Venus Women's Healthcare Professionals

COMPASSIONATE, PERSONALIZED OB/GYN CARE

PATIENT DEMOGRAPHIC FORM

Today's Date: _____

Name: _____ DOB: _____ Age Today: _____

Driver's License# _____ State _____ Social Security# _____

Home Phone# _____ Cell Phone# _____

Can we leave a message at this number? Yes No

Home Address _____ City _____

State _____ Zip Code _____ Email Address: _____

Please check one: [ ] Single [ ] Married [ ] Domestic Partner [ ] Widowed [ ] Separated [ ] other

Primary Language: [ ] English [ ] Spanish [ ] other _____

Employer: _____ Occupation: _____

Work Address _____ City _____ State _____ Zip Code _____

Name of Spouse/ Partner: _____ DOB: _____ SS# _____

Employer: _____ Work# _____ Occupation: _____

Work Address: _____City _____ State _____ Zip Code _____

Primary Insurance Carrier: _____ Policy # _____

Subscriber [ ] Self [ ] Spouse/Partner [ ] Other: _____

Secondary Insurance Carrier: _____ Policy# _____

Subscriber: [ ] Self [ ] Spouse/Partner [ ] Other: _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone# _____

Address _____ City _____ State _____ Zip Code _____

How did you hear about us? [ ] Internet [ ] Newspaper/Ad [ ] Dr. _____ [ ] Hospital _____

[ ] Friend/Relative _____ [ ] Other _____

I agree to provide changes of any of the above information as soon as possible after changes occurs.

Patient Signature _____ Date _____

If patient is a minor, Signature of Parent or Guardian _____ Date _____

Name _____ **Date**_____ **Date of Birth** _____ **Age** _____

Ethnicity _____ Martial Status _____

Chief Complaint/ History of Present Illness:

_____

In the case of an Emergency, would you consent to a Blood Transfusion [ ] YES [ ] NO

Past Medical History (Have you ever had any of the following?) Please circle

Anemia	Cancer	Epileptic Attacks	Asthma	Heart Disease
Heart Disease	Disease of gallbladder		Migraines	Pneumonia
High Blood Pressure	Blood Transfusion	Liver Disease		Diabetes
Rheumatic Fever	Pelvic Infection	Depression/Anxiety		Anemia sickle cell
Mitral Valve prolapse	Bladder Infection	Problems with Drugs or alcohol		Blood clot in leg/lung
Thyroid problem	Genital herpes	Chlamydia/syphilis	Deficiency of minerals in bones (Osteopenia)	

Last Colonoscopy _____ **Last bone density test** _____ **Last Cholesterol Test** _____

Are you taking any medications? [ ] YES [ ] NO (if Yes, list all) _____

_____

Do you have any allergies? [ ] YES [ ] NO (if Yes, list all) _____

Past Surgical History

Year	Name of Surgery/Hospitalizations

Past Obstetrical History **Please list all pregnancies in order (including miscarriages, premature births, abortions, etc.)**

DOB (birth of baby) mo/day/yr	**GA WKS** How many wks when delivered	**Length of Labor** Hours in Labor	**Birth WT** lbs.	**SEX M/F**	**Type of Delivery** Vag/C-sect	**Epidural Y/N**	**Complications**

Social History

Do you smoke?	[ ] YES [ ] NO	How many cigarettes?	When did you start?
Do you drink alcohol?	[ ] YES [ ] NO	How often do you drink?	At what age did you start drinking?
Do you use drugs?	[ ] YES [ ] NO	If yes, please specify:	

Are you interested in any Cosmetic treatment (botox, fillers) /rejuvenation? [ ] YES [ ] NO

Past Gynecological History

Are you sexually active?: □ □□ YES □□ NO Method of Birth Control?: _____

Date of the beginning of last menstrual period?: _____

Date of last pap?: _____ Have you ever had an abnormal pap? □□ YES □□ NO

Have you had treatment due to an abnormal pap? (If yes, please indicate when): _____

- **Family History** (Has any of your relatives ever had)

	Who		Who		Who
□ Hereditary disease		□ Heart problems		□ Mental illness	
□ Cancer		□ High blood pressure		□ Embolism	
□ Diabetes		□ Problems with the kidneys		□ TB	
□ Epilepsy		□ Anemia sickle cell		□ Bleeding problems	

- **Review of Symptoms** (Do you currently have any of the following problems?)

Physical Symptoms		**Cardiovascular**		**Psychiatric**	
Fever/Chills	□ YES □□ NO	Chest pains	□ YES □□ NO	Depression/crying	□ YES □□ NO
Weight loss	□ YES □□ NO	Difficulty breathing	□ YES □□ NO	Anxiety	□ YES □□ NO
Headaches	□ YES □□ NO	Swelling	□ YES □□ NO	Suicidal thoughts	□ YES □□ NO
		Palpitations	□ YES □□ NO		
Eyes		**Respiratory**		**Skin**	
Blurred Vision	□ YES □□ NO	Wheezing	□ YES □□ NO	Rash/sores	□ YES □□ NO
Double vision	□ YES □□ NO	Shortness of breath	□ YES □□ NO	Mole changes	□ YES □□ NO
Changes in vision	□ YES □□ NO	Cough	□ YES □□ NO		
		Sleep Apnea	□ YES □□ NO		
Allergies		**Musculoskeletal**		**Breasts**	
Hay Fever	□ YES □□ NO	Joint pain	□ YES □□ NO	Nipple discharge	□ YES □□ NO
Medicines	□ YES □□ NO	Muscle Weakness	□ YES □□ NO	Lumps	□ YES □□ NO
		Muscle Pain	□ YES □□ NO	Skin Changes	□ YES □□ NO
Neurological		**Ears/Nose/Throat/Mouth**		**Genitourinary**	
Dizziness	□ YES □□ NO	Sore Throat	□ YES □□ NO	Urine Leakage	□ YES □□ NO
Seizures	□ YES □□ NO	Sinus Problem	□ YES □□ NO	Urinary retention	□ YES □□ NO
Numbness	□ YES □□ NO	Hearing problems	□ YES □□ NO	Burning with Urination	□ YES □□ NO
Tingling	□ YES □□ NO	Hot flashes	□ YES □□ NO	Frequent Urination	□ YES □□ NO
		Excessive thirst	□ YES □□ NO	Vaginal discharge	□ YES □□ NO
				Abnormal Bleeding	□ YES □□ NO
Endocrine		**Hematologic/Lymphatic**		Painful periods	□ YES □□ NO
Hair loss	□ YES □□ NO	Swollen glands	□ YES □□ NO	Pain with intercourse	□ YES □□ NO
Heat/cold intolerance	□ YES □□ NO	Frequent bruising	□ YES □□ NO	Fibroids	□ YES □□ NO
				Infertility	□ YES □□ NO
Gastrointestinal					
Nausea	□ YES □□ NO				
Vomiting	□ YES □□ NO				
Constipation	□ YES □□ NO				
Diarrhea	□ YES □□ NO				
Abdominal pain	□ YES □□ NO				

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PERMISSION TO FURNISH MEDICAL INFORMATION

_____ Initial here if you wish us to **furnish information ONLY to you**.

In this instance, we will leave a message for you to call our office if you are not immediately available.

OR

Please list persons to whom we may furnish medical information about you (example: blood test results, other test results, doctor's instructions, etc.) in the event you are not immediately available. Unless otherwise indicated, we will leave a message on your answering machine or voice mail with any routine results or instructions.

THIS AUTHORIZATION WILL BE IN EFFECT UNTIL REVOKED IN WRITING

Approved Person(s)	Relationship to you
_____	_____
_____	_____
_____	_____

_____ _____

Patient Name (please print) Date of Birth

_____ _____

Signature Date

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OFFICE POLICY

Our office provides women's healthcare services specializing in Obstetrics & Gynecology. It is our goal to help you obtain your optimal level of health and wellness. Please review our Office policy, let us know if you have any questions, and sign and date the second page. If you would like a copy, please ask staff.

Specialists: As specialists in Obstetrics & Gynecology, we do not perform management in primary care. For your primary health care needs, you may be better served by a primary health care provider. We can help you establish care with a primary health care provider if you do not have one. Please keep our staff updated on who your primary care provider is, including their office telephone number.

Scheduling: Our OB/GYN physicians deliver babies and cover the hospital for emergencies 24 hours per day. We do our best to keep your wait times to a minimum, but sometimes due to unscheduled events, the physician may be running late or need to reschedule your appointment to take care of urgent needs. We appreciate your understanding of this, and will continue to do the best we can to accommodate all of your patient's needs. If we must reschedule your appointment and you feel you have an urgent need, please talk to our staff and we will assist you. There is a board certified or board eligible OB/GYN physician on-call at all times for deliveries and emergencies.

Facilities: We perform deliveries, surgeries and admit patients to Tri-City Medical Center. We also perform outpatient surgeries at the North Coast Surgery Center.

Consultations: It is difficult to provide adequate medical care by telephone or fax. For this reason we ask that non-emergent needs, such as prescription refills, be addressed at scheduled office visits. Emergent calls will be addressed by staff and the physicians. **If you are pregnant and think you may be in labor, or have any other pregnancy concern, go to Labor and Delivery. If you have a life-threatening emergency, call 911 or go to the nearest emergency room.**

Intake Requirements: As part of your intake into our OB/GYN practice, we ask you to provide a valid photo ID, a copy of both sides of your insurance card and a credit card number and expiration date that we can keep on file. Be assured any personal information you provide will be kept confidential with access limited to those who require the information only for the purposes of your medical care and billing. Any credit card information will be kept only in our secure system.

Insurance and IPA Requirements & Authorizations: We are providers for patients of both Greater tri-Cities IPA and Primary Care Associates Medical Group (PCAMG). Many insurance carriers and IPA's require that you use specific providers, including laboratory and radiology services. It is your responsibility to be aware of which providers are contracted with your insurance carrier or IPA. In many cases, an authorization may be required prior to services being rendered. If this is the case, our office staff will obtain the authorization and contact you with the outcome and schedule your testing or procedure upon approval.

Contact Information & Pharmacy: It is your responsibility to notify the office of any changes in your telephone number or address immediately, so we may contact you at any time, or in the case of an emergency. Please keep our staff updated on any changes with your preferred pharmacy.

Financial Policy and Payment: Full payment is expected at the time of service, including any co-pays or outstanding balances. Payment is accepted in the form of cash, check, or credit card (Visa, MasterCard or Discover). Your insurance will be billed with the information you provide. It is your responsibility to provide the appropriate billing information and to determine covered services through your individual health plan and/or IPA. If you have two insurances, you are required to provide us with both insurances. All insurance eligibility will be verified. If you have any questions about your deductible or network status, please contact your insurance carrier directly. You will be responsible for any balances remaining after your insurance has been billed, and you will be notified of such balance. If you fail to make payment on

outstanding balances, you authorize the charge to your credit card on file for that amount plus any late fees. If you feel there has been an error, or have any questions about your bill, please contact the office for explanation of your bill.

Private Pay Patients: If you do not have active medical insurance and are in need of OB/GYN services, please discuss with our staff the arrangements that can be made if you will private pay for services. Please keep in mind there will be charges for the visit and for any testing done in the office. If you require testing that is sent out or done at a laboratory or radiology facility, you will make payments directly to those locations for those services. If you require surgery at the hospital or outpatient surgery center, our office staff can assist you in working with those facilities to determine their costs for services. In general, payment plans in this office can be arranged for private pay patients, however full payments must be received prior to rendering services. If you have any questions, please do not hesitate to ask.

Out of pocket expenses: The following services are not covered by insurance

Missed appointment (cancelled with less than 24 hours' notice)	**$50 1st time, full visit cost 2nd time**
Returned check fee	**$30**
Medical records request (no charge to requesting physician)	**$25**
Disability and other forms, including FMLA forms	**$20 per packet**
Late payment fee (on balance over 30 days)	**$25 per month**

No-Show Policy: If you are unable to keep your appointment, we ask you to kindly call our office at least 24 hours prior to your appointment in order to reschedule. This is very important so that we may provide an appointment to another patient who may have been waiting. If you fail to give at least 24 hours advanced notice, there will be a $50 fee for the first incident. Once payment is received for the missed appointment, you may have another appointment scheduled. If you miss a second appointment without giving 24 hour notice, you will be charged the full visit charge for the missed appointment, and may be dismissed from the practice if this is a recurrent issue.

Late Policy: Due to the nature of our specialty, and for the courtesy of all patients, we generally cannot accommodate appointments if you arrive after you scheduled appointment time. Please arrive in advance of your appointment time to complete any necessary paperwork. If you are running late for your appointment, please call the office and we can advise if you will need to be rescheduled, or if we can accommodate the appointment that day. If you are late, you may be asked to come in at the end of the day, after the other scheduled patients are seen, or reschedule to another day. Thank you in advance for your cooperation.

Privacy Practices: privacy of your medical information is of the utmost importance. A Health Insurance Portability and Accountability Act (HIPAA) office policy is in place. A copy may be requested on how your information I used, disclosed, and accessed. Please ask our staff for a copy of our Notice of Privacy Practices. With only a few exceptions defined by Federal Law, we cannot release any of your medical information to anyone, including your spouse and/or other family members, without your specific written consent. Your request for release of information must be made in person—we do not accept phone, fax, or mailed requests.

Health Care Choices: We are here to give options for health care management specific to your needs. You have the right to decline any medical therapy or evaluation that we may recommend. If it is the physician's medical opinion that medical complications may arise if you do not follow recommendations, you will be informed of this by the physician and recommendations will be documented in your file.

I have read and agree to these policies and have had the opportunity to receive a copy of the office policy.

Patient Signature:_____Date_____

Staff Witness:_____Date_____

Notice of Privacy Practices

This notice describes how protected medical information about you may be used and disclosed and how you can gain access to this information.

The privacy of your health information is important to us. Venus Women's Healthcare Professionals are required by law to maintain the security and confidentiality of your medical information as well as other identifiable information such as your name, address, and telephone number. We are required to extend certain protections to your "protected Health information" (PHI), which includes any identifiable information about your past, present, or future health care services or payment for your health care.

We are required by law to provide you with this notice regarding our legal duties and our privacy practices. We are required to abide by the terms of the notice currently in effect. We reserve the right to change our Privacy Practices and the terms of the notice at any time. For example, if privacy laws change, we will change our practices to comply with the law. Venus Women's Healthcare Professionals will provide you, at your request, a copy of any revised Notice of Privacy Practices at the time of your appointment, in the mail, or you may view the revised Notice of Privacy Practices or in our offices.

Uses and Disclosures of your Health Information

Venus Women's Healthcare Professionals is permitted to make uses and disclosures of your protected health information. For some of these purposes, we are required to obtain your consent. For others we may be required to obtain your individual authorization. In a limited number of circumstances, we will be authorized by law to disclose your protected health information without your consent or authorization.

Following is a description of these uses and disclosures:

- For treatment- We may use or disclose your protected health information to provide and coordinate your care and treatment and any other related services. For example, we will disclose your protected health information as necessary to a health care provider or agency that provides care to you. We may also provide your protected health information to a specialist, laboratory, or pharmacy that is involved in your care by providing assistance with diagnosis or treatment.
- For payment- We may disclose your health information to coordinate claims processing and payment from third party payers. This may include activities such as needed for your health plan to determine eligibility and benefits and utilization review activities. Information on or accompanying the bill may include information that identifies you as well as your diagnosis, procedures and supplies use.
- For health care operations- We may disclose your health information to support the business activities of Venus Women's Healthcare Professionals. These activities include but are not limited to, quality assessment activities, employee and health care professional review activities, staff training and other business activities.

Your Rights Regarding Your Medical Information

The health and billing records we maintain are the physical property of Venus Women's Healthcare Professionals. You have the following rights regarding your medical information: Right to Inspect and Copy: you have the right to inspect and copy medical information that may be used to make decisions about your care. (Usually, this includes medical and billing records but does not include psychotherapy notes.)

To inspect and/or copy medical information about you, contact Venus Women's Healthcare Professionals. If you request a copy of the information, we will charge a fee for the costs of copying, mailing, or other expenses associated with your request.

Right to Amend: If you feel that medical information Venus Women's Healthcare professionals has about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Venus Women's Healthcare Professionals.

To request a change, you must submit it in writing to Venus Women's Healthcare Professionals. You must also provide a reason that supports your request. We may deny your request for a change if it is not in writing or does not include a reason to support the request. In addition, we may deny your request to change information if the information:

- Was not created by us, unless the person or company that created the information is no longer available to make the amendment.
- Is not part of the medical information kept by or for us
- Is not part of the information which you would be permitted to inspect and copy under the law
- Is accurate and complete
- Right to an Accounting of Disclosures: You have the right to ask for an accounting of disclosures. This is a list of the disclosures we made of medical information about you to others, except for purposes of treatment, payment and operations identified earlier.
- To request an accounting of disclosures list, you must submit your request in writing to Venus Women's Healthcare Professionals
- The requirement that we provide you with information about the times we have disclosed your protected health information applies for six years from the date of the disclosure. This applies to disclosures made on or after April 14, 2003

Right to request Restrictions: You have the right to ask that we limit the information we use or disclose about you or treatment, payment or health care operations. You also have the right to ask for a limit on the medical information we provide about you to someone who is involved in your care, like a family member or friend.

We are required to agree to your request. If we do agree, we will complete your request unless the information is needed to provide emergency treatment.

To request restrictions, you must submit your request in writing to Venus Women's Healthcare Professionals. In your request, you must tell us what information you want to limit.

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ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this medical practice's Notice of Privacy Practices. I understand that a copy of the current privacy notice will be available to me at any time. If any information has been updated or amended the updated Notice of Privacy Practices will be available to me at each appointment.

Print Name: _____

Signature: _____

Date: _____

If signed by Parent, Guardian or Conservator, please indicate your name and relationship to the patient:

_____