

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

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: _____

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 #: _____

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 hereby 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.

Consent Form: I hereby authorize the physicians 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.

<input type="checkbox"/> Eyes, Ears, Nose and Throat	<input type="checkbox"/> Bowel Problems	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Blood Clots in Legs or Lungs
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Urinary Tract Infections	<input type="checkbox"/> Genital Herpes
<input type="checkbox"/> Breast	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Gonorrhea
<input type="checkbox"/> Asthma, Bronchitis, Pneumonia	<input type="checkbox"/> Seizure Disorders	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Heart Disease or Murmur	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Condyloma (Warts)
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Anxiety Disorder, Depression	<input type="checkbox"/> Chlamydia
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Blood Disorder, Easy Bruising	<input type="checkbox"/> AIDS or HIV Exposure
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Anemia	<input type="checkbox"/> Trichomonas
<input type="checkbox"/> Stroke	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> DES Exposure - Did your mother take it? YES NO
<input type="checkbox"/> Liver Disease, Hepatitis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer (Specify) _____
<input type="checkbox"/> Stomach Problems	<input type="checkbox"/> Varicosities	<input type="checkbox"/> 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 indicated 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) _____
Do you feel you have a street drug or prescription pain drug problem? YES NO If yes, what and how often? _____
- 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.
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.

Our self pay patients are receiving a 25% discount at this time when the amount of the charge is paid in full at or before the time of service. This does not apply to supplies or certain services that is purchased by the office such as IUD, hormone medications, etc. This policy is subject to change without notice.

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 from 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 or your surgery may be cancelled. 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. Usually, half of the amount due must be paid before surgery and the balance may be paid in one to two equal monthly payments. 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 also verified for obstetrical care. Self-pay patients must pay the delivery fee in full by their second 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 may be placed with a collection agency. If further arrangements are needed, you must contact the billing office immediately. If an account is placed with a collection agency, you will be responsible for the fees charged by the agency. This will increase the amount you owe by 30% or whatever the rate is at the time of placement.

It is your responsibility to notify this practice of any changes in your insurance coverage or your personal information. Please notify us of name, address, phone number or work changes.

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.

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 Guarantor (if minor)

Date

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 Portability 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/Committee.