Arcadia Well Woman

Dale Ann Dorsey, MSN WHNP-BC Mary Frazee, MSN WHNP ARDMS Elia Valdivia, WHNP

Date _____Name _____DOB _____Age _____

Address _____
City State Zip Code

Home phone _____ Cell phone _____

Has your insurance changed? □ No □ Yes New insurance _____

ID # _____ Group # _____

Pharmacy_____ Cross Streets_____

Symptoms Checklist

	Y/N		Y/N		Y/N
Change in moles		Painful Intercourse		Menstrual Changes	
Digestive issues		Shortness of Breath		Breast Changes	
Hot Flashes		Vaginal Issues		Urinary Issues	
Other:					

Health History Dates

Date of Last Pap Smear		Date of Last Menstrual Period		Date of Last Mammogram	
Date of Last Bone Density		Date of Last Colonoscopy			
Other:					

Personal Social History

Relationship Status?		Are you sexually active?		What method of birth control do you use?	
Do you perform self-breast exams monthly?		Medication or Surgery change since last visit?		Family History Changes?	
Major life changes (death of family member, loss of job, etc):					

Lifestyle Choices

Check which issues apply to you and indicate the frequency of occurrence: occasional, daily, or throughout the day.

□ Caffeine use _____ □ Recreational drug use _____

□ Tobacco use _____ □ Unusual stress _____

□ Vaping/E-Cigarette _____ □ Alcohol use _____

□ Other _____

Do you take calcium supplements? □ Yes □ No What is your exercise level? □ Good □ Fair □ Poor

Describe _____

Screening

Over the last two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

I certify that I have answered the questions on this form to the best of my knowledge.

Patient Signature _____ Date _____

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PATIENT AGREEMENT: FOR WELL WOMAN/COMPLETE PHYSICAL EXAM VS. PROBLEM VISIT

Due to time constraints and insurance regulations, our office policy does not allow for both a **Well woman exam/Complete Physical Exam** and a **problem visit** at the same time.

I understand that my appointment for today is for: **(Please mark number 1 OR number 2)**

1.____**My well woman visit/Complete Physical Exam**. Insurance companies define this as a breast exam, pelvic exam, and a pap smear as indicated. It also includes an appropriate screening exam, review of current medical conditions and medications, and labs as included in my policy provisions. A well woman exam does **NOT INCLUDE DETAILED DISCUSSION OR DIAGNOSIS OF MEDICAL PROBLEMS.** I understand that I will need to schedule a problem visit for any problems I am experiencing at a later date.

2.____**My problem visit**. This will require my **well woman visit/complete physical** to be done at a later date, as insurance requires. **My Main Concern is**: _____. If time permits I would also like to discuss _____.

Arcadia Well Woman wants to stress the importance of the annual well woman exam/complete physical exam. If you have chosen to see the provider for your problem today, our staff will assist you in making the appointment for your well woman exam/complete physical exam for a later date before you leave the office today. Arcadia Well Woman strongly urges you to keep this appointment and to check with your insurance to see what wellness and preventive benefits are available to you.

_____ _____

Patient's Signature Date

Patient Name: _____ DOB: _____

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PATIENT OFFICE POLICIES

Thank you for choosing **Arcadia Well Woman** for your Obstetrics and Gynecology care needs. We are committed to providing you with quality and affordable health care. We are pleased that you have placed your trust and confidence in us. In order to help acquaint you with our practice, we would like to make you aware of the following policies.

INSURANCE: We participate in many insurance plans, including some Medicare and Medicaid. We will attempt to bill whichever insurance you have advised us of as a courtesy. Please help us maintain accurate records by filling out forms legibly, and letting us know whenever there are important changes (like your address, telephone number[s], any changes in your name, your medical insurance, etc.). Contracts with insurances are constantly changing. It is the **patient's responsibility** to call the office prior to your appointment to verify that the office is contracted with your insurance.

KNOW YOUR BENEFITS: Each and every insurance company and plan, including Medicare and Medicaid, has different plans, each with different benefits. Because your health insurance is an arrangement between you and your insurer, you should understand what services are covered under your specific plan. Some insurance companies require referrals or authorizations. It is your responsibility to acquire the appropriate referrals and authorizations prior to your appointment. Your insurer can assist you with any questions you have relative to your own benefits with them. **Arcadia Well Woman cannot be held responsible for informing patients whether a particular service is "covered" or not**. However, our staff will make every effort to try to assist you in understanding your health benefits or supply you with other health plan related resources.

PROOF OF INSURANCE/ID: All patients must complete our patient information form. We must also obtain a copy of your driver's license or photo ID, and current, valid insurance card. If you are unable to present an insurance card at the time of service, or if you are covered by an insurance company with which we are not contracted, we require that you pay in full for services in advance.

COPAYMENTS, COINSURANCE AND DEDUCTIBLES: All copayments, and patient balance of coinsurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure to do so may be considered a breach of your contract with your health plan. We may decline to see patients for non-emergent visits if copayments are not made at the time of the visit.

NONPAYMENT: In the event that your insurance does not pay your claim to us in sixty (60) days, we will transfer the remaining balance to you and will send you a statement. If the account becomes 90 days past due, then the unpaid balance may be turned over to a collection agency. Please be aware that all collection fees and/or legal fees will be owed in addition to the remaining balance.

NON-COVERED SERVICES: Your Arcadia Well Woman provider may provide services that may not be covered as a benefit of your specific plan with your insurer. Patients or Guarantors are financially responsible for any and all services provided that may not be covered by your insurance plan. It is your responsibility to know and understand your specific insurance plan and what benefits are provided.

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PRIVATE PAY/SELF PAY: Payment in full is due at the time of visit, without exceptions.

CANCELLATION POLICY: "NO SHOW" POLICY: Any patient that does not show for their scheduled **office visit** appointment, or fails to cancel prior to 24 hours of their appointment will receive a **$50 charge**. Continual missed appointments or rescheduled appointments with less than 24 hours' notice will be a cause for dismissal from the practice.

OUTSIDE PATHOLOGY, LAB FEES: Biopsy, Pathology and Lab samples sent outside of our office are billed independently of Arcadia Well Woman. You may receive a bill from the outside lab and will be responsible for payment to that facility.

TESTING/TREATMENT: The provider may send out specimens to the laboratory in order to properly diagnose and treat specific and ongoing issues. You may receive a bill from the outside lab and will be responsible for payment to that facility. Your signature at the bottom of this office policy authorizes our providers to treat you, and to recommend and/or order laboratory tests or other specialized tests as indicated for diagnosis for your medical condition.

RETURNED CHECKS: $30.00 Fee for returned checks. If your check is returned from the bank, we may NOT ACCEPT an additional check as payment on your account. Future payments must be made with cash, money order or credit card.

MINOR AGE PATIENTS: In accordance to Arizona state law, a young woman, aged 13 and older can access sexual and reproductive health services (such as STD testing and treatment, birth control and pregnancy testing, etc.) without parental consent. All other health issues do require consent from a parent or legal guardian if the child is under the age of 18. **The parent or legal guardian who brings the minor in for medical attention will be held responsible for payment at the time of services that are rendered**.

I have read and agree with the above Patient Office Policy. I understand the terms and conditions outlined herein as confirmed by my signature below.

Patient Name (print)	Patient or Legal Guardian Signature	Date