Providence Women's Health Care

PATIENT DEMOGRAPHIC FORM

Phone: 770-670-6170
FAX: 770-670-6171
www.PWHCares.com

EMAIL ADDRESS:_____

LAST NAME:_____ FIRST:_____ MI:_____

DATE OF BIRTH: _____ SOCIAL SECURITY#: _____ - _____ - _____

MAILING ADDRESS: _____

CITY:_____ STATE: _____ ZIP:_____

PHONE CONTACTS: PLEASE CHECK BEST CONTACT NUMBER

◯ **HOME:** _____ ◯ **CELL:** _____ ◯ **WORK:**_____

EMERGENCY CONTACT: _____ **PHONE#:** _____

RELATIONSHIP TO YOU:_____

Do You Authorize us to Release Medical Information to this person? ◯ **YES** ◯ **NO**

PHARMACY NAME: _____ **CITY:** _____ **PHONE#:**_____

I hereby give authorization for Providence to access my Prescription History _____

Please Sign Here

INSURANCE INFORMATION

◯ **NO INSURANCE , Self Pay**

PRIMARY Company Name:_____ Phone #:_____

Name of Policy Holder: _____Policy Holders DOB: _____/_____/_____
(If not yourself)

Relationship to Policy Holder: _____Policy Holders Social Security #: _____ - ____ - _____

Policy Holder's Address (**if different than yours**)_____

SECONDARY Company Name:_____Phone #:_____

Name of Policy Holder: _____ Policy Holders DOB: _____/_____/_____
(If not yourself)

Policy Holders Social Security #: _____ - ____ - _____ Relationship to Policy Holder: _____

RACE: ◯ **Caucasian** ◯ **African American** ◯ **Hispanic** ◯ **Other** ◯ **Refused**

ETHNICITY: ◯ **Hispanic/Latino** ◯ **NON Hispanic/Latino** ◯ **Refused**

LANGUAGE: ◯ **English** ◯ **Spanish** ◯ **Russian** ◯ **Other** _____

HOW DID YOU HEAR ABOUT US?_____

Providence Women's Healthcare

OFFICE POLICIES Effective 10/1/2014

Prescription Refills- Please allow 48 hours for refills. We will not be able to refill anything not prescribed from our offices.

- Please leave your name, date of birth and pharmacy name and number when calling for a prescription refill.
- Please check your bottles early and call us before you are out of your medication.
- Please check with your pharmacy at the end of the day. We will only call you if there is a problem filling your request.

Messages- All calls after 3:00 pm will be returned the next business day.

- Our providers and clinical staff cannot diagnose your symptoms over the phone. If you require a new prescription for symptoms you are experiencing, please be advised that you will need to schedule an appointment to see one of our providers.
- If you call and leave us a message, there is no need to leave multiple messages throughout the day.
- If you require a call back but it's not an emergency, we will contact you by the end of the day.

Appointments

If you are unable to keep an appointment, please call as soon as possible to reschedule. If you are more than 15 minutes late for your appointment, we will do our best to fit you into the schedule, but we may need to reschedule you. If you do not cancel 24 Hours in advance of your appointment or do not show for an appointment without 24 Hour Notice, you will be charged $25 per visit. In consideration of our other patients, please know that If you have three (3) or more No Shows or Cancellations Without Notice, we have the right to deny you further appointments.

Lab/Test Results

- Our office will contact you with any ***ABNORMAL*** lab results and instruct you on appropriate follow up. If you do not hear from us, your results are within normal range and no follow-up is necessary.
- However, If you want to know any test results, please call us, and our medical assistant will return your call within 48 hours.
- Please allow 7-10 business days for most pap and lab results.
- Our labs are processed through **LABCORP. It is your responsibility to inform us if your insurance requires a different laboratory.**

Obstetrical Administrative Fee

There is an *optional* $75 Administrative Services Fee for obstetrical patients to cover all administrative services that are not covered by your insurance. If you choose to not pay this optional fee:

- There is a $35 fee per form for completion of all forms including disability, FMLA and health assessments.
- There is a $35 administrative fee for each requested copy of your medical records from our office.

Patient Refund:

The following criteria must be met prior to issuing a patient refund. There should be no outstanding insurance claims or balances on any of the patient's accounts. Refunds will be issued once all outstanding insurance claims have been paid and all office charges are current. Refunds will be issued once a month.

Surgical Procedures:

The patient will be charged a fee of $300.00 in the event that a surgical procedure which has been scheduled for the patient is cancelled without 72 business hour notice. Exceptions may be made on a case by case basis.

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Authorization of Insurance Benefits, Medical Treatment, Patient Responsibility and Information Release

I hereby give consent for medical treatment and authorize direct payment of surgical/medical benefits to Shelley Dunson-Allen, MD, PC for services rendered by her in person, by her employees/affiliates or under her supervision at Providence Women's Healthcare. Our office will file primary insurance claims for you; however, office visit co-pays, deductibles, and co-insurances are due at the time these services are rendered. In the event that a non-covered service is performed, or non-covered lab work is ordered and performed; insurance coverage is not in effect because we are not participating in your plan; or insurance coverage is not in effect on the date of service; you will be responsible for all the charges related to your medical care. Please remember it is YOUR responsibility to contact your insurance company to verify that Dr. Shelley Dunson-Allen, at 1300 Upper Hembree Road, Roswell, GA 30076 is a participating physician with your particular insurance plan.

Patient Financial Responsibility: The patient is expected to present all insurance cards at each visit. All co-payments, deductibles, and co-insurance are due at time of service. No new services will be rendered if you have an outstanding balance.

Self-Pay Account: Self-pay accounts are patients who are covered by insurance plans that our office does not participate with, patients without a correct insurance card on file, or patients that do not have insurance at time of service. It is expected that payment is required at time of service for all services including surgeries.

Authorization to Release Information

I hereby authorize Providence Women's Healthcare to release my medical or incidental information that may be necessary for medical care or in processing applications for financial reasons.

_____ _____

Patient or Parent/Guardian Signature (if patient is a minor/under age 16) **Today's Date**

Providence Women's Healthcare

Notice of Privacy Policies (HIPPA)

At Providence Women's Healthcare we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes personal information we collect from you, and how and when we use or disclose that information. It also describes you rights as they relate to your protected health information. This notice is effective 10/01/2014 and applies to all protected health information by federal regulations.

Understanding Your Health Record/Information

Each time you contact Providence Women's Healthcare a record of your contact is made. Typically, this contains symptoms, diagnosis, treatment and plan for future care. It also contains a description of the equipment or supplies we provided for you. The information is often referred to as health or medical record and serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party payer can verify that services billed were actually provided
- A tool in which we can assess and continually work to improve the care we render and outcomes we achieve

Understanding what is in your record and how your health information is used to help you to: ensure its accuracy, better understand, who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Your health record is the physical property of Providence Women's Healthcare, but the information it contains belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect a copy of your health record as provided for in CFR 164.524
- Request amendment to your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative locations
- Request a restriction on certain uses and disclosures of your health information as provided by 45 CFR 164.522, and revoke authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Providence Women's Healthcare is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy with respect to information we collected and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction, and accommodate reasonable requests you may have to communicate health information be alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us with.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in this authorization.

For More Information or to Report a Problem

If you have any questions and/or would like any additional information, you may contact the office manager at Providence Women's Healthcare at (770)670-6170.

If you believe your privacy rights have been violated, you can file a complaint with the privacy officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filling a complaint with either the Privacy Officer or the Office of Civil Rights. The address for the OCR is: Office of Civil Rights: U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building , Washington, D.C. 20201

Examples of Disclosure for Treatment, Payment and Health Options	
For treatment	Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your provider will document in your record his/her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.
For payment	A bill may be sent to your or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedure and supplies used.
For regular health operations	Members of the medical staff may use information in your health record to assess the care and outcomes in your case and other cases like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.
For business associates	There are some services provided in our organization through contact with business associates. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered to protect your health information however, we require our business associate to appropriately safeguard your information.
For Workers' Compensation	We may disclose health information to the extent authorized by and the extent necessary to comply with laws relating to workers compensation or other similar programs established by law
For Public Health	As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
For Law Enforcement	We may disclose information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

_____ _____

Patient or Parent/Guardian Signature (if patient is a minor/under age 16) **Today's Date**

Initial Patient Information

Patient Name: _____ Age:_____ Date:_____

What is the **main** reason for your appointment today? _____

_____

Please list your pharmacy **name, address and phone number** where you would like your prescription refills to be called in for you:
_____ _____ _____

Obstetrical History
Please indicate total number of:

Pregnancies	Full Term Births	Preterm Births	Miscarriages	Abortions	Ectopic/Tubal Pregnancies	Live Births	Living Children

Number of Cesarean sections _____ List the date of each delivery: _____
Any pregnancies complicated by:
☐ High blood pressure ☐Hemorrhage ☐ Preterm labor ☐ Gestational Diabetes ☐Other: _____

Were you ever hospitalized before labor? ☐ YES ☐ NO If yes, why _____

Gynecological History
Please fill out completely

I had my very first period at age _____. My most recent period started on _____/_____/_____ (date). My period comes approximately every _____ (number) days and stays on for a total of _____ days. On average, I use _____ (number) of pads/tampons on the heaviest day of my period.

If not menstruating, age when stopped _____ Any bleeding or spotting since last period? ☐ YES ☐ NO

Do you have…?	Yes	No	
Painful periods?			If yes, please indicate: ☐ Mild ☐ Moderate ☐ Severe ☐Incapacitating
Any clots?			
Bleeding or spotting between periods?			
Bleeding after intercourse?			
Pain with sexual intercourse?			

Have you had…?	Yes	No	If yes, give date	Result
A Pap test (cervical cancer screening)?			/ /	☐ Normal ☐ Abnormal:_____
Mammogram?			/ /	☐ Normal ☐ Abnormal:_____
Colonoscopy?			/ /	☐ Normal ☐ Abnormal:_____
Bone Density Test?			/ /	☐ Normal ☐ Abnormal:_____
Cholesterol Check?			/ /	☐ Normal ☐ Abnormal:_____

Contraceptive/Sexual History	Yes	No	
Are you sexually active?			How many partners in the last 12 months: _____ Lifetime: _____
	If yes, do you have sex with…? ☐ Men ☐ Women ☐ Both		
Have you ever tested positive for STDs?			☐Genital Herpes ☐ Genital Warts ☐ Chlamydia ☐ Gonorrhea ☐ Trichomonas ☐ Cervical Human Papilloma Virus (HPV) on Pap
Type of contraception used:	☐ Pills ☐ Mirena IUD inserted:_____ ☐ ParaGard IUD inserted:_____ ☐ Diaphragm ☐ Condoms ☐ Rhythm ☐ Withdraw ☐ Tubal Ligation ☐ Vasectomy ☐ Foam ☐ Other: _____ ☐ None		
Are you happy with your current method?			

Medical History

Do you presently have any of the following?

☐ Chills or Fevers	☐ Fainting	☐ Diarrhea	☐ Sudden need to urinate
☐ Night sweats	☐ Headaches	☐ Constipation	
☐ Recent weight change	☐ Hearing aid	☐ Change in bowel habit	☐ Loss of urine with coughing or sneezing
☐ Poor appetite	☐ Breast tenderness	☐ Blood in stool	☐ Abnormal pain other than period cramps
☐ Unusual hair growth	☐ Blood or milk from breast	☐ Frequent night urination	
☐ Marked tiredness	☐ Lump(s) in breast		
☐ Dizziness	☐ PMS	☐ Painful urination	
	☐ Nausea or vomiting		

Any unusual vaginal discharge? If yes, Indicate characteristics.

☐ Watery	☐ Clear	☐ Burns	☐ Brown	☐ Odor
☐ Yellow	☐ Bloody	☐ Mucous	☐ Itches	

Have you ever had any of the following surgeries?

	Year		Year		Year
Appendix		Hernia		Womb/Uterus	
Gallbladder		Hemorrhoids		Vaginal repair	
Kidney Stones		Chest		C-section	
Tonsils		Breast		D&C	
Tumor		Ovary		Cryo/Cautery	
Varicose Veins		Fallopian Tubes		Cosmetic	

List Others:

_____

_____

Other than surgery have you ever been hospitalized? If yes, why? _____

Have you ever been diagnosed with any of the following?	Yes	No	Details
HIV/AIDS			
Blood Clot/Embolism			
Cancer			Type:

Have you ever had a blood transfusion			

List Allergies (Drugs/Food/Environmental)	Reaction

List Current Medications	Dose/Strength	Frequency

Social History

Please provide the following information

Marital Status:	□ Single □ Married □ Separated □ Divorced □ Widowed

	Yes	No	Details
Do you smoke cigarettes?			How many per day? _____ For how long?_____
Have you ever smoked cigarettes?			When did you quit?
Do you drink alcohol?			How many drinks per day? _____ Per week?_____
Do you use street drugs?			What kind?
Do you get any regular exercise			How often?
Have you been emotionally or physically abused by your partner or someone important to you?			
Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone			

Family History

Have your biological grandparents, parents, brothers, sisters or children ever been diagnosed with or treated for?:

	Relationship
Tuberculosis	
Diabetes	
High blood pressure	
Heart Disease	
Breast Cancer	
Ovarian Cancer	

	Relationship	Type
Blood Disease		
Nervous Disorder		
Muscular Disorder		

Past Medical History

Have you ever had treatment for any of the following? (*If yes, please indicate year respectively)*

	Yes	No	Year
German measles			
Poliomyelitis			
Tuberculosis			
Ears			
Eyes			
Headaches			
Hepatitis			
Thyroid problem			
Liver disease			
Gallbladder disease			
Diarrhea			
Kidney Infection			
Kidney Stones			
Varicose veins			

	Yes	No	Year
Pneumonia			
Asthma			
Coughed up blood			
Heart problem			
Shortness of breath			
Anemia			
Bleeding			
Diabetes			
Yellow jaundice			
Chronic constipation			
Blood in stool			
Bladder Infection			
Blood or pus in urine			
Muscle or joint problems			

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