operation purposes (example: quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

CONSENT TO EMAIL, CELLULAR TELEPHONE, OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

If at any time I provide an email address or cellular phone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided for you. I agree that I may be contacted at any number that has been obtained or forwarded from that number. These instructions may include, but are not limited to: pre-procedure instructions, educational information, prescription information, post-procedure instructions, follow-up instructions, communications to family or designated representatives regarding my treatment or condition, and reminder messages regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

NOTE: This location uses an Electronic Medical Record that will update all of your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an Electronic Health Record in which you have a relationship.

PATIENT HIPPA ACKNOWLEDGEMENT AND CONSENT FORM CONTINUED

Women's Wellness Clinic			
Patient Last Name (Printed)	Patient First Name (Printed)	Middle Initial	Date of Birth (MM/DD/YYYY)

RELEASE OF INFORMATION

I hereby permit this practice/clinic and the physicians or other healthcare professionals involved in my inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service at other affiliated providers may be made available to subsequent affiliated providers to coordinate care and for the purpose of continuity of care. Health care information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment, and discharge summaries.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and /or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records, decreasing the time needed to access my information, aggregating and comparing my information for quality improvement purposes, and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological or psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions, and/or infectious diseases including, but not limited to: blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient or Representative's Signature: _____ Date: _____

PRESCRIPTION ORDER PICK-UP

There may be times when you need a friend or family member to pick up a prescription order from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present a valid picture ID and sign for the prescription.

I DO WANT _____ (Patient/Representative's Initials) to designate the following individual(s) to pick up a prescription order on my behalf.

Name	Relationship to Patient

I DO NOT WANT _____ (Patient/Representative's Initials) to designate anyone to pick up my prescription order on my behalf.

Patient's Name: _____ Date of Birth: _____

MEDICATIONS

Medication Name (please include all prescriptions, vitamins and OTC medications)	Dose (ex: 25 mg)	Frequency (ex: 2 times daily)

Please use the back of this form to list any additional medications that you are taking.

ALLERGIES/CONTRAINDICATIONS ____ No Known Drug Allergies

Name	Reaction

Please use the back of this form to list any additional medication, food, or drug allergies that you may have.

MEDICAL HISTORY

Allergies	Yes	No		Depression	Yes	No		Lupus	Yes	No
Anemia				Diabetes Mellitus				Myocardial Infarction		
Anxiety				Diverticulitis				Nerve/Muscle Disease		
Arthritis				Diverticulosis				Osteoporosis		
Asthma				Emphysema				Parkinson's Disease		
Anorexia				GERD				PCOS		
Bulimia				Glaucoma				Seizures		
Blood Transfusion				Gastritis				Shortness of Breath		
Cancer				Gallstones				Sickle Cell Anemia		
Cataracts				Heart Murmur				Stroke		
Chest Pain				HIV/AIDS				Scoliosis		
CHF				Hypertension				Substance Abuse		
Clotting Disorder				High Cholesterol				Thyroid Disease		
COPD				Kidney Stones				Tuberculosis		
Cardiomegaly				Kidney/Renal Disease				Ulcers (peptic)		

Other Medical History Not Listed Above: _____

_____

SURGICAL HISTORY

Aneurysm Repair	Yes	No		Cosmetic Surgery	Yes	No		Joint Replacement	Yes	No
Appendectomy				Eye Surgery				Intestine Surgery		
Brain Surgery				Fracture Surgery				Spine Surgery		
CABG				Hernia Repair				Tubal Ligation		
Cholecystectomy				Hysterectomy				Transplant		
Cataract Removal				Oophorectomy						
Colon/Bowel Surgery				Breast Implants						

Other Surgical History Not Listed: _____

Name: _____ Date of Birth: _____

FAMILY MEDICAL HISTORY

Relationship	Living?		Alcohol Abuse	Arthritis	Asthma	Autoimmune Disease	Cancer	COPD	Depression	Diabetes	Drug Abuse	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Learning Disability	Mental Illness	Stroke	Vision Loss	Other/Comments
Mother	☐ Y ☐ N																			
Father	☐ Y ☐ N																			
Sister 1	☐ Y ☐ N																			
Sister 2	☐ Y ☐ N																			
Sister 3	☐ Y ☐ N																			
Brother 1	☐ Y ☐ N																			
Brother 2	☐ Y ☐ N																			
Brother 3	☐ Y ☐ N																			
Daughter 1	☐ Y ☐ N																			
Daughter 2	☐ Y ☐ N																			
Daughter 3	☐ Y ☐ N																			
Son 1	☐ Y ☐ N																			
Son 2	☐ Y ☐ N																			
Son 3	☐ Y ☐ N																			
Mat GM	☐ Y ☐ N																			
Mat GF	☐ Y ☐ N																			
Pat GM	☐ Y ☐ N																			
Pat GF	☐ Y ☐ N																			

___ Adopted

___ Family History Unknown

Other Family History: _____

_____

_____

_____

Patient's Name: _____ Date of Birth: _____

ALCOHOL SCREEN

Do you drink alcohol? ___ Yes ___ No Are you ready to quit? ___ Yes ___ No

Have you ever had more than 4 drinks in a day? ___ Yes ___ No

How many times in the past 12 months? ___ 0 ___ 1 ___ 2 ___ 3 ___ 4 ___ 5+

Drinks per week?

	Glasses of wine
	Cans of beer
	Shots of liquor
	Cocktails

SOCIAL HISTORY

Are you sexually active? ___ Yes ___No ___ Not Currently Partners: ___ Male ___ Female ___ Both

Do you use birth control/protection? ___ Yes ___ No

If so, which types?

Abstinence	Coitus Interruptus (the pull out method)	Female Condom	Male Condom
Diaphragm	Implant	Injection	Inserts
IUD	Oral Contraceptive Pill	Patch	Post-Menopausal
Spermicide	Sponge	Surgical Intervention	None
Other:			

Drug Use? ___ Yes ___ No Use/Week? _____ times per week

Types used:

☑

	Amphetamines		Amyl Nitrate		Anabolic Steroids		Barbiturates		Benzodiazepines
	Crack Cocaine		Cocaine		Codeine		Fentanyl		Gamma Hydroxybutyrate
	Hashish		Heroin		Hydrocodone		Hydromorphone		Ketamine
	LSD		Marijuana		Ecstasy/Molly		Mescaline		Flakka/Gravel
	Methamphetamine		Methaqualone		Methylphenidate		Morphine		Nitrous Oxide
	Opium		Oxycodone		PCP		Psilocybin Mushrooms		Solvent Inhalants

	Other:

Patient's Name: _____ Date of Birth: _____

SOCIAL HISTORY CONTINUED

Tobacco Use? ___ Yes ___ No Vape Use? ___ Yes ___ No

If so? Are you ready to quit? ___ Yes ___ No

Check One:

___ Current Smoker # Packs per day: ____

___ Former Smoker Quit Date: _____ #Packs per day: _____

___ Current Smokeless Tobacco Use

___ Former Smokeless Tobacco use Quit Date: _____

Comments: _____

SOCIOECONOMIC HISTORY

Occupation: _____ ____ Retired

Employer: _____ ____ Unemployed

Check One: ____ Single ____ Engaged ____ Married ____ Divorced ____ Widow ____ Widower

Spouse/Significant Other/Life Partner's Name: _____

How Many Children? _____

Who Do You Live With? _____

HEALTH MAINTENANCE

Please document the date of last completion and the result if appropriate for the following:

Screening	Date Completed	Results/Comments
Pap Smear/ Pelvic Exam		Normal or Abnormal
Mammogram		Normal or Abnormal
Colonoscopy		Normal or Abnormal
DEXA/Bone Density Scan		Normal or Abnormal
Eye Exam		Normal or Abnormal
Dental Exam		Normal or Abnormal
Diabetic Foot Exam		Normal or Abnormal

Comments: _____

_____

_____