Women First PC

PATIENT REGISTRATION FORM

Account_____ Date_____

Patient Name_____
Last *First* *Middle* *Maiden*

DOB_____ Age_____ SS#_____ Marital Status S M D Separated

Permanent Address
(Not PO Box)_____
Street *City* *State* *Zip*

Mailing Address (if different) _____

Home Phone_____Cell Phone_____Work Phone_____

Pharmacy_____

Email Address_____

Place of Employment or School_____

Occupation_____

Family Physician_____ Referred by_____

Last Menstrual Period_____ Hysterectomy: Yes No Reason for Visit_____

Spouse Name_____ DOB_____ SS#_____

Spouse Place of Employment_____

Insurance Cardholder's Name_____DOB_____Employer_____

Emergency Contact Info (other than significant other) _____

Phone Number_____ Relationship to Patient_____

If a minor, please fill in responsible part information below:

Responsible Party_____ Relationship_____

Address if different from above

_____
_____

Place of Employment

_____
_____

Guarantor SS#_____

AUTHORIZATION TO TREAT MINOR

I authorize the physicians of Women First PC to treat and prescribe medications to:

_____ _____
Minor Child Relationship to Minor

_____ _____
Signature Date

Authorization SS# _____

Please present insurance card to receptionist

CONCERNING INSURANCE

I hereby authorize **Women First PC** to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or, in the case of Medicare Part B benefits to the social security administration and health care financing administration.) A copy of this authorization may be used in place of the original. This authorization may be revoked by me or my insurance carrier at any time in writing.

_____ _____

Signature of Patient, Insured, or Beneficiary *Date*

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to **Women First PC** for services rendered. I further authorize the release of any information needed to process my insurance claims(s). A copy of this authorization may be used in place of the original.

_____ _____

Signature of Patient, Insured, or Beneficiary *Date*

FINANCIAL RESPONSIBILITIES

In the event my unpaid account must be turned over for collection, I understand I will be responsible to pay all reasonable costs including 40% of all collection fees and any attorney's fee(s).

_____ _____

Signature of Patient, Insured, or Beneficiary *Date*

LABORATORY FEES

Dr Reese may perform and/or recommend preventative and diagnostic tests. These recommendations are individualized to your needs, findings at the time of your appointment and are based on her education, her review of the scientific literature, and standards set by national organizations who specialize in women's healthcare, i.e., American College of Obstetricians and Gynecologists, the Centers for Disease Control, the American Cancer Society, and the North American Menopause Society. These recommended tests MAY NOT be covered by your insurance company. We encourage our patients to know what their plan covers. The staff Women First cannot guarantee coverage for any recommended tests. When prior authorizations occur for procedures the insurance carrier finalizes the authorization with the phrase "this authorization does not guarantee payment".

We copy your card to send with any specimens that are sent to the lab. The lab will file with your insurance company for the processing of these specimens. If you have not provided us with your updated insurance card, we will not file a claim for you and you will be responsible for the entire bill through the laboratory.
Dr Reese utilizes Sunrise laboratory, if your insurance company requires use of another laboratory, it is your responsibility to provide that information to the staff at Women First at check in and to arrange for the transfer of the specimen to that lab.

Medicare, Medicaid, Blue Shield, and other certain insurance companies require you to be informed in advance that there may be certain laboratory procedures which may not be covered because the carrier may determine that the service is not "reasonable and/or necessary". It must be emphasized that in your physician's professional judgement these services are needed in order to render high quality medical care to you. However, in order for you to make an informed decision, you are advised that based on insurance guidelines, it is possible that your carrier may deny certain procedures.

By signing the statement, you are agreeing to pay for laboratory tests, even if your carrier determines that according to its guidelines the services are not "reasonable and/or necessary".

_____ _____

Signature of Patient, Insured, or Beneficiary *Date*

Women First PC

Financial Policy

Insurance and Patient Responsibility:

As a courtesy to our patients, we will file the necessary forms to help you receive the full benefits of your medical coverage. We encourage you to review your insurance policy to understand any limitations on the benefits provided. If you have concerns about coverage for our services, please contact your insurance company prior to your visit.

Please be aware that if your insurance company denies coverage or if we do not receive payment within 60 days of filing your claim, the outstanding amount will become your responsibility. Remember that your coverage is a contract between you and your insurance company (and/or your employer). While we will make every effort to assist you in obtaining your benefits, we cannot compel your insurance company to pay for the services provided.

It is also your responsibility to obtain any necessary documents if your insurer requires a referral for your appointment. Failure to secure the required referral may result in the entire bill being deemed your responsibility.

Financial Arrangements:

Because we realize that every person's financial situation is different, we provide a variety of payment options. For your convenience, we accept all major credit cards, Care Credit and checks (returned checks will be subject to a $35 returned check fee). If the check is returned to Women First for any reason, you will have 7 days to contact our office and arrange another form of payment.

Appointments/Cancellations:

We gladly reserve appointment times for you and appreciate that you have chosen Women First for your care. We strive to remain on time as medical emergencies allow. Late arrivals will be asked to reschedule to the next available appointment time. Late arrivals are considered a no show and assessed a no show fee. As a courtesy, we will remind you of your appointment by calling and/or text/emailing you 7 and 4 days prior to your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patient's valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment.

We reserve the right to charge a fee for missed appointments as follows:

- Established Regular Appointments: $35
- New Patient Appointments, Wednesday Evenings, and Office Procedures: $75
- Office surgeries: $150

Please give at least 24 hours' notice of any cancellations to avoid these charges. Thanks for understanding.

Initial: _____

Patient/Parent/Guardian Responsibility:

- I understand that whoever accompanies my child to their appointment has authorization to consent to medical care as needed, and is responsible for payment of medical services.
- I acknowledge my responsibility for payment of all medical services provided by Women First in accordance with the practice's fees and terms.
- In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment.
- At the initial visit you may sign our consent for minor treatment form that allows us to render care at follow up visits without the presence of a parent or guardian. Under Virginia Law a minor has the right to medical privacy when the care rendered pertains to discussion, testing and treatment of STDs and contraception. We may not discuss any of these results with a parent without written consent of the minor signed in our office.

Late Fees:

I understand that my account will be considered delinquent if not paid within 30 days of billing. The unpaid balance will incur a monthly finance charge of 1.5% (18% APR) or $35, whichever is greater. Further delinquency may result in the balance, along with any applicable administrative fees, being assigned to a collection agency.

Assignment and Release:

I authorize payment to be made directly to Women First PC by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information.

Credit Card on File Policy:

At Women First, we are committed to making our billing process as simple and efficient as possible. We require all patients to have a credit card on file with our office. Your card information will be securely stored in your electronic medical record and processed through Athena Health Services for incidental charges. For your security, only the last four digits of your card number will be visible to our staff. The credit card on file will be used to pay co-pays and account balances after your insurance processes your claim.

If we do not receive payment or establish a payment plan for the amount listed on your statement within 13 days, we will charge the credit card on file for the full amount owed. If your payment is declined, we will contact you. If we do not receive a response to our reminder call within one week, a $35 declined payment fee will be applied, and another statement will be mailed.

Your account will be considered delinquent if payment is not made within 60 days from the date of the original statement. An unpaid balance will incur a finance charge of 1.5% (18% APR) or $35, whichever is greater. Further delinquency may result in collections, along with additional finance fees.

I give Women First permission to charge my credit card for any patient balance due on my account. If I have insurance coverage, my card will be charged AFTER my insurance has paid their portion.

Initial: _____

HIPAA/Patient Consent Policy

Notice of Privacy Practices Written Agreement:

I have read a copy of Women First's Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request.

Name (please print):_____ **Date:** _____

Signature of Responsible Party
(Guarantor): _____

Relationship to Patient(s) (please check): ___ **Self** ___**Other:** _____

Witness Signature: _____

Note: The patient (or guarantor) must sign this sheet and present a valid photo identification before the patient can be seen.
This is for your protection and to prevent fraud.

Women First complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Women First PC
480 W Jubal Early Dr, Suite 300
Winchester, VA 22601

Authorization for release of Information

Name of Patient_____ Date_____

WOMEN FIRST is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient of others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released** Check each that can be given to person/entity on the left in same section.
☐ Voice Mail	☐ Results of lab test/x-rays ☐ Other_____
☐ Spouse (provide name & phone number)	☐ Financial ☐ Medical as follows: _____
☐ Parent (provide name & phone number)	☐ Financial ☐ Medical as follows: _____
☐ Other (provide name & phone number)	☐ Financial ☐ Medical as follows: _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature of Patient or Personal Representative: _____

Date: _____

Description of Personal Representative's Authority (attach necessary documentation)

GYNECOLOGIC INTAKE HISTORY

Date: _____

Name: _____ Date of Birth: _____

Spouse/Partner: _____ Referred by: _____

Family Doctor: _____ Specialist: _____

PAST MEDICAL HISTORY

MAJOR ILLNESSES	YES	NO
Asthma		
Pneumonia		
Chronic Lung Disease		
Kidney Infections/Stones		
High Cholesterol		
Heart Attack		
Diabetes		
High Blood Pressure		
Stroke		
DVT/PE		
Heart Murmur		
MRSA		

	YES	NO
Cancer		
Ulcers		
Depression/anxiety		
Anemia		
Seizure/convulsions/epilepsy		
Bowel trouble		
Blood Transfusion		
Arthritis/Joint pain		
Fracture		
Hepatitis/Fatty liver		
Thyroid Disease		
Migraine		

SURGICAL PROCEDURES

Reason	Date	Reason	Date

HOSPITALIZATIONS

Type	Date	Type	Date

LAST IMMUNIZATION OR TEST

Type	Date	Type	Date
Gardasil/ HPV		Varivax/ Chicken Pox	
Tetanus		Pneumonia	
FLU Shot		Covid vaccine	
		COVID Test Positive: Yes ☐	

OB/GYN HISTORY

	Number		Number
Births		Abortions	
Miscarriages		Living Children	

CURRENT MEDICATIONS

Drug Names	Dosage	Drug Names	Dosage

FAMILY HISTORY

Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			High Cholesterol		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		
DVT			Birth Defects		

HABITS	**YES**	**NO**				
Smoking			Packs per day		Years	
Alcohol			Drinks per day		Drinks per week	
Drug Use						
Seat Belt Use						
Regular Exercise						

PERSONAL PROFILE

Marital Status: Married ☐ Single ☐ Widowed ☐ Divorced ☐

Number of Living Children: _____

Number of People in Household: _____ Sexual Orientation: _____

School Completed High School ☐ College ☐ Grad Degree ☐ Other ☐

Current or most recent job: _____

PERSONAL SAFETY	**YES**	**NO**
Has anyone close to you ever threatened to hurt you?		
Has anyone ever hit, kicked, choked, or hurt you physically?		
Has anyone, including your partner, ever forced you to have sex?		
Are you ever afraid of your partner?		

MEDICARE "HIGH RISK" CRITERIA

Have you ever been treated for any of these infections?

Vaginosis	Genital Warts	Chlamydia	Herpes	Trichomonas	Gonorrhea	Syphilis
☐	☐	☐	☐	☐	☐	☐

	YES	NO	
Have you had a Pap smear in the last 7 years?			
Have you ever had an abnormal Pap smear test?			When?
• Treatment for Abnormal Pap			
Did you begin sexual activity before you were 16 years old?			
Have you had more than 5 sexual partners in your lifetime?			
Have you ever tested positive for the HIV virus?			
Did your mother take the drug DES while pregnant with you?			
Are you sexually active?			
Fibroids			
Endometriosis			
Hysterectomy			
Ovaries Removed			

Last Colonoscopy Date: _____ DEXA Scan Date: _____

GYN CONCERNS:

Completed by: Patient: ☐ Office staff: ☐ Physician: ☐

Patient Signature: _____

Date reviewed by physician with patient: _____

Physician Signature: _____