PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name:	☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Marital Status:

Is this your legal name? ☐ YES ☐ NO	If not, what is your legal name?	Birthdate:	Age:	Sex:

Street or Mailing Address:	City:	State:	Zip Code:	Home Phone Number:

Cell Phone Number:	E-Mail Address (To be used for appointment reminders):	Social Security:

Occupation:	Employer:	Employer Phone Number:

Employment Status: ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military **Student Status:** ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N - Not a Student

Race:
Ethnicity:
Language:

Pharmacy:	Do you have a living will? ☐ YES ☐ NO

Referred By (Please check one box)
☐ Dr. _____ ☐ Insurance ☐ Hospital ☐ Family ☐ Friend ☐ Yellow Pages ☐ Other _____

Other Family Members Seen Here

PCP Name Phone #

Consent to text ☐ Yes ☐ N

Sexual Orientation- ☐ Lesbian ☐ Gay or Homosexual. ☐ Straight or heterosexual. ☐ Bisexual. ☐ Don't Know. ☐ Choose not to disclose.

Gender Identity -

Assigned Sex at birth - ☐ Male ☐ Female. ☐ Choose not to Disclose

RESPONSIBLE PARTY INFORMATION

Responsible Party: ☐ Another Patient ☐ Guarantor ☐ Self ☐ Check here if information is same as patient

Name:	Address:	Home Phone Number:
Birth Date:	E-Mail Address:	

Occupation	Employer	Employer Address	Employer Phone Number

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? ☐ WORKERS COMPENSATION (WC)
☐ OCCUPATIONAL MEDICINE (OM) ☐ MOTOR VEHICLE ACCIDENT (MVA) ☐ ACCIDENT DATE: _____

Does the patient have healthcare coverage? ☐ YES ☐ NO	**Insurance Name:**

Name of Insured	Social Security Number	Birth Date	Effective Date	Group ID	Subscriber ID (Policy Number):

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of Secondary Insurance:	Name of Insured	Date of Birth	Group ID	Subscriber ID (Policy Number):

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

EMERGENCY CONTACT

Name (Last, First):	Relationship to Patient:	Home Phone Number:	Other Phone Number:

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____
Patient/ Guardian Signature Date

Updated 03/2017

Communication Authorization

We take your medical confidentiality very seriously. We will not and cannot release information without your authorization.

This authorization allows our staff members to speak only with individual(s) you designate in the event you are not available to receive phone calls or you have an adult individual that helps coordinate your medical care.

As part of our Patient Privacy Policy, we will not leave any health information with any other persons unless you specifically authorize below.

_____ I do not authorize anyone to receive information regarding my medical care.

_____ I authorize my physician and staff of the clinic to speak with:

Name: _____ Phone _____

Relationship _____ [ ] Appointments [ ] Account [ ] Lab/Test Results [ ] Medical Care

Name: _____ Phone _____

Relationship _____ [ ] Appointments [ ] Account [ ] Lab/Test Results [ ] Medical Care

Name: _____ Phone _____

Relationship _____ [ ] Appointments [ ] Account [ ] Lab/Test Results [ ] Medical Care

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are to be referred to this staff.

I agree that should I desire to revoke this authorization, I will give written notices.

Patient Signature: _____ Date/Time: _____

MINDEN PHYSICIAN PRACTICES
PATIENT'S RIGHTS AND RESPONSIBILITIES

Minden Physician Practices Patient's Bill of Rights and Responsibilities, distributed to all patients upon request at any time during patient care.

Patients of Minden Physician Practice shall have the right to:

- Be treated equally and receive care without regard to age, sex, religion, race or creed;
- Receive care that is not determined by patient's ability to pay for service;
- Confidentiality of her clinical records;
- Be informed of all costs and expected payment from other resources:
- Be treated with respect for the individual patient's comfort, dignity and privacy;
- Be informed of her rights in advance of care being provided;
- Access information contained in her clinical records within a reasonable time frame;
- Make decisions regarding her care;
- Formulate advance directives and have staff/practitioners to comply with those directives;
- Maintain personal privacy and receive care in a safe setting;
- Be free from verbal and physical abuse or harassment from staff.

The Practice understands that:

- Providing, to the extent possible, information needed by professional staff in caring for the patient;
- Following instructions and guidelines given by those providing health care services.

_____

Printed Name of Patient or Representative

_____ _____

Patient Signature Date/Time

Updated: 10/15/2019

the Women's Clinic
Caring for and about women.

CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorizations, releases and agreements
so that we may proceed with the care and treatment ordered by your physician.

1. CONSENT TO SERVICES: I understand that a patient's care is directed by his/her attending physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician (s).

2. FINANCIAL AGREEMENT: I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the physician/clinic in accordance with the charges listed on the claim and, if applicable, the physician/clinic's charity care and discounted payment policies and state and federal law. The physician/clinic may provide, upon my request, a reasonable estimated of charges for items and services based on the charge fee schedule. If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the physician/clinic may bill my insurance company or health benefit plan but is not required to do so. I agree and understand, except where prohibited by law, the financial responsibility for the services rendered belong to me, the undersigned. I further understand that the obligation to pay the physician/clinic may not be deferred for any reason, including pending legal actions against other parties to recover medical cost. The physician/clinic shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including radiologist, pathologist, emergency physician, anesthesiology, hospitalist, and others if applicable will bill separately for their services. For your convenience we accept cash, personal checks, MasterCard, Visa, Discover, and American Express.

3. REFERRALS: If your insurance plan requires a referral from a Primary Care Physician, it is your responsibility to make sure that the form is received PRIOR to scheduling an appointment. If you do not have your referral, the practitioner will be happy to see you, but you will be financially responsible for your charges.

4. SECONDARY MEDICAID POLICY: The Women's Clinic does not accept secondary Medicaid coverage. If the patient has primary commercial insurance coverage and secondary Medicaid coverage, The Women's Clinic will only file claims for services rendered to the primary commercial insurance company. Any copays, deductible, or out of pocket expenses not paid by the primary insurance will be the responsibility of the patient.

5. PHYSICIAN/CLINIC TO ACT AS AGENT: I irrevocable assign and transfer to the physician/clinic all rights, benefits, and any other interest in connection with any insurance plan health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the physician/clinic of all insurance and health plan benefits payable for any services rendered. I agree that the insurers or plans payment to the physician/clinic shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal lay. I agree to cooperate with and take all steps reasonably requested by this physician/clinic to perfect, confirm, or validate this assignment. I also hereby authorize the physician/clinic, or its designee, to act on my half in any dispute with a managed care organization government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursing such appeals.

6. CONSENT TO WIRELESS TELEPHONE CALLS AND TEXT MESSAGES: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the clinic/physician to the contrary in writing. In this section, calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, test messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

7. CONSENT TO EMAIL USAGE: If at any time I provide an email address at which I may be contact, unless I notify to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at the email address from the clinic/physician.

8. ELECTION TO ELETRONICALLY TRANSMIT MEDICAL INFORMAITON AT DISCHARGE: I authorize physician or clinic to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care providers(s) or facility (ies) identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information related to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list

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of my current and historical problems and my current medication list. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

9. ELECION TO PARTICIPATE IN HEALTH INFORMAITON EXCHANGE(S): I hereby authorize physician/clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which physician/clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, and health care operations and, in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or network with which physician/clinic participates may be found in the Notice of Privacy Practices, which is available upon request, and this list may be updated from time to time if and when physician/clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information related to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

10. PATIENT APPOINTMENT AND CONDUCT: I understand that unless cancelled 24 hours in advance, you are expected to appear on time for your appointment. Three (3) or more missed appointments in a 12 month period may results in dismissal from the practice and patients will be asked to seek treatment elsewhere. I am expected to be respectful to clinic staff and other patients. This includes use of appropriate language and heavier. Patients who use profane language or cause physical harm or threaten to cause harm will be dismissed from the practice.

11. HIPAA ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES/PATIENT RIGHTS: I understand and have been provided with a Notice of Privacy Practices and patient rights that provides a more complete description of my health care information uses and disclosures.

12. AUTHORIZATION TO DOWNLOAD PHARMACY INFORMATION: I understand and authorize physician/clinic to download my last 13 months of prescription history.

13. CHILDREN IN THE WAITING ROOM: Due to OSHA regulations, and for the safety of your children, NO children over the age of 12 months will be allowed in the waiting area or in the patient rooms. Please make necessary arrangements for your appointment. If unable to find childcare during the time allotted for your visit, please reschedule your appointment in a timely fashion. Please understand that if you arrive at your appointment with your child you will be asked to reschedule.

14. CONSENT TO PHOTOGRAPH: I consent to photographs, videos or other images where deemed medically necessary by my physician before, during, or after a procedure. This is to provide documentation of my treatment and medical condition and will be kept as a part of my medical record.

15. ADVANCE DIRECTIVE ACKNOWLEDGEMENT: I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. U understand that the terms of my Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

☐ Yes, I have executed an Advance Directive
☐ No, I have not executed an Advance Directive.

My signature indicates that I have read and fully understand this Patient Consent and Financial Agreement and have been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

_____ _____

Signature of Patient or Legal Representative Date/Time

_____

Relationship to Patient

_____ _____

Signature of Witness Date/Time

THE WOMEN'S CLINIC ADULT HEALTH FORM

REASON FOR VISIT: _____ PROBLEM (PLEASE LIST):_____

PREFERRED PHARMACY: _____ **PHARMACY LOCATION:** _____

PRIMARY CARE PHYSICIAN: _____

ALLERGIES: _____

LIST ANY CURRENT MEDICATIONS (INCLUDING BIRTH CONTROL): _____

_____

HAVE YOU HAD THE INFULENZA VACCINE? YES NO PNUEMONIA VACCINE IN THE LAST 5 YEARS? (>65 YEARS OLD) YES NO

GYN HISTORY:

LAST MENSTRUAL PERIOD_____ LENGTH OF CYCLE FLOW_____ HOW MANY DAYS BETWEEN YOUR PERIODS _____

DO YOU HAVE A PERIOD EVERY MONTH: YES NO IS YOUR FLOW: LIGHT MEDIUM HEAVY

HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST PERIOD: _____

CURRENT BIRTH CONTROL: (INCLUDES VASECTOMY, TUBAL, CONDOMS, IUD, SHOTS, PILLS, PATCHES, RINGS) OR NONE: _____

IF POST-MENOPAUSAL, AGE AT MENOPAUSE: _____

WHEN WAS YOUR LAST COLONOSCOPY? (IF OVER 50YRS OLD)_____

WHEN WAS YOUR LAST BONE DENSITY TEST (IF OVER 50YRS OLD) _____

WHEN WAS YOUR LAST MAMMOGRAM (IF OVER 40 YRS OLD) _____

HAVE YOU EVER HAD THESE SEXUALLY TRANSMITTED DISEASES?

HERPES: YES NO HIV: YES NO GONORRHEA: YES NO SYPHILLIS: YES NO

CHLAMYDIA: YES NO TRICHOMONAS: YES NO HPV: YES NO

OBSTETRIC HISTORY

HOW MANY TIMES HAVE YOU BEEN PREGNANT? _____ HOW MANY LIVING CHILDREN DO YOU HAVE? _____

WHAT KIND OF WORK DOES YOUR PARTNER DO? _____ NAME OF BABY'S FATHER: _____

RECORD OF PAST PREGNANCIES:

DATE OF DELIVERY or MISCARRIAGE	TERM DELIVERY OR PRETERM DELIVERY? (Weeks)	BABY'S BIRTH WEIGHT	SEX OF BABY	ANESTHESIA	COMPLICATIONS

HAS ANY OF YOUR FAMILY HAD THE FOLLOWING CONDITIONS?

PLEASE SPECIFY MATERNAL OR PATERNAL SIDE OF FAMILY AND RELATION TO YOU

Example: Paternal side, aunt; Maternal side grandmother; brother/sister

	Yes	Mother (M) Father (P) Relation to you		Yes	Mother (M) Father (P) Relation to you
Anesthesia complications			Heart Problems		
Anxiety Disorder			Hepatitis		
Asthma			High Blood Pressure		
Bipolar Disorder			High Cholesterol		
Birth Defect or Inherited Disease			Kidney Disease		
Breast Cancer			Mental Retardation (Chromosome Disorders)		
Breast problems			Osteoporosis		
Cancer			Ovarian Cancer		
Cervical Cancer			Pulmonary Embolism		
Cystic Fibrosis			Seizures/Epilepsy		
Depression			Sickle Cell Disease/Trait		
Diabetes			Stroke		
Diverticulitis			Tay Sachs		
Endometriosis			Thalassemia		
Fibroids			Thyroid Problems		
Fragile X			Uterine Cancer		
Heart Disease			Varicose Veins		

SOCIAL HISTORY:

(CIRCLE ONE) MARRIED ENGAGED DOMESTIC PARTNER TOGETHER SEPERATED SINGLE WIDOWED

WHAT KIND OF WORK DO YOU DO: _____ HIGHEST GRADE YOU COMPLETED: _____

EXERCISE LEVEL: NONE OCCASIONAL, MODERATE, HEAVY DIET: _____

ALCOHOL INTAKE: NEVER OCCASIONAL DAILY

CAFFIENE INTAKE: NONE OCCASIONAL, MODERATE, HEAVY

SMOKING HISTORY: NEVER FORMER DAILY OCCASIONALLY AMOUNT: _____ HOW MANY YEARS: _____

HISTORY OF OR CURRENT DRUG USE: YES NO LIST ANY STREET DRUGS USED IN THE LAST YEAR: _____

DO YOU USE A SEATBELT ROUTINELY? YES NO DO YOU USE SUNSCREEN ROUTINELY? YES NO

WHO LIVES WITH YOU? _____ NUMBER OF CHILDREN IN THE HOUSE: _____

SEXUAL ORIENTATION: HETEROSEXUAL HOMOSEXUAL BISEXUAL SEXUALLY ACTIVE: YES NO

SURGERIES (LIST TYPE OF SURGERY AND APPROXIMATE YEAR INCLUDING C-SECTION, TUBAL, D&C, BLADDER SUSPENSION):

Surgery Type and Year	Surgery Type and Year

List any hospitalizations not related to childbirth:

_____ _____

HAVE **YOU** HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	Yes		Yes
Abnormal pap		Heart Disease	
Anemia		Heart Problems	
Anesthesia complications		Hepatitis	
Anxiety Disorder		High Blood Pressure	
Asthma		High Cholesterol	
Bipolar Disorder		Hyperthyroidism	
Birth Defect or Inherited Disease		Hypothyroidism	
Bladder or Kidney Problems		Infertility	
Blood Diseases		Kidney Disease	
Breast Cancer		Liver Disease	
Breast problems		Lung Disease	
Cancer		Muscle, Joint or Bone	
Cervical Cancer		Osteoporosis	
COPD		Ovarian Cancer	
Cystic Fibrosis		Pulmonary Embolism	
Depression		Seizures/Epilepsy	
Diabetes		Sickle Cell Disease	
Diverticulitis		Sickle Trait	
Endometriosis		Stroke	
Fibroids		Tay Sachs	
Fibromyalgia		Thalassemia	
GERD/Reflux		Thyroid Problems	
GI problems		Uterine Cancer	
Hearing problems		Varicose Veins	
Headaches		Vision or Eye Problems	
Migraines			

Any other conditions not listed above: _____