

NEW RIVER WOMEN'S HEALTH P.C.
Patient Registration Form

PATIENT INFORMATION

Patient Name: _____
(First) (Middle) (Last)

Sex: Female Male Decline to Specify

Marital Status: Married Divorced Single Separated Domestic Partner Widowed

Date of Birth: ____/____/____ Social Security Number: ____-____-____

Mobile Number: (____) ____-____ Email Address: _____

Home Number: (____) ____-____ Work Number: (____) ____-____

Home Address: _____

City: _____ State: _____ Zip _____

Preferred Pharmacy: _____

How did you hear about New River Women's Health? _____

ETHNICITY/ RACE : Hispanic or Latino Asian White or Caucasian
 American Indian or Alaska Native Black or African American
 Native Hawaiian or Other Pacific Islander Patient declines to specify

Emergency Contact:

Name: _____ Relationship to patient: _____

Phone: _____

RESPONSIBLE PARTY (if other than patient)

Guarantor's Name: _____ Phone Number: (____) ____-____

Address: _____ City: _____ State: _____ Zip _____

(If different from Above)

Patient Relation to Guarantor: _____ Guarantor's Employer: _____

Employer Address: _____

City: _____ State: _____ Zip _____

Guarantor Social Security #: ____-____-____ Guarantor D.O.B ____/____/____

I hereby authorize New River Women's Health P.C., to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to New River Women's Health P.C of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient Signature (or Responsible Party) _____ Date: ____/____/____

PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize New River Women’s Health P.C., to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to New River Women’s Health P.C of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient Signature (or Responsible Party)

Date: ____/____/____

Printed Name of Patient or Personal Representative

Relationship to Patient

SPECIFIC INFORMATION RELEASE (If applicable)

I request and authorize New River Women’s Health P.C. to disclose protected health care information to the individual(s) listed here:

Name _____ Contact # _____

Name _____ Contact # _____

Name _____ Contact # _____

Patient Signature

Date: ____/____/____

Printed Name of Patient or Personal Representative

Relationship to Patient

NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Patient Signature

Date: ____/____/____

Printed Name of Patient or Personal Representative

Relationship to Patient

CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby consent to New River Women’s Health P.C. using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice’s health care operations. I also consent to New River Women’s Health P.C. using or disclosing my protected health information for treatment activities provided by another provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operation including quality assessment and reviewing the competence of health care professionals.

Patient Signature

Date: ____/____/____

Printed Name of Patient or Personal Representative

Relationship to Patient

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received from the Group a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this Group's privacy practices and my rights regarding privacy of my protected health information.

Patient's Printed Name or Guardian's Printed Name

Patient's Signature or Guardian Signature

____/____/____
Date



New River Women's Health Cancellation / No Show Policy

1. Cancellation / No Show for Scheduled Appointment:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a Thirty Five Dollar (\$35) fee; this will not be covered by your insurance company. This appointment will also be marked as a No Show since adequate cancellation notice was not given. We will limit the number of No Shows or late cancellations allowed per patient. If you are a No Show three (3) times, we will no longer schedule appointments for you at our practice.

2. Late Arrival for Scheduled Appointments:

We understand that delays can happen; however we must try to keep the other patients and doctors on time. If a patient arrives 15 minutes past their scheduled time we will have to reschedule the appointment.

Patient's Printed Name or Guardian's Printed Name

Patient's Signature or Guardian Signature

____/____/____
Date

New River Women's Health
COLLECTIONS POLICY



Collection Agency/Attorney Fees - In the event that your account is turned over to a collection agency or attorney, you agree that you will be responsible for a collection fee equal to 33.3% of the outstanding balance due on the date the account is turned over for collection.

Collection Costs - In the event that the account becomes delinquent and is necessary to expend costs for the collection of the account, you understand that you will be responsible for the costs. These costs could include court costs for filing suit against you.

Patient Printed Name or Responsible Party Printed Name

Patient Signature or Responsible Party Signature

____/____/____
Date

Clinical Profile

Patient Name: _____ DOB: ____/____/____

Marital Status: (Circle One) Single Married Widowed Divorced Domestic Partner Separated

Sexual Orientation: Heterosexual ___ Homosexual ___ Bisexual ___ Other ___ Decline to specify ___

Your Employment / Profession: _____

Spouse / Partner's Name: _____

Preferred Pharmacy: _____

Family Doctor or Primary Care Doctor: _____

Date of Last Menstrual Period: _____

Form of Contraception: _____

Allergies: _____

List all Current Medications and the dosage and frequency (including over the counter):

Current Tobacco Use: Yes No

If YES, how long: _____ how much: _____

Former Tobacco Use: Yes No

If YES, how long: _____ how much: _____

Alcohol Use: Yes No

If YES, how many drinks per week: _____

Recreational Drug Use: Yes No

If YES, what: _____ how often: _____

Date of last Women's Health Exam / Pap Smear: _____

Do you have a history of an abnormal pap? Yes No

If so, when? _____

Date of last mammogram: _____ Location of last mammogram: _____

Date of last colonoscopy: _____

Date of last bone density: _____

Date of last cholesterol check: _____ Results: Normal High

Pregnancy History: please check all that apply and how many of each:

Pregnancies: # _____ Vaginal Births: # _____ Cesarean Sections: # _____

Miscarriages: # _____ Fetal Demise: # _____ Elective Abortion: # _____

Patient Name: _____

Past Medical History: Please check all that apply

<input type="checkbox"/> Acid Reflux <input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma/Emphysema/Lung Disease <input type="checkbox"/> Cancer – What kind: _____ <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Crohns/Ulcerative Colitis <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Cholesterol <input type="checkbox"/> History of Blood Transfusion <input type="checkbox"/> Hypertension <input type="checkbox"/> Leukemia <input type="checkbox"/> Liver Disease/Hepatitis <input type="checkbox"/> Lymphoma	<input type="checkbox"/> Migraines <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Disorder <input type="checkbox"/> Other: Details: _____ _____ _____ _____
---	--	--

Past Surgical History: Please check all that apply

Procedure	Date if Known	Procedure	Date if Known
Appendix		Tonsillectomy	
Gall Bladder		D&C	
Hysterectomy		Endometrial Ablation	
C-Section		Hernia	
Incontinence Procedure		Right or Left Ovary Removal	
Sterilization <input type="checkbox"/> Tubal <input type="checkbox"/> Essure <input type="checkbox"/> Partner Vasectomy			

Other surgeries: _____

.....

Family History: Please check all that apply

- Asthma
- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Melanoma
- Mental Health Disorder
- Osteoporosis
- Stroke
- Breast Cancer: Family Member: _____ Age Diagnosed: _____
- Ovarian Cancer: Family Member: _____ Age Diagnosed: _____
- Uterine Cancer: Family Member: _____ Age Diagnosed: _____
- Colon Cancer: Family Member: _____ Age Diagnosed: _____
- Other: _____