***Women's Health of Augusta***
***1303 D'Antignac Street, Suite 2500***
***Augusta, GA 30901***
***Phone 706-733-4427 Fax 706-922-7456***

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*To Our New Patient,*

*Welcome to our Practice.*

*Please complete the enclosed forms for medical records. Present these forms, your* ***insurance card*** *and a* ***picture ID*** *to the front desk when you arrive for your appointment. Please do not mail the forms to the office.*

*Each visit you will need to present your insurance card and a picture ID.*

*If you are taking any medications, please bring a list of the medications with you to present to the nurse.*

*We look forward to meeting you and providing you with professional and quality medical care.*

# Patient Information Sheet

Date:_____ Physician you are seeing:_____

Referred by:_____ Name you prefer to be called:_____

Patient's Last Name:_____First:_____ Middle:_____

Birthdate:_____Social Security #:_____ Race _____ Religion _____

Address, City, State, Zip:_____

Phone # Home:_____Cell:_____ Work:_____

Marital Status_____ Email Address:_____

Employment Status: _____ Employed _____ Unemployed _____ Student _____ Retired

Employed by:_____ Occupation:_____

Nearest relative not living with you: _____ Phone number:_____

Relationship to patient:_____

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Insurance Policy Holder is the person who holds the insurance policy on the patient.

Insurance Company Name: _____

Name of Policy Holder:_____ Relationship to Patient:_____

Policy Holder's DOB:_____ Policy Holder's Social Security #:_____

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**Insurance benefits.** Women's Health of Augusta, PC wants to help you receive your maximum insurance benefits. In order to do this, you need to know if your policy has annual preventative / routine coverage. We code and bill for services according to your medical record documentation. We cannot comply with any request to improperly alter coding of your office visit procedures. Improperly altering coding and billing information is considered Healthcare Fraud.

**All co-payments, co-insurance and deductible amounts must be paid at time of service.** If you do not have insurance or we do not participate with your insurance plan, payment is expected in full at time of service. I understand and will abide by the payment policy above and will also be responsible for any additional charges submitted to a radiology or laboratory facility.

**Insurance payment order.** I hearby authorize and direct you to pay directly to Women's Health of Augusta, PC benefits due me out of indemnity under the terms of my policy issued by your company. Payment is authorized upon your receipt of an itemized statement for services rendered to me. This policy was in full force and effect at the time that these services are rendered. Payment of this amount is hereby directed, in whole or in part, shall be considered the same as if paid by your company directly to me.

**Medical records authorization release.** I hereby authorize Women's Health of Augusta, PC, to disclose, when requested to do so by insurance carrier(s) or its representatives for application to obtain insurance or to pay a claim, any and all information with respect to illness, injury, medical history, consultation, prescription or treatment, included copies of all medical records.

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**Consent Form:** I hereby authorize the physcians of Women's Health of Augusta, PC to perform/administer the following treatment: Medical and/or surgical procedures, performance of diagnostic procedures, tests and cultures, administration of anesthetics, use of prescribed medications as deemed necessary and authorize release of information needed to secure payment. This consent will remain in affect until revoked in writing.

Legal Signature:_____ Date: _____

# New Patient Questionnaire

Name: _____ Date: _____ Account #: _____

Birthdate: _____ Age: _____ Occupation: _____ Husband's Occupation: _____

***DIRECTIONS: Please circle, check ( ) or fill in the blanks with the answers best describing your situation. All information will be held confidential and used to provide proper care.***

Reason for seeing doctor: _____

_____

## OBSTETRICAL AND GYNECOLOGIC HISTORY:

1. How old were you when you first started your period? _____
2. Do you have pain with your period? YES NO
   If yes, when do you have pain? (Before, During, After) _____
   If yes, how long does the pain last? _____
3. Do you have swelling before your periods? YES NO
4. DATE OF THE FIRST DAY OF YOUR LAST MENSTRUAL PERIOD: _____
5. How many days pass between the first day of each period? ____ days pass
6. How long do your periods last? ____ days
7. On your heaviest day, how many pads and/or tampons do you use? ____ pads and/or ____ tampons at most
   ____ soaked ____ mild ____ moderate
   How many pads at one time? ____ pads at one time
   How many days are heavy? ____ days
8. Do you have pain with intercourse? YES NO
9. Do you have bleeding with intercourse? YES NO
10. Do you bleed between periods? YES NO
11. When was your last pap smear? _____
12. Have you ever had an abnormal pap smear? YES NO
    If Yes, What treatment was done? _____
13. Contraception (pills, condoms, etc.) _____
14. Tubal Ligation? YES NO
15. Vasectomy? YES NO
16. Last Mammogram _____

## PREGNANCY HISTORY

____ # of Pregnancies ____ # of Miscarriages ____ # of Abortions ____ # of Living Children

**Term Births:**

| | BORN MONTH/YEAR | HOSPITAL CITY/STATE | HOURS IN LABOR | SEX | WEIGHT | TYPE OF DELIVERY | COMPLICATIONS |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |

## MEDICAL HISTORY

1. Please list any type of surgery you have had and the year of the surgery:
   _____
   _____
2. Please list any other hospitalization you have had and the reason (not including childbirth):
   _____
   _____
3. Did you have any childhood diseases? YES NO If yes, please list: _____
   _____

*(continued on reverse)*

## MEDICAL HISTORY (CONTINUED)

4. Last Colonoscopy _____
5. Age 65 and older: Pneumovax Immunization YES NO If yes, when: _____
   Date of last tetanus shot: _____
6. Please list any medications you are now taking, the dosages, and reason for medication. Include over the counter medications:

_____

_____

7. Are you allergic to any medications, latex or iodine? YES NO If yes, please list & describe how you react to them: _____

_____

8. Have you ever had any injuries (i.e. broken bones, concussions)? YES NO If yes, please list: _____

_____

_____

9. Have you ever had a blood transfusion? YES NO If yes, when _____

10. Do you have or have you ever had any problems with any of the following? Check (✓) appropriate line and explain positive finding below.

| | | |
|---|---|---|
| ❑ Eyes, Ears, Nose and Throat | ❑ Bowel Problems | ❑ Phlebitis |
| ❑ Thyroid Disease | ❑ Kidney Disease | ❑ Blood Clots in Legs or Lungs |
| ❑ Diabetes | ❑ Urinary Tract Infections | ❑ Genital Herpes |
| ❑ Breast | ❑ Mental Disorders | ❑ Gonorrhea |
| ❑ Asthma, Bronchitis, Pneumonia | ❑ Seizure Disorders | ❑ Syphillis |
| ❑ Heart Disease or Murmur | ❑ Migraine Headaches | ❑ Condyloma (Warts) |
| ❑ Heart Attack | ❑ Anxiety Disorder, Depression | ❑ Chlamydia |
| ❑ High Cholesterol | ❑ Blood Disorder, Easy Bruising | ❑ AIDS or HIV Exposure |
| ❑ High Blood Pressure | ❑ Anemia | ❑ Trichomonas |
| ❑ Stroke | ❑ Hemophilia | ❑ DES Exposure - Did your mother take it? YES NO |
| ❑ Liver Disease, Hepatitis | ❑ Arthritis | ❑ Cancer (Specify) _____ |
| ❑ Stomach Problems | ❑ Varicosities | ❑ Other _____ |

DETAIL POSITIVE FINDINGS: _____

_____

_____

Primary Care Physician (Family Practitioner or Internist): _____
Last Exam: _____
Other Specialists you see: _____

## FAMILY HISTORY

Are you adopted? YES NO
If any family member has had any of the problems inidicated above (SEE QUESTION #10), please list problem(s) on appropriate line.

| | Problems | If Deceased, Cause of Death | Age at Death |
|---|---|---|---|
| Father: | | | |
| Mother: | | | |
| Brothers: | | | |
| Sisters: | | | |
| Grandparents: | | | |
| Other: | | | |

## HEALTH HISTORY

1. Number of caffeine drinks per day (coffee, tea, soda): _____
2. Number of alcoholic drinks per day (beer, wine, liquor): _____
   Do you feel you have a drinking problem? YES NO
3. Smoking: Never_____ Quit (when) _____ Yes (number per day) _____ How many years?_____
4. Street drugs (cocaine, marijuana, others) YES NO If yes, what and how often? _____
   Do you feel you have a street drug or prescription pain drug problem? _____
5. Calcium servings (milk, cheese, yogurt, etc.) or supplements (mg.) per day: _____
6. Do you perform monthly breast self exams? YES NO
7. What do you do for exercise? _____
   Frequency per week and duration: _____
8. Do you have any sex related concerns? _____
9. Have you ever been sexually or emotionally abused? YES NO
10. Are you interested in HIV (AIDS), Syphilis or other sexually transmitted disease testing? YES NO If yes, which one: _____
11. Do you feel you need treatment for anxiety/depression? YES NO

# WOMEN'S HEALTH OF AUGUSTA, P.C.

## Patient Acknowledgement of Notice of Privacy Practices

A copy of the Privacy Policy for Women's Health of Augusta, PC has been presented to me. If so requested, a copy will be given to me.
I understand that if any changes are made to this Notice of Privacy Practices, a revised copy of the Notice will be posted in the offices of Women's Health of Augusta, PC.
I also understand that if I wish to receive additional copies of this Notice of Privacy Practices in the future or if I have any questions with regard to this Notice of Privacy Practices, I may contact:

**HIPAA OFFICER**
**WOMEN'S HEALTH OF AUGUSTA, PC**
**1303 D'ANTIGNAC STREET, SUITE 2500**
**AUGUSTA, GA 30901**
**PHONE: 706-733-4427 FAX: 706-922-7456**

**Patient Signature:** _____

**Print Name:** _____ **D.O.B.** _____

**Date:** _____

**PHI DESIGNATED CONTACT LIST**

Under the Health Insurance Portablity and Accountability Act of 1996, as amended, patients have the right to agree, restrict or object to providing PHI (protected health information) to family members, friends and/or persons identified as involved in the patient's care or payment for the patient's health care. To comply with the regulations, as outlined in the HIPAA Privacy Policy, documentation of the patient's wishes must be presented in the medical record.

Unless you object, PHI can be **verbally** disclosed to those individuals listed below for medical purposes.

Please list all individuals that you authorize for **VERBAL** disclosure of medical information for one year:

Spouse: _____ D.O.B. _____ Phone _____

Significant Other: _____ D.O.B. _____ Phone _____

Child _____ D.O.B. _____ Phone _____

Confidential messages **MAY** be left on my answering machine: Circle YES or NO

**Womens Health of Augusta, P.C.**
**1303 D'Antignac St., Suite 2500**
**Augusta, Ga 30901**
**Phone 706-733-4427 Fax 706-922-7456**

# Authorization for Disclosure of Protected Health Information

Patient Name _____ DOB _____
Patient SSN _____

I understand that the Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.
By signing the authorization, I authorized Women's Health of Augusta, PC to use and/or disclose certain Protected health information (PHI) to or for the party listed below

**Signed by:** _____ **Date** _____
*Signature of Patient or Personal Representative*

**Print Name** _____

If signed by a Personal Representative, please state such person's authority to act for the Individual.

**Date the authorization will expire:** _____

**Please check appropriate authorization request:**

☐ This authorization permits the Women's Health of Augusta to **REQUEST RECORDS FROM**

☐ This authorization permits Women's Health of Augusta to **SEND the REQUESTED RECORDS**

**Patient completes name and address of where to send records or request records**

Name/Facility _____
Address _____
Fax _____ Phone _____

**Patient chooses dates and name of records to be sent or requested**

Medical Records: _____ all records for the last five years, including HIV
_____ specific date(s) _____
_____ specific items _____

Contact Person at Women's Health of Augusta _____

I understand that when my PHI is disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except (i) to the extent that the Practice already acted on this authorization, or (II) to the extent that the Authorization was obtained as a condition of obtaining insurance coverage. I understand that my revocation must be submitted in writing to the Practice's Privacy Official/Committee at 1303 D'Antignac St., Ste 2500, Augusta, Georgia 30901 by sending a written request stating that I wish to revoke this Authorization to the attention of the Privacy Official/Committe.

**Women's Health of Augusta, P.C.**

**FINANCIAL POLICY**

Women's Health of Augusta participates with most major insurance plans. You are required to bring your insurance card with you for each appointment and present it to the front desk staff.

Please refer to your plans provider directory to be sure our physicians are listed. If you have any questions, please ask our front office staff or one of our financial specialists. Please remember it is your responsibility to know your preferred providers which includes physicians, hospitals, radiologists and labs. It is also your responsibility to know your benefits, copays, deductibles and if referrals prior authorization or precertification is required. We will verify benefits and obtain precertification if required for inpatient and outpatient surgery and for obstetrical care. However, your insurance coverage is a contract between you and your insurance company. If you dispute the amount of the copay, coinsurance or deductible you owe, it is your responsibility to contact your insurance.

It is the policy of this office to collect in full any copay, deductible or coinsurance due from you at the time service is provided. We accept cash, check, debit, or credit cards including Visa, Mastercard, Discover and American Express.

Any service or supply provided that is considered non-covered by your insurance company, must be paid at the time of service.

If you are scheduled for surgery at the hospital, we will verify your benefits for the PHYSICIAN only. Time permitting, you will receive a cost estimate form in the mail with the amount you will be required to pay before surgery and the date the payment is due. Surgery prepayments must be paid by cash, credit card, money order or cashiers check. No personal checks please. If for some reason we do not have time to notify you by mail, a financial counselor will call you with the details. We realize there may be times when financial arrangements may be necessary. However, this is determined on a case by case basis. If the surgery is not considered an emergency, the surgery may be postponed until your financial obligations can be met. Please contact the financial counselor as soon as possible if you need to discuss arrangements. Any payment due for an elective procedure MUST be paid before surgery. Self pay patients must pay in full before surgery.

Benefits are verified for obstetrical care. Self-pay patients must pay the delivery fee in full at their first office visit. All charges for sonograms, labs, nst's, etc. must be paid at the time of service. Any coinsurance and deductible due must be paid by the designated time given. The financial counselor will discuss your payments with you after your insurance has been verified. If sonograms, labs, nst's, etc. are applied to the deductible, then the allowed amount determined by your insurance company must be paid at the time of service.

If you have a balance due, you will receive a statement. Payment is due upon receipt of the statement. If you have not paid your account in full after 90 days, your account can be turned over to a collection agency. If an account is placed with a collection agency, you will be responsible for any fees charged by the agency. This will increase the amount you owe to the collection agency.

**It is your responsibility to notify this practice of any changes in your insurance coverage or your personal information.**

Women's Health of Augusta is committed to providing you with the best possible care. Our physicians and staff value you as a patient and hope to establish a relationship based on understanding and excellent communication.

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## Financial Policy Agreement

*I have read* and agree to the financial policy given to me by Women's Health of Augusta.

_____

**Print Patient Name**

_____ _____

**Patient Signature** or Responsible Party (if minor) **Date**

_____ _____

Responsible Party Address Responsible Party SSN

_____ _____

Address (cont.) Responsible Party D.O.B.

_____

Responsible Party Telephone #