FEDERAL WAY WOMEN'S HEALTHCARE: MEDICAL HISTORY QUESTIONNAIRE (CoV)

Please mark an answer for every question

Have you ever been diagnosed with Covid-19? (YES/NO) if YES, when?_____

Have you been in contact with anyone who has been diagnosed with Covid-19? (YES/NO)

In the last few weeks, have you had any of the following symptoms?

Fever (YES/ NO) if YES, when was the last day of your symptom? _____

Cough (YES/ NO) if YES, when was the last day of your symptom? _____

Shortness of Breath (YES/ NO) if YES, when was the last day of your symptom? _____

New loss of taste (YES/ NO) if YES, when was the last day of your symptom? _____

Seasonal Allergies (YES/NO) if YES, what type of allergy? _____

I am certain that I have marked the above with the best of knowledge. I sign that if I experience any of the above symptoms or possibly have any exposure to Covid-19 I will let the Federal Way Women's Healthcare know.

Name:_____

Signature:_____

Date:_____

Federal Way Women's Healthcare

32114 First Ave S. Suite
203 Federal Way, WA
98003

Patient Information

Name:_____SSN:_____Date of Birth:_____Race:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Home Address:_____City:_____State:_____

Zip:_____Email:_____

Education:_____Occupation:_____

Employer:_____City:_____State:_____

Marital Status:_____Married_____Single_____Widowed____Divorced_____Separated

Spouse/Father of Baby:_____Occupation:_____

Spouse/father of Baby Employer:_____City:_____State:_____

Home Phone:_____Cell Phone:_____Work Phone_____

Emergency Contact:_____Relationship to you: _____

Home Phone:_____Cell Phone:_____Work Phone:_____

Primary Care Provider:_____Referred By:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY NE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Federal Way Women's Health Care respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this notice, or as required by law.

1) **Your health information rights.**
   The health and billing records we create and store are the property of Federal Way Women's Healthcare. The protected health information in it, however, generally belongs to you. You have the right to
   - Receive, read, and ask questions about this notice**.**
   - Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosures of your protected health information to a health plan for payment or health care operations and the protected health information is about an item or service for which you paid in full directly.
   - Request and receive from us a paper copy of the most current Notice of Privacy Practices.
   - Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
   - Have us review a denial of access to your health information-except in certain circumstances.
   - Ask us to change your health information that is inaccurate or incomplete. You must give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included in any release of records.
   - When you request, we will give you a list of certain disclosures of your health information. The list will not include disclosures for treatment, payment, or health care operation. You may receive this information once without charge every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
   - Ask that your health information be given to you by another confidential means of communication or at another location. Please sign, date, and give us your request in writing.
   - Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we received the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

   For help with these rights during normal business hours, please contact:
   Vicki Chen
   253-838-0219
2) **Our Responsibilities**.
   We are required to:
   - Keep your protected health information private.
   - Give you this notice.
   - Follow the terms of this notice as long as it is in effect.
   - Notify you if we become aware of a breach of you unsecured protected health information.

We reserve the right to change our privacy practices and the terms of this notice, and to make the new privacy practices and notice provisions effective for all of the protected health information we maintain. If we make material changes, we will update and make available to you the revied notice upon request. You may receive the most recent copy of this notice by calling and asking for it, by visiting our office to pick on up, or by visiting our website.

3) To ask for help or complain.

If you have questions, want more information, or want to report a problem about the handling of your PHI, you may contact:

Vicki Chen
253 838 0219

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to **Vicki Chen** at **Federal Way Women's Healthcare**. You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR).

We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

4) How we may use or disclose your protected health information.

Under the law, we may use of disclose your PHI under certain circumstances without your permission. The following categories describe the different ways we may use of disclose your protected health information without your permission. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways are permitted to use or disclose information will fall in one of the following categories.

Below are examples of uses and disclosures of protected health information for treatment, payment, and health care operations.

For Treatment:

- We may contact you to remind you about appointments.
- We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used by members of our health care team to help decide what care may be right for you.
- We may also provide information to healthcare providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.

For Payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

For Health Care Operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of health care providers and to train our staff.

- We may use and disclose your information to conduct or arrange for services, including:
  - ◊ Medical quality review by your health plan
  - ◊ Accounting, legal, risk management, and insurance services.
  - ◊ Audit functions, including fraud and abuse detection and compliance programs.

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows.

- **Required by law:** We must make any disclosure required by state, federal, or local law.
- **Business Associates:** We contract with individuals and entities to perform jobs for us or provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.
- **Notification of family and others:** Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital, when applicable.
- **Public Health and Safety Purposes:** As permitted or required by law, we may disclose protected health information:
  - ◊ To prevent or reduce a serious, or immediate threat to the health or safety of a person or the public.
  - ◊ To public health or legal authorities
    - ♦ To protect public health and safety
    - ♦ To prevent or control disease, injury, or disability
    - ♦ To report vital statistics such as births or deaths
    - ♦ To report suspected abuse or neglect to public authorities
- **Research:** We may disclose protected health information to researches, if the research has been approved by an institution review board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **Coroners, medical examiners, and funeral directors:** We may disclose protected health information to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.
- **Organ-procurement organizations:** Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **Food and Drug Administration (FDA):** For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to jurisdiction of the FDA.
- **Workplace injury or illness:** Washington State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We may also disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.
- **Correctional Institutions:** If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.
- **Law enforcement:** We may disclose protected health information to law enforcement officials as required by law; such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.

- **Government health and safety oversight activities:** We may disclose protected health information to an oversight agency that may be conducting an investigation. For example, we may share health information with the Department of Health.
- **Disaster Relief:** We may share PHI with disaster relief agencies to assist in notification of your condition to family or others.
- **Military, Veteran, and Department of State:** We may disclose protected health information to the military authorities of the U.S., and foreign military personnel; for example, the law may require us to provide information necessary to a military mission.
- **Lawsuits and disputes:** We are permitted to disclose protected health information in the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- **National Security:** We are permitted to release protected health information to federal officials for national security purposes authorized by law.
- **De-identifying information:** We may use your protected health information by removing any information that could be used to identify you.

5) Uses and disclosures that require your authorization.

Certain uses and disclosures of your health information require your written authorization. The following list contains the types of uses and disclosures that require your written authorization:

- **Psychotherapy Notes:** If we record or maintain psychotherapy notes, we must obtain your authorization for most uses and disclosures of psychotherapy notes.
- **Marketing Communications:** We must obtain your authorization to use or disclose your health information for marketing purposes other than for face to face communications with you, promotional gifts of nominal value, and communications with you related to currently prescribed drugs such as refill reminders.
- **Sale of Health Information:** Disclosures that constitute a sale of your health information require your authorization.

In addition, other uses and disclosures of your health information that are not described in this notice will be made only with your written authorization. You have the right to cancel prior authorizations for these uses and disclosures of your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

6) Web Site

We have a website that provides information about us. For your benefit, this information is available on the website at the following address: **www.federalwayobgyn.com**

7) Effective date

This notice is effective as of December 30, 2019.

Notice of Privacy Practices Acknowledgement

Federal Way Women's Health Care has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact **Vicki Chen at 253 838 0219** to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By my signature below, I agree that I have received the Notice of Privacy Practices of Federal Way Women's Health Care.

Printed Name of Patient

Patient or legally authorized individual's signature Date Time

---

Printed Name if signed of behalf of the patient Relationship (parent, guardian, personal representative)

This form will be retained in your medical record

For Office Use Only

Office Staff complete below:

I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date_____ Staff Member Initials_____

Reasons:_____
_____

_____

Federal Way Women's Health Care

Financial Agreement

Thank you for choosing Federal Way Women's Health Care to partner in your health care. This financial agreement should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement and sign in the space provided. You will be given a copy of this agreement for your records.

Your insurance coverage is a contract between you and the insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill both your primary and secondary insurance companies. In order to do this, we must receive all the insurance information necessary to bill. **You are responsible to notify us of any insurance change and any new insurance cards received. You are responsible to notify us of ALL insurances you may have such as state, federal, or private insurance.** Failure to comply with your insurance company may result in a rejection of submitted claims in which you will be responsible for. If the information is not supplied and the window for filing has passed, you will be billed, and payments in full will be your responsibility.

Medicare and Medicaid

We participate in the Medicare and Medicaid program. You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare and Medicaid Explanation of Benefits. Regardless of Medicaid or Medicare insurance coverage, you are required to notify us of **ANY** other insurance you have.

Responsibility for Payment

You are responsible for payment of any co-payment, co-insurance, deductible, or service not covered by your insurance. If you do not have insurance you are responsible for payment of all services. Co-payments are due at the time of service. Patient balances noted on your monthly statement are due within 30 days of receipt. **Minors** who consent to care without parent consent are responsible for paying for services.

Outside Laboratories

We utilize outside laboratories for necessary testing. We will send your samples to the following outside labs: LabCorp, Incyte Diagnostics, Integrated Genetics, Genzyme and Sequenom. You will receive a statement from the lab which you will be responsible for paying. It is your responsibility to let us know whether your insurance is contracted with these labs. We are not responsible in the cases that the lab has to outsource a test to another lab that is not covered by your insurance.

Payment Options

We understand that financial circumstances vary from patient to patient. If you are unable to pay your patient due balance in full, you must call our biller at (253) 838-0219 to make payment arrangements. We offer uninsured patients a cash discount on office visits due at the time of service. Discount does not apply to lab or supply charges.

Non-Payment

Failure to pay will result in your account being referred to a collection agency. Referral to a collection agency or naming Federal Way Women's Health Care in a bankruptcy filing will result in you being charged a processing fee and any applicable legal fees. NSF checks will result in a $25 processing fee. If you fail to pay your co-payment at the time of visit, you will be charged a $15 fee.

Financial Agreement Continued

Your Insurance Information

List ALL insurance you are covered by in the provided fields below, even if you are not the subscriber. This information is needed to properly file your claims.

Primary Insurance_____Member ID_____Group Number_____
Subscriber Name_____Birth Date_____SSN_____
Relationship to Subscriber_____Subscriber's Phone_____
Subscriber's Address_____State_____Zip_____
Date this insurance policy first took effect: Month_____Day_____Year_____
I ( ) do not have any other insurance
I ( ) do have other insurance. If yes, fill in the fields below.

Secondary Insurance_____Member ID_____Group Number_____
Subscriber Name_____Birth Date_____SSN_____
Relationship to Subscriber_____Subscriber's Phone_____
Subscriber's Address_____State_____Zip_____
Date this insurance policy first took effect: Month_____Day_____Year_____
I ( ) do not have any other insurance
I ( ) do have other insurance. If yes, fill in the fields below.

Any Other Insurance_____Member ID_____Group Number_____
Subscriber Name_____Birth Date_____SSN_____
Relationship to Subscriber_____Subscriber's Phone_____
Subscriber's Address_____State_____Zip_____
Date this insurance policy first took effect: Month_____Day_____Year_____
I ( ) do not have any other insurance
I ( ) do have other insurance. If yes, fill in the fields below.

I_____have read this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment on my account. I understand that delinquent accounts will be referred to a collection service. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses, including reasonable attorney fees. I believe the information supplied is complete and true. I also acknowledge that I have received a copy of this financial agreement for my records.

_____ _____ _____

Patient Signature Printed Name Date

_____ _____ _____

Parent/Guardian Signature Printed Name Date

Name:_____

FEDERAL WAY WOMEN'S HEALTH CARE: MEDICAL HISTORY QUESTIONNAIRE

Do you have any medical problems?

_____
_____
_____
_____

Please list any past surgeries you have had. (Include dates and reason for the surgery)

_____
_____
_____
_____

Are you taking any medications? What dosage?

_____
_____
_____
_____

Are you allergic to any medications? What kind of reaction?

_____
_____
_____

Have you ever been pregnant? (YES/ NO) if yes, please answer the following:

How many children do you have?_____How many times have you been pregnant?_____

Please list pregnancies, including miscarriages, terminations, ectopic pregnancies etc.

Pregnancy	Month/Day/Year of Delivery	Weeks of Gestation	Vaginal Birth or C-Section	Weight/ Gender of Baby	Complications During Pregnancy	Epidural
First						YES/NO
Second						YES/NO
Third						YES/NO
Fourth						YES/NO
Fifth						YES/NO
Sixth						YES/NO
Seventh						YES/NO
Eighth						YES/NO
Ninth						YES/NO

Name:_____

FEDERAL WAY WOMEN'S HEALTH CARE: MEDICAL HISTORY QUESTIONNAIRE

How old were you when you had your first period? _____

Have you been through menopause?_____If so, at what age?_____

List any problems you experience with your period? _____

When was your last pap smear? (Month/Year)_____/_____(**NORMAL/ABNORMAL)** *please circle one*

When was your last Mammogram? (Month/Year)_____/_____(**NORMAL/ABNORMAL)** please circle one

*From where?*_____

Have you ever had any sexually transmitted diseases? Please list dates of diagnosis and treatments.

_____

Do you smoke?_____How often?_____For how many years?_____

Do you drink alcohol?_____How often?_____How much? _____

Do you use any recreational drugs? _____ Current birth control?_____

Do you have a family history of any medical problems (ex: Diabetes, high blood pressure, heart attacks, cancers, strokes, hereditary disorders, mental retardation, birth defects, etc)? Please specify on which side of the family ex: mother's or father's side.

_____

_____

_____

Do you have any of the following symptoms? (mark all that apply)

Fever		Fatigue		Difficulty Breathing	
Chest Pain		Palpitations		Vaginal Discharge	
Night Sweats		Chronic Cough		Urinary Incontinence	
Nausea		Skin Rash		Cold Intolerance	
Back Pain		Muscle Ache		Abdominal Pain	
Breast Mass		Hot Flashes		Painful Urination	
Anxiety		Depression		**OTHER**	

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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