Axia Women's Health

Patient Demographic Form

Please complete this form in order to ensure proper billing of your services.

Patient Information

Last Name: _____ First Name: _____ Today's Date: _____

Other Name: _____ Date of Birth: _____

Address (street): _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PCP: _____ Ref. Physician (if different): _____

Address (street): _____ Address (street): _____

City, State, Zip: _____ City, State, Zip: _____

Telephone #: _____ Telephone #: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Employment Information

Employer: _____

Employer Address (street): _____ City, State, Zip: _____

Emp. Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self-Employed ☐ Active Military

Student Status: ☐ Full Time Student ☐ Part Time Student

Emergency Contact Information

Emergency Contact: _____ Relationship to You _____

Home Phone: _____ Alt. Phone: _____

Insurance Information

PRIMARY CARRIER: _____ Telephone #: _____

Address: _____ City, State, Zip: _____

ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

SECONDARY CARRIER: _____ Telephone #: _____

Address: _____ City, State, Zip: _____

ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

Parent / Guardian Information

Contact: _____ Relationship to You _____

Home Phone: _____ Alt. Phone: _____

Contact: _____ Relationship to You _____

Home Phone: _____ Alt. Phone: _____

Electronic Communications

We offer secure electronic communications between you and our office via our Patient Portal. Secure messages and information can only be read by someone who knows the right password to log in to the Portal site. The communications are automatically encrypted and for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

☐ Yes, I want to participate, my email is provided below.

Home Email: _____

☐ No, I do not wish to participate at this time.

As an added convenience, we offer appointment reminders via a text message for those who want to participate. The reminders are sent from a computer and cannot be used as a way for you to communicate back to us. If you should need to reach us, please call our main number. If at any time you should change your mind, please let us know what other method you would prefer for appointment reminders.

☐ Yes, I want to participate, my cell number is provided below.

Cell Phone Number: _____

☐ No, I do not wish to participate at this time. I would prefer to be notified by:

☐ Mail ☐ Telephone ☐ E-mail (via the Portal – you will need to participate, see above.)

Additional Information

Race: Which category best describes your racial background?

☐ American Indian or Alaska Native

☐ Asian

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

☐ Unreported/Refused to Report

Ethnicity: How would you describe you ethnicity, such as your family background or ancestry?

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unreported/Refused to Report

Preferred Language: What language do you usually speak at home?

☐ English ☐ Spanish ☐ Other _____

How did you hear about our practice? ☐ Health Plan ☐ Internet ☐ Our Web Site ☐ ER/Hospital

☐ Newspaper/Magazine ☐ Patient _____ ☐ Other _____

Pharmacy Information

Pharmacy Name: _____ ☐ Local ☐ Mail away

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

Pharmacy Name: _____ ☐ Local ☐ Mail away

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

Axia Women's Health

HIPAA

Acknowledgements and Authorizations

I. HIPAA Notice of Privacy Practices

Patient Acknowledgement

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review this Notice of our Privacy Practices:

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

II. Authorization for use or Disclosure of Health Information

Patient Contact Information

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

I authorize messages with medical information to be left on voicemail at (check all that apply): ☐ HOME ☐ CELL ☐ WORK

I authorize brief message details: ☐ HOME ☐ CELL ☐ WORK

I authorize extended message details: ☐ HOME ☐ CELL ☐ WORK

I authorize secure electronic communications be sent to my email address at: _____

Restrictions/Instructions: _____

Release of Medical History and Treatment Information

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name: _____ Relationship: _____ DOB: _____ Ph: _____

Name: _____ Relationship: _____ DOB: _____ Ph: _____

Restrictions/Instructions: _____

Release of Billing Information

I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

Name: _____ Relationship: _____ DOB: _____ Ph: _____

Name: _____ Relationship: _____ DOB: _____ Ph: _____

Restrictions/Instructions: _____

Patient Acknowledgement

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to your office address. My revocation will be effective once received by the practice, Axia Women's Health, LLC.
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name: _____ Date: _____

Signature: _____ Relationship: _____

Additional Authorizations

Emergency Contact: _____ Relationship: _____ Ph: _____

I request a female escort to be present during my examination? ☐ Yes ☐ No ☐ Other: _____

Axia Women's Health

Patient's Name: DOB:

Authorization for Treatment & Payment of Medical Benefits
Patient Financial Responsibility Form

Thank you for choosing our practice, a division of Regional Women's Health Group, LLC, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

Authorization for Treatment & Payment of Medical Benefits

I give permission to the practice, a division of Regional Women's Health Group, LLC, to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice, a division of Regional Women's Health Group, LLC.

Use of Photography

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

e-Prescription Consent for Medication History

With your consent, we may request and use your prescription medication history information using our e-prescription feature. This is for only informational purposes so that an up-to-date record of your medication is available for your treatment and safety.

☐ Yes, I give consent to obtain my medication history using the e-Prescribing feature.

☐ No, I do not give consent to obtain my medication history using the e-Prescribing feature. I understand that my medication information may not be complete when making treatment decisions.

Patient Financial Responsibilities

- I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
    - Charge for returned checks.
    - Charge for the copying and distribution of patient medical records.
    - Charge for forms completion.
    - Charge for missed appointments.

Patient Authorizations

- By my signature below, I hereby authorize the practice, a division of Regional Women's Health Group, LLC, to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to the practice, a division of Regional Women's Health Group, LLC. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:

Signature of Patient or Guardian Date

Contemporary Women's Care
An Axia Women's Health Care Center
Financial Policies and Procedures

Thank you for choosing Contemporary Women's Care, a division of Axia Women's Health, LLC, for your care. In the last few years we have noticed an increase in the number of patients with insurance coverage which includes a substantial deductible or large uncovered portion in their benefit plan. We recognize that in the recent economic climate, many patients have also lost insurance through their employer. We hope the information below will provide a clear understanding of our policies and your options in these situations. In doing so, we can then focus on your clinical care. Our administrative staff is available for any other specific questions regarding insurance and financial matters.

Insurance Plan Participation
We participate in a variety of insurance plans and our group considers new options regularly. Our staff will verify your insurance plan coverage, provided we participate with your plan. Please have your insurance card available so you can provide the most current information to our staff when making your appointment. This will ensure that your claims are submitted to the correct insurance plan.

Documentation of Insurance
We ask all our patients to complete our patient information forms prior to their appointment. Our staff will provide instructions for completing the forms. On the date of your appointment, we will need your current insurance card for proof of coverage benefits. Please also bring a valid driver's license or other valid photo identification.

Processing Your Insurance Claims
We will submit your claims to the insurance plan you have provided at the time of your visit. If your insurance changes during the course of your care, it is your responsibility to provide us with the correct information. If we do not receive the correct information in a timely manner you may be responsible for the entire balance of your insurance claim. In processing your claims, the insurance company may need you to supply certain information before they will pay the claim. It is your responsibility to comply with their request.

Services Not Covered by Your Insurance Plan
Please understand your insurance coverage is a contract between you and the insurance company. Any disagreements or disputes regarding your specific benefits should be directed to the insurance plan or your employer's Human Resource Department.

Plan Co-payments, Deductibles and Health Savings Accounts

- Plan Co-payments – It is our policy to collect all plan co-payments at the time of your visit. Certain types of exams or testing may not require a copayment. We cannot always determine this for every insurance plan. If we collected a co-payment in error, the amount will be refunded to you after we have received notification from your insurance plan.

- Health Savings Accounts, Deductibles or Co-insurance Patient Responsibility – You will receive a statement for any portion of our services that is your responsibility after the claim has been processed by your insurance company. We will make every effort to verify your benefits for certain procedures such as surgical procedures or special testing. We may provide you with the estimated amount and a written agreement.

Many patients are being told by their insurance carriers that health care providers are not permitted to collect any balance amount in advance or at the time of service. This is not always correct. If permitted by the insurance plan, and we know the contracted payment amount we will receive and what percentage of that amount you will be responsible for, then we can advise you of the balance and prepare a payment plan.

- If our contracted payment amount changes or your benefits changed and we collect more than the amount due, the excess amount will be refunded to you.

- If you have any balances on other services we have provided, the excess amount will be applied to those services before any refunds are issued.

- If we collected less than the amount due, you will be billed for any balance due upon receipt of payment from the insurance plan.

Obstetrical Care (if applicable)
We make every attempt to verify your benefits for maternity. Maternity benefits include your routine prenatal visits, the delivery, and your 6 week post-partum visit. This is known as global care. Any services such as ultrasounds, lab tests, or other testing done at our office, at the hospital or by other specialists may not be covered, or only a portion may be covered by your plan. We will contact you or review this information at a scheduled visit. Based on your specific financial responsibility, a payment agreement may be provided for you to review and sign. We can provide the payment plan to you so you can better manage the estimated cost during pregnancy.

In the unfortunate situation that your insurance is terminated any time during your pregnancy, please notify our office immediately.

Collection Policy for Non-Payment of Services
Failure to pay any outstanding balance may result in your account being forwarded to a collection agency.
Please contact Regional Women's Health Group's Central Billing Office at (856) 669-6025.

Questions About Your Account
We are available to assist you with a billing, referral, or insurance question.
Please call our main number during regular business offices.

If you receive a statement from a Lab such as Quest or LabCorp, or any bill from the hospital, please contact the customer service number on the statement.

Contemporary Women's Care

Patient Medical History

Name:_____ DOB: _____

Please list any present medications: _____

_____

Medical History

Please check all that apply:

[ ] Anxiety	[ ] Asthma	[ ] Depression	[ ] Melanoma	[ ] Epilepsy
[ ] Fibroids	[ ] Stroke	[ ] Heart Murmur	[ ] Colonic Polyps	[ ] Kidney Stones
[ ] Cancer, Breast	[ ] Cancer, Colon		[ ] Cancer, Rectal	[ ] Cancer, Ovarian
[ ] Cancer, Uterus	[ ] Cancer, Endometrial		[ ] Cancer, Cervical	

Allergies:

Please list any drug allergies: _____

GYN History:

Last Pap Smear (mm/yyyy): _____

Self Breast Exam: [ ] Monthly [ ] Do not perform [ ] Sometimes

Have you had a Gardisil HPV Vaccine: [ ] Yes [ ] No

Result of last pap: [ ] Normal [ ] Abnormal [ ] No pap ever done

Last Mammogram Date (mm/yyyy): _____

Result of last Mammogram: [ ] Normal [ ] Abnormal [ ] No mammo ever done

Last Dexa (Bone Density) scan (mm/yyyy): _____

Result of last Dexa scan: [ ] Normal [ ] Osteopenia [ ] Osteoporosis

Last colonoscopy (mm/yyyy):_____

Menstruation: (If you are menopausal, skip to Menopause section)

Age of Onset: At what age did your periods start? _____

LMP: Date of last menstrual period (dd/mm/yy): _____

(If menopausal, skip to Menopause section now)

Time Between Periods: [ ] Irregular [ ] 21- 32 Days apart

[ ] > 45 Days apart [ ] < 21 days apart

[ ] 33 – 44 Days

Duration: How long does your period last? [ ] < 7 days [ ] 2 - 7 days [ ] 3 days

Pad / Tampon Use Per Day: [ ] 1-3 [ ] 4-6 [ ] 7+

Associated Signs/ Symptoms: How would you describe your period:

[ ] with severe pain
[ ] with moderate pain
[ ] with mild discomfort
[ ] without discomfort/ pain
[ ] heavy
[ ] light

Menstruation Symptoms:

Premenstrual Syndrome: [ ] Yes [ ] No

If yes, please mark any symptoms you are experiencing:

[ ] Withdrawal [ ] Weight gain [ ] Tension [ ] Pelvic pain
[ ] Mood swings [ ] Tiredness [ ] Headaches [ ] Depression
[ ] Bowel changes [ ] Bloating [ ] Anxiety [ ] Changes in desire
[ ] Breast swelling/discomfort

Menopause: [ ] Yes [ ] No

If yes, began at age: _____

Current menopausal symptoms:

[ ] None
[ ] Headache
[ ] Hot flashes
[ ] Irritability
[ ] Memory Loss
[ ] Loss of Sexual Desire
[ ] Weight Gain
[ ] Vaginal dryness

Birth Control:

[ ] Condoms
[ ] Oral contraceptive pills
Indicate which pill: _____
[ ] Mirena IUD
[ ] Paraguard IUD
[ ] Skyla IUD
[ ] Diaphragm
[ ] Nuvaring
[ ] Bilateral Tubal Ligation
[ ] Vasectomy
[ ] None
[ ] Depo-Provera
[ ] Ortho Evra Patch
[ ] Spermicide
[ ] Nexplanon

If using an IUD or Nexplanon, please list the date of insertion (mm/yy): _____

Sexual activity:

[ ] Currently sexually active
[ ] Not currently sexually active
Total Number of Sex Partners: _____
[ ] Past history of sexual abuse: _____
_____

Currently or in the past, I have had sex:

[ ] With men, [ ] With women [ ] With both men and women

Sexually Transmitted Infections (STI's)?

[ ] None
[ ] Human Papilloma Virus (HPV)
[ ] Chlamydia
[ ] Human Immunodeficiency Virus (HIV)
[ ] Hepatitis B
[ ] Syphilis
[ ] Herpes Simplex Virus (HSV)
[ ] Gonorrhea
[ ] Trichomoniasis (Trich)
[ ] Hepatitis C

OB History

Total pregnancies: _____ Total living children: _____
Total full term pregnancies: _____ Total pre term pregnancies: _____
Total miscarriages/abortions: _____
Total Ectopic Pregnancies: _____
Please fill out the following to the best of your recollection regarding prior pregnancies:

Birth Date	# Weeks Pregnant at Birth	Hours in Labor	Birth Weight	Anesthesia	Deliver Method	Delivery Location & Provider
					[ ] vaginal [ ] c-section	
Comments or Complications (i.e. diabetes, blood pressure, etc.)						
					[ ] vaginal [ ] c-section	
Comments or Complications (i.e. diabetes, blood pressure, etc.)						
					[ ] vaginal [ ] c-section	
Comments or Complications (i.e. diabetes, blood pressure, etc.)						

Surgical History

Please list any previous surgeries and c-sections (include minor surgeries like wisdom teeth, appendix, etc.). Please indicate approximate date:

_____

_____

_____

Have you ever had a blood transfusion? [ ] Yes [ ] No

Hospitalizations:

Please list any hospitalizations:

_____

_____

_____

Family History

Please check all that apply for the corresponding family member. Under status, please indicate "alive", "deceased", or "unknown". Please put an "X" in the appropriate boxes below.

	Status	Year of Birth	Age	Blood Clotting Disorder	Bleeding Disorder	Breast Cancer	Ovarian Cancer	Colon Cancer
Mother								
Father								
Sister #1								
Sister #2								
Brother #1								
Brother #2								
Son #1								
Son #2								
Daughter #1								
Daughter #2								
Maternal Grandmother								
Maternal Grandfather								
Paternal Grandmother								
Paternal Grandfather								

Social History:

Smoking:

Current smoking status:

[ ] Current smoker [ ] Current every day smoker

[ ] Current some day smoker [ ] Smoker [ ] Former smoker

[ ] Current status unknown [ ] Nonsmoker [ ] Unknown if ever smoked

How many cigarettes a day do you smoke?

[ ] 5 or less [ ] 6-10 [ ] 11-20 [ ] 21-30 [ ] 31 or more

Are you interested in quitting?

[ ] Ready to quit [ ] Thinking about quitting [ ] Not ready to quit

Alcohol:

How often do you consume alcohol, including beer and ~~wine~~, in a week:

[ ] Never consumed alcohol (If no, skip other alcohol questions)

[ ] 1-2 times [ ] 3-5 times [ ] >5 times [ ] Socially [ ] Rarely

Did you have a drink containing alcohol in the past year?: [ ] Yes [ ] No

How often did you have a drink containing alcohol in the past year?

[ ] Never [ ] Monthly or less [ ] 2-4 times a month [ ] 2-3 times a week

[ ] 4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

[ ] 1-2 drinks [ ] 3-4 drinks [ ] 5-6 drinks [ ] 7-9 drinks [ ] 10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year?

[ ] Never [ ] Less than monthly [ ] Monthly [ ] Weekly [ ] Daily or almost daily

Drugs:

Have you used drugs other than those for medical reasons in the past year? [ ] Y [ ] N

Caffeine Intake: [ ] None [ ] 1-2 cups per day [ ] 2-3 cups per day

[ ] 3-4 cups per day [ ] More than 4 cups per day

Exercise Frequency: [ ] Never [ ] Occasionally [ ] 1-2 times per week

[ ] 2-3 times per week [ ] 3-4 times per week [ ] 4-7 times per week

Any history of domestic violence?

[ ] None [ ] History in the past [ ] Has restraining order

[ ] Feel unsafe at home [ ] Have a safety plan

Any history of verbal abuse?

[ ] None [ ] Occasional [ ] Frequent

[ ] Seeking counseling [ ] Has safety plan

Has your current partner ever threatened you or made you feel afraid?

[ ] Yes [ ] No

Does your current partner or someone important to you hurt you physically or emotionally? [ ] Yes [ ] No

If you are currently pregnant, please answer the questions below:

- Date of first positive pregnancy test *(mm/dd/yy)*: _____
- List any medications you have taken during this pregnancy: _____

_____

- Were you on the pill or using contraception when you became pregnant? [ ] Y [ ] N
- Name of baby's father: _____
- Name of partner: _____
- How much alcohol, including beer, have you drank during this pregnancy? (if none, write none) _____
- Do you have a cat? [ ] Yes [ ] No
- What is the baby's father's family/ethnic background? _____
  _____
- Have you or the baby's father ever been tested for Tay-Sachs,Canavan,or Gaucher's Disease? [ ] Yes [ ] No
- Have you or the baby's father ever been screened for Sickle Cell Disease? [ ] Yes [ ] No
- Does the baby's father have any family history of birth defects? [ ] Yes [ ] No
- Will you be age 35 or older when the baby is born? [ ] Yes [ ] No
- Have you or the baby's father or anyone in either of your families ever had the **following:**

Down Syndrome	[ ] Yes [ ] No
Spina Bifida	[ ] Yes [ ] No
Hemophilia	[ ] Yes [ ] No
Muscular Dystrophy	[ ] Yes [ ] No

Do you or the father of the baby have a <u>family</u> history of the following (only check one of the options below if the relationship is mother, father, maternal or paternal grandparent, sister, or brother and list the relationship next to the disease):

Diabetes	[ ] No [ ] Yes	Relationship _____
Heart Disease	[ ] No [ ] Yes	Relationship_____
Hypertension	[ ] No [ ] Yes	Relationship_____
Cancer Type	[ ] No [ ] Yes	Relationship_____
Birth Defects	[ ] No [ ] Yes	Relationship_____
Blood Clot Issues	[ ] No [ ] Yes	Relationship_____

- Have you or the baby's father ever had a child born with a defect <u>not</u> listed above?
  [ ] Yes [ ] No
  If "yes", please describe: _____
  _____
- Have you or the baby's father ever had a stillbirth?
  [ ] Yes [ ] No
- Have you or the baby's father, even in a previous relationship, experienced two or more miscarriages? [ ] Yes [ ] No
- Have you or the baby's father ever been screened for cystic fibrosis, or is anyone in either of your families affected by cystic fibrosis? [ ] Yes [ ] No

- Do you or the baby's father have any close relatives who are mentally disabled? [ ] Yes [ ] No

  If so, whom? _____

Do you or the baby's father or close relatives in either of your families have any inherited genetic or chromosomal diseases or disorders not listed above?

[ ] Yes [ ] No

If "yes", please describe: _____

Providers in this practice will administer blood or blood products in the event of a life-threatening hemorrhage. Do you object to blood or blood products in the event of a life threatening hemorrhage?

[ ] Yes [ ] No

Is there any other information or suggestions you can provide that could make your obstetrical care and delivery a more memorable experience?

_____

_____

_____