WOMEN'S HEALTH FOR LIFE, INC.

1005 Bellefontaine Ave., Suite 175
Lima, OH 45804
Tel. No.: 419-227-2727
Fax No.: 419-227-2737

770 W. High St, Suite 400
Lima, OH 45801

Thank you for selecting Women's Health for Life, Inc. to provide your OB/GYN care.
Your appointment is scheduled for:

To make your first appointment run smoothly, please complete the enclosed information and bring it with to your appointment. Any transferred records we receive from a previous physician are always kept confidential and will not be disclosed without your written permission.

HIPAA: If the patient is a minor, for any results to be released to the patient's parents, the patient must sign an authorization to release information form.

Our office hours are Monday thru Friday from 7:30-11AM and 12-4:30PM. We lunch from 11AM till noon.

ALL prescriptions and authorizations for renewals must be requested during normal office hours. Normal test results will be mailed to you unless you have a return appointment. Any abnormal results will be called to you.

There may be instances when you will see a mid-level provider within our office.

PATIENT RESPONSIBILITIES:

1. If you are unable to keep your appointment, you must notify this office at least 24 hours in advance.
2. If you are fifteen minutes late, your appointment WILL be rescheduled.
3. Please notify our office immediately of any changes in your insurance, address, phone number.
4. If we are providers for your insurance, you will be asked to pay your deductible or co-pay at the time of service. If you are self-pay you will need to pay for your visit in full.
5. Accepting all forms of payment, cash, check ,debit or credit cards (do not accept Discover or American Express)
6. You are responsible to know how your insurance plan works.
7. You are responsible to tell the nursing staff if your insurance requires you to use a certain lab (ex:pap specimen, cultures, labs, etc.)

FEES NOT COVERED BY INSURANCE:

1. Third occurrence of not presenting for a scheduled appointment-$28
2. Prescriptions rewritten - $11
3. Disability, FMLA forms - $6 per form
4. Non-sufficient funds returned check fee - $33

Please bring the following to your appointment:

1. The forms included with this letter
2. Photo of yourself (this photo will be returned)
3. Your insurance card
4. Any questions for the practitioner

We are glad you have chosen us to provide your care. The mission of our medical practice is to provide women with the best of care. We treat all patients with courtesy and respect and we expect our patients to return that courtesy to our personnel.

Patient Information

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Ms / Mrs (Circle One)	First Name	MI	Last Name

Address	City	State	Zip Code

Home Telephone Preferred #	Cell Phone	Date of Birth	Spouses name

Social Security Number	

Pharmacy Name	Pharmacy Address

Marital Status S M	

Emergency Contact	Relationship	Emergency Contact Phone Number (Other than home number)

Employed By (Patient)	Work Telephone Ext

Address of Employer	City	State	Zip Code

Primary Insurance Plan	Social Security Number of Policy Holder

Policy Number	Group Number	Expiration Date

Name of Policy Holder	Date of Birth	Relation to Insured

Address	City	State	Zip Code

Telephone Number	Employer of Policy Holder	Employer Phone

Secondary Insurance Plan	Social Security Number of Policy Holder

Policy Number	Group Number	Expiration Date

Name of Policy Holder	Date of Birth	Relation to Insured

Address	City	State	Zip Code

Telephone Number	Employer of Policy Holder	Employer Phone

PLEASE READ AND SIGN THE FOLLOWING: Thank You

Authorization for Treatment: I authorize Women's Health For Life, Inc. and it's staff to provide routine examinations, diagnostic tests, procedures and treatments as deemed necessary. By signing, I give consent for the above and I understand that this consent will remain in effect until I withdraw it in writing.

Signature	Parent or Guardian Signature if Minor

Date

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Financial Policy

We are committed to providing you with the best possible care. We need your assistance, and your understanding of our payment policy. It is your responsibility to obtain preauthorization from your insurance company when required to process and pay your claims. Payment is due at the time of services, either in the form of presenting an active insurance card, using a debit or credit card, check or cash. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Co-Pays- are due at the time of service. If you do not have your co payment or your insurance information with you at the time of your appointment, you will be rescheduled. Discounts are given to patients with no insurance if payment is made on the day of your appointment. If you do not pay in full, then you will not qualify for the prompt pay discount.

Yearly exam-Most insurance companies pay for one annual in a 12 month period. If you have a problem at the time of your annual visit that is not "wellness" related, and the problem is taken care of at the same visit, your insurance company will be billed for both, so you may have some extra expenses.

Surgeries- Our billing department will check with your insurance company for coverage on the procedure you are having done. We will estimate how much your responsibility to pay will be. A deposit is required prior to surgery as well as a payment agreement for any remaining patient balance. Checking your benefits does not guarantee payment. You are ultimately responsible for payment. If you insurance company does not pay within a reasonable time, you will be billed for services.

Obstetrical Services- After your first OB education visit, we will contact your insurance company and verify your benefits. Our fee for your maternity care will be billed to your insurance company AFTER your delivery. This fee includes all of your regularly scheduled prenatal visits, the delivery and your six week postpartum check up. HOWEVER, ultrasounds, non-stress tests, lab, non-pregnancy related office visits are billed separately and will require separate co payments/deductibles. We will set you up on a payment plan for your estimated out-of-pocket expense. You can pay it all at once or make payments. Any amounts for non-included services will be billed to you separately. We will reimburse you for any over payment that we may have received. You **MUST** notify our office immediately of any changes in your insurance plan or benefits. We must have satisfactory payments on your account each month or it may impact the practice's ability to continue to provide care for you.

In Office Procedures-Prior to being scheduled for an office procedure, the billing department will check with your insurance company for benefit coverage. If you do not have coverage, the procedure must be paid for at the time of services. Payments for an IUD and Implanon MUST be submitted at the time of service and are not discounted under the prompt payment fee schedule. This policy includes; IUD's, ultrasounds, colposcopy and endometrial biopsies.

Divorce: In case of divorce or separation, the responsibility party for the account prior to the divorce remains responsible for the account.

AUTHORIZATION AND ASSIGNMENT

I authorize the release of any medical or other information necessary to process my medical claims. I also authorize and request that payment of benefits be made directly to Women's Health For Life, Inc. I understand that this authorization will remain until I withdraw the authorization in writing. I have read and understand the above Financial Policy. I also understand that payment of all services rendered is ultimately my financial responsibility. We do reserve the right to pursue collection proceedings if outstanding balances are not paid for in a timely fashion.

_____ _____

Patient Signature/Responsible Party Date

Updated February 2012

OB NUTRITION QUESTIONAIRE

Name _____ DATE OF BIRTH:_____

Date: _____ Height: _____ Weight Pre-pregnancy: _____ Today: _____ BMI: _____ Wt. Gain: _____

EATING BEHAVIOR

1) Are you frequently bothered by any of the following?
(Circle all that apply)
Nausea Vomiting Heartburn Constipation

2) Do you skip meals at least three times a week? No Yes

3) Do you try to limit the amount or kind of food you eat to control your weight? No Yes

4) Are you on a special diet now? No Yes

5) Do you avoid any foods for health or religious reasons? No Yes

FOOD RESOURCES

6) Do you have a working stove? No Yes

7) Do you have a working refrigerator? No Yes

8) Do you sometimes run out of food before you are able to buy more? No Yes

9) Can you afford to eat the way you should? No Yes

10) Are you receiving any food assistance now? No Yes
(Circle all that apply)

Food stamps	School breakfast	School lunch
WIC	Donated food/commodities	CSFP
Food pantry	Soup kitchen	Food bank

11) Do you feel you need help in obtaining food? No Yes

FOOD AND DRINK:

12) Which of these did you drink yesterday?
(Circle and list servings of all that apply)

Soft Drink	Coffee	Tea	
Orange Juice	Grapefruit Juice	Fruit drink	
Milk	Kool-Aid	Water	
Beer	Wine	Alcoholic Drink	Other (List) _____

13) Which of these foods did you eat yesterday?
(Circle and list servings of each)

Cheese	Pizza	Macaroni and Cheese	
Yogurt	Cereal with Milk	Tacos with Cheese	
Enchilada	Lasagna	Cheeseburger	
Other (List) _____			
Corn	Potatoes	Sweet Potatoes	Green Salad
Carrots	Collard Greens	Spinach	Turnip Greens
Broccoli	Green Beans	Green Peas	Other Vegetables _____
Apples	Bananas	Berries	Grapefruit
Melon	Oranges	Peaches	Other Fruit _____
Meat	Fish	Chicken	Eggs
Nuts	Seeds	Peanut Butter	Dried Beans
Cold Cuts	Hot Dog	Bacon	Sausage
Cake	Cookies	Doughnut	Pastry
Chips	French Fries	Other Fried Foods _____	
Bread	Rolls	Rice	Cereal
Noodles	Spaghetti	Tortillas	

Were any of these whole grain? No Yes

14) Is the way you ate yesterday the way you usually eat? No Yes

15) Do you exercise for at least 20 minutes three times a week? No Yes
What type of exercise do you enjoy? _____

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Obstetrical Information

Please answer the following questions as completely as possible.

Last Name _____ First Name _____
Date of Birth _____ Age _____ Marital Status _____
Occupation _____ Last Grade Completed _____
Family Physician _____ Insurance _____

Date of Last Menstrual Period _____ Average Periods are every ____ days for ____ days long.
Was this pregnancy planned? Y / N Were you taking birth control at conception? Y / N

PAST PREGNANCIES:

Date	Weeks	Length of labor	Weight	Delivery type	Where delivered	Complications

Past Medical History: Have you ever been told you have the following:

	Yes	No		Yes	No
Sugar diabetes	___	___	Infertility	___	___
High Blood Pressure	___	___	Blood transfusions	___	___
Heart Problems	___	___	Mother exposed to DES	___	___
Heart Valve Problems	___	___	Rh sensitization (Rhogam)	___	___
Kidney disease or infections	___	___	Tuberculosis	___	___
Neurologic/Seizures	___	___	Lung Problems-Asthma	___	___
Depression/mental problems	___	___	Anesthetic complications	___	___
Hepatitis/Liver disease	___	___	History of an abnormal Pap	___	___
Leg vein problems	___	___	Uterine Abnormality	___	___
Thyroid Problems	___	___	Major Accident	___	___

Have you, the baby's father or anyone in either family had:
Thalassemia, neural tube defects, downs syndrome, tay-sachs disease, sickle cell, hemophilia, muscular dystrophy, cystic fibrosis, huntington's chorea, mental retardation, inherited chromosomal defects, or baby's born with birth defects? If so indicate whom.

_____

Have you been exposed to anyone with tuberculosis? _____
Do you or your partner have genital herpes? _____
Have you had a rash or illness since your last menstrual period? _____
Have you ever had a sexually transmitted disease (gonorrhea, chlamydia, condyloma, trichomonas or syphillis? _____

Details of yes answers. _____

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Obstetrical Information – Page 2

Surgical History:

Year	Operation	City	Surgeon	Complications

Current Medications: _____

_____

Allergies: _____

_____

Cigarette smoking: How much before pregnancy_____
How much now _____
Alcohol consumption: How much before pregnancy_____
How much now _____
Drug or marijuana usage: How much before pregnancy_____
How much now _____

Family Medical History:
Father _____ Mother _____
Siblings _____
Children _____
Grandparents _____
Aunts/Uncles _____ Cousins _____

Current Medical History: Please circle if you have any of the following::

Weight changes, appetite changes, unusual weakness, bleeding, chills, fevers, recent accidents or infections. Vision changes, hearing changes, bloody noses, unusual sneezing, sore throat, swallowing difficulties, ear pain, or face pain. Neck pain, swelling or stiffness. Cough, difficulty breathing or coughing up blood. Chest pain or chest fluttering. Abdominal pain, sickness to stomach, throwing up, diarrhea, constipation, or problems with stools. Difficulty with urination. Joint stiffness, back pain, muscle cramps. Rash, skin lesions, easy bruising or itching. Memory loss, dizziness, double vision, clumsiness, or headaches.

Other issues to bring to the attention of our staff: _____

_____

_____

Thank you.

Signature	Parent or Guardian Signature if Minor
Date	Witness

Women's Health For Life, Inc.

OBSTETRICAL BILLING POLICY

In an attempt to assist you in budgeting your out-of-pocket expenses, and to reduce the stress on you during the last couple months of your pregnancy, Women's Health for Life has developed this financial policy and an "OB Estimate & Payment Agreement."

If you **have insurance,** we will verify coverage with your insurance carrier and estimate the amount of your out-of-pocket costs for the global OB fee prior to your OB exam in our office. Deductibles or co-insurance for services such as lab tests, ultrasounds, non-stress tests, etc., must be paid in full by the first of the month of your due date. Our billing department will discuss the estimated costs and you will need to sign our "OB Estimate & Payment Agreement."

If you are covered by **Medicaid** or any other **State Government Funded Plan** you are ***REQUIRED*** to bring your card each visit. If you do not have active coverage at your first visit you are required to pay $50.00 at each visit until you obtain proof of coverage. Medicaid/Healthy Start will be back dated in some cases, but only 90 days from the date you are covered. Anything prior to that date will be your responsibility to pay and will need to be paid by the first day of the month of your due date.

Our fee for your maternity care will be billed to your insurance AFTER your delivery. This fee includes all of your regularly scheduled prenatal visits, the delivery and your six-week postpartum check up. If your responsibility for the costs of maternity care is different from our estimate, we will refund any overpayment or bill you for any portion of your out-of-pocket costs not yet paid. We don't recognize HSA's, HRA's, etc. as part of insurance benefits. You must pay us first. We will provide you with your supporting documentation so that you can be reimbursed. However, if you have an HSA or HRA debit card you can use this to pay your account.

At the signing of the agreement, our billing department will give you the payments for your estimated out-of-pocket expense. You may choose to pay the entire amount in full immediately, or you may opt to pay in monthly installments. If you choose to pay in full this must be done by the second visit. All payments must be completed by the first day of your due date month. You must notify our office immediately of any changes in your insurance plan or benefits.

After pregnancy, if you need any disability insurance or any other forms completed there will a nominal charge. The charge is $6.00 for the form. It may take up to one week to complete, so please bring the form in early , along with your payment.

We must have satisfactory payments on your account each month or it may impact on the practice's ability to continue to provide you with care.

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FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time that services are rendered unless payment arrangements have been approved in advance by our billing staff or office manager. We accept cash, check, credit or debit cards. It is, however, your responsibility to provide us a copy of all current insurance cards. If your yearly deductible has been met and you wish for our office to accept assignment, you will need to bring your most recent explanation of benefits from your insurance company showing that you have reached your deductible.
IT IS YOUR RESPONSIBILITY TO OBTAIN PREAUTHORIZATION FROM YOUR INSURANCE COMPANY WHEN REQUIRED TOPROCESS AND PAY YOUR CLAIMS. Most insurance policies require that individuals first meet a deductible and that a specific amount be paid by an individual before reimbursement is allowed. Please contact your insurance company prior to your first visit.

For insurance plans in which Women's Health For Life, Inc. is a participating provider, we will still need a copy of your insurance card. You will be responsible for applicable co-payments as specified by your insurance company.

Returned checks will be assessed an additional $25.00 charge. Balances over 30 days may be subject to additional collection fees and interest unless special arrangements are made with our billing staff.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We do realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact the billing department promptly for assistance in the management of your account.

If you have any questions or uncertainty about the above information, PLEASE don't hesitate to ask. We are here to help you.

I have read and understand the above Financial Arrangement statement and have read the Financial Policy. I also understand that payment of all services rendered is ultimately my responsibility.

AUTHORIZATION AND ASSIGNMENT

I authorize the release of any medical or other information necessary to process my medical claims. I also authorize and request that payment of benefits be made directly to Women's Health For Life, Inc. I understand that this authorization will remain until I withdraw the authorization in writing.

_____ _____
Patient Signature (Guardian/Parent if under 18 years old) Date

_____ _____
Witness Date

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Patient Notice-Of-Privacy-Policy (To be given to all patients)

What you need to know about the Confidentiality Policy

Women's Health For Life, Inc. is committed to providing you with high quality health care and to forming a relationship with you that is built on **trust**. That means respecting your **privacy** and **confidentiality** of your medical information. We protect your privacy and confidentiality rights by creating and putting into practice policies and procedures that allow access to your personal medical information **only** for legitimate reasons.

Your medical record

As we provide your health care, we are required to maintain a complete copy of your medical history, current condition, treatment plan, and all treatment given, including the results of all tests, procedures, and therapies. Whether this information is stored in writing, on a computer, or other means, we will keep this information in a safe and secure way that protects your privacy and confidentiality. Of course, the physicians and other health care professionals who are involved in your care need to access this information in order to provide appropriate treatment for you.

Your medical information is private and confidential

You, or anyone whom you give written permission, or your legal representatives, have the right to read or get a copy of your medical information. Your medical record is the physical property of Women's Health For Life, Inc.

How do we assure your privacy?

Women's Health For Life, Inc. has put in place detailed policies regarding access to medical records by our staff and employees and has carefully outlined the circumstances under which your medical information may be released to parties outside Women's Health For Life, Inc. These policies conform with state and federal law and are designed to safeguard your privacy. Our staff and employees are trained in the appropriate use of medical information and know that it is available to them only to continue to provide care to you or for other limited but legitimate reasons. A violation of confidentiality or the failure of an employee to protect your information from accidental or unauthorized access will not be tolerated. This may include the employee being fired from her job.

We ask for your permission

We do not allow others outside Women's Health For Life, Inc. to access your medical information unless we have the appropriate authorization to do so. We will request your authorization to release information at your fist visit. In addition, some laws prevent certain types of patient information from being released without specific patient permission. Examples include, but are not limited to:

- Confidential details of:
  - Psychotherapy (from records of my treatment by a psychiatrist, licensed psychologist, or psychiatric clinical nurse specialist)
  - Other professional services of a licensed psychologist
  - Social Work Counseling/Therapy
  - Domestic Violence Victims' Counseling
  - Sexual Assault Counseling
- HIV test results (Patient authorization required for **EACH** release request.)
- Records pertaining to Sexually-Transmitted Diseases
- Alcohol and Drug Abuse Records

Please note, however, that the law requires some information to be disclosed in certain circumstances. This includes mandatory reports of abuse of children or elderly or disabled persons. Also, subpoenas or court orders may compel the disclosure of confidential or privileged health information in the context of a lawsuit or administrative proceeding. Medical records are sometimes used for reasons other than patient care. For example, records are periodically reviewed to evaluate the quality of care, or to be sure that it follows the rules of regulatory agencies for the efficient and effective utilization of care such as Medicare, Department of Public Health, or Department of Mental Health. Your insurance company may request information that we are required to submit in order to provide and bill for your care. Anyone reviewing records must follow the same confidentiality laws and rules required of all health care providers. Patient records are valuable tools used by researchers in finding the best possible treatments for diseases and medical conditions. All researchers must follow the same rules and laws that other health care workers are required to follow to insure the privacy of patient information. Information that may identify you will not be released to anyone outside Women's Health For Life, Inc. without your written approval. In all research conducted within Women's Health For Life, Inc., concern for your privacy and well-being is our first priority.

If you have questions about the privacy of your medical records, please speak with your physician or the office manager, as appropriate. We will be happy to help you.

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PH (419)227-2727
FAX 419-224-1589

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

FROM: _____
_____
_____
_____

To: Women's Health for Life, Inc.
High Street Location:_____
Bellefontaine Ave Location:_____

This information may include but is not limited to the following please check the lines you would like released:

Medical Summary Sheet ___ Office Notes/Progress Notes___ Lab and Radiology Results___
Obstetrics Records____ Operative Notes____ Pathology Results___ Surgical Photos_____ Ultrasound____
Pap Smears___ Mammograms___ (from the past 5 years) ___Immunization or Shot Records
I consent to HIV, Physical abuse or Mental Health or Alcohol and Drug Records be released: Y___ or N____
Additional information requested to be released:_____
_____
_____

Date of Request:_____ Patient Name:_____ DOB:_____

Name used when treatment occurred:_____

Social Security Number: _____ Minor patient: ( ) Yes ( ) NO

Dates (if known) of requested information:_____ or ( ) All treatment dates

Reason for Request: ( ) work ( ) Insurance ( ) second Opinion ( ) Transfer of care ( ) Personal
( ) Other- Please describe:_____
I hereby authorize the entity named above to release and/or exchange the above identifying information from my medical records. This release will remain in effect for six months from the date of my signature below unless I revoke this request in writing at any time. This revocation will not apply if the records have already been released to the party listed above. I understand that the office of Women's Health for Life, Inc. will not re-disclose any information contained in this authorization at any point and time with the exception of continuity of care for a condition being co-managed or referrals made from our office.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Guardian if Minor Patient Date

Request records to be sent:
( ) U.S. Mail ( ) Fax ( ) Electronic_____

Released to Physician ( ) or Patient ( )

If we are unable to provide an electronic copy of your medical records a hard copy will be released to you instead via U.S. Mail unless fax is checked above.

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HIPAA PRIVACY NOTICE CONSENT FORM

By signing this form I acknowledge that I have received and read the patient Notice of Privacy Policy, Financial Policy and HIPAA Notice and my signature acknowledges my understanding.

HIPAA AUTHORIZATION TO DISCUSS YOUR MEDICAL INFORMATION:
Please choose one of the following:

_____ Patient ONLY **OR**

_____ You may disclose my medical information to:

_____	_____	___-___-____	_____
Please release info to: Print name	Relationship	Phone number	DOB
_____	_____	___-___-____	_____
Please release info to: Print name	Relationship	Phone number	DOB

_____	_____	_____
Patient Signature OR Parent/Guardian of Minor Patient	DOB	Date

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CONSENT EXCEPTION FOR TREATMENT TO A MINOR PATIENT
(14 YEARS OLD TO 18 YEARS OLD)

Your parent or legally appointed guardian has allowable access to all your medical information, healthcare concerns and diagnoses, these will be discussed without consent with the **exception** of:

I **DO** authorize the release of the below information ____
I **DO NOT** authorize the release of the following: ____

_____ Sexually transmitted diseases results (STD's)

_____ Drug, alcohol or substance abuse

_____ Pregnancy

_____	_____
Minor (14-18 years old) signature/ Printed name	Date

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Name (print): _____Date: _____

How would you like to receive NORMAL lab/pap/x-ray results?

- E-Mail—E-Mail address: _____
- Mail
- Text—Cell phone Number: _____-_____-_____
  Cell phone carrier: (Circle one)
  - AT & T –number@txt.att.com
  - Verizon—number@vtext.com
  - Alltel—number@message.alltel.com
  - T-Mobile—number@tmomail.com
  - Sprint—number@messaging.sprintpcs.com
  - Virgin Mobile—number@vmobl.com
  - Boost—numbr@myboostmobile.com

New guidelines from the American Medical Association in conjunction with the Center for Disease Control and the Federal Government require physician's office to ask the following information. Certain sub-populations of patients are at risk for certain diseases just because of Ethnicity.

Please complete the following questions:

Language Spoken Primary: _____Secondary: _____

Race (check one please):
____Indian____Asian____Hispanic____African American____Latino____White

Ethnicity: Hispanic or Latino____
Non Hispanic or Non Latino____

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*Date of visit*_____

Name_____ Date of birth _____ Age _____
Why did you make this appointment? _____
How did you hear about us? _____ Family physician _____
Marital status M S D W Insurance _____ Occupation _____

Medical History:

Have you ever had problems with any of the following?

Heart disease.....	Yes	No
Lung disease	Yes	No
Kidney/bladder disease.....	Yes	No
Seizure disorder.....	Yes	No
High blood pressure.....	Yes	No
High cholesterol.....	Yes	No
Diabetes.....	Yes	No
Cancer.....	Yes	No
Endometriosis.....	Yes	No
Tuberculosis.....	Yes	No
Liver disease.....	Yes	No
Blood disease.....	Yes	No
Thyroid problems.....	Yes	No
Mental illness/depression/anxiety.....	Yes	No
Physical/sexual/verbal abuse.....	Yes	No
Anesthesia problems.....	Yes	No

If you answered yes to any of the above please explain:_____

_____

Other medical history not listed above: _____

_____

Allergies/Reaction Drug/Food/Environment

1._____
2._____
3._____
4._____

Family Health History

Father_____
Mother_____
Siblings_____
Children_____
Maternal Grandmother_____
Maternal Grandfather_____
Paternal Grandmother_____
Paternal Grandfather_____

Surgical History

	Year	Surgery	City	Surgeon
1.				
2.				
3.				
4.				

Pregnancy History

	Date of birth	Months Pregnant (Baby)	Type of Delivery (Vaginal or C section)	Boy/Girl	Problems ?	Physician
1.						
2.						
3.						
4.						
5.						

Menstrual History

Age periods started_____ Regular? Yes___ No___
How long? _____ days from start to stop.
Pain with periods? Yes___ No___
First day of last menstrual period? _____/_____/_____

How often are your periods? Every _____ days.
Number of pads or tampons used each day? _____
Spotting between periods? Yes___ No___

CONTINUED ON BACK>>>>>>>>>>>>>>>>>

Patient Name:_____

Are you sexually active? Yes___ No___
Age of first sexual encounter _____ Number of partners (Lifetime) _____
History of sexually transmitted disease? Yes____ No____ What _____ When _____
Did you receive treatment? Yes____ No____

Are you using birth control? Yes___ No___ Method? _____
Problems with current birth control? _____
Vasectomy? Yes___ No___ Tubal ligation Yes___ No___

Do you perform self breast exams? Yes___ No___ Last mammogram? _____ normal abnormal
Last pap smear _____ normal abnormal History of abnormal pap smear? _____
Last bone density study/Dexa scan _____ normal abnormal
Last Colonoscopy _____normal abnormal

If you are postmenopausal:
Are you on hormone replacement? Yes___ No___ If yes what? _____
Did you have a hysterectomy? Yes___ No___ Do you have your ovaries? Yes___ No___

Do you get immunizations? Yes___ No___
Last flu shot _____ Last pneumonia shot _____ Shingles vaccine _____ Other _____
Have you had chicken pox before? Yes___ No___ Have you had the chicken pox vaccine? Yes___ No___
Last Tetanus/Diptheria/and Pertussis vaccine _____

Medication name Strength How often? Why are you taking this medication?

_____
_____
_____
_____
_____
_____

Are you experiencing any of the following symptoms/or having any problems with the following:

	Yes	No
Ears, eyes, nose, throat, or neck problems		
Appetite changes/weight loss/gain		
Infection/recent illness		
Breathing or heart problems		
Abdominal pain, bowel changes		
Skin problems, joint or muscle aches		
Memory loss or headaches		
Menstrual periods/female organs/breast problems		
Low energy/fatigue		
Urinary symptoms		
Abnormal bleeding		
Hot flashes/night sweats		
Hair growth		
Pelvic pain with intercourse		
Weight loss/gain		
Chills/fever		
Cold symptoms		

How much do you smoke? _____
_____
How much alcohol do you drink? _____
_____
Do you use or have you used IV/illegal drugs? _____
_____
Which drugs? _____

Other information you would like us to know:
_____
_____
_____
_____
_____

Patient Signature: _____ Clinical staff initials _____ Practitioner initials _____

Women's Health for Life, Inc. Financial Policy

We are committed to providing you with the best possible care. We need your acknowledgement and understanding of our offices financial policy. Please read and initial each section. We do reserve the right to refuse to treat you for unwillingness to sign our financial policy. This document is designed for full disclosure of fees that you may incur while being a patient in our office. A copy will be given to you to keep.

A- **Valid Insurance** is required to submit your claims for payment. Payment is due at the time of service if you are unable to supply us with your valid insurance card. These visits are not submitted to insurance at a later date. This includes Ohio Medicaid in most cases. You must come prepared with all insurance information. _____

B- **Co-payments** are due at the time of service. If you do not have your copayment with you at the time of service, we reserve the right to reschedule you**. We do charge an additional billing fee of $10.00** if we must bill you for your copayment. It is your responsibility to know what your copayment is if it is not listed on your insurance card. _____

C- **Deductibles/Co-insurance-** You will be billed for any amounts over and above your copayment. A reasonable payment plan will be accepted to pay off these remaining balances. Your payment plan cannot exceed 6 months unless other arrangements are made with our office. Once your account becomes delinquent, we do send it to an outside collection agency to collect payment within 90 days of your first notice of delinquency. Should collections or legal action be necessary on your account, we do reserve the right to charge you for any applicable collection fees or legal fees as a result of this process. This amount will not exceed 30% and will only be the cost of the actual fee to collect the debt.____

D- **Non-Covered Services-** We do our best to make sure you are aware if services will not be covered by your insurance, but sometimes we don't know this. While the filing of insurance claims is a courtesy to you, you are responsible for payment for services rendered to you from the date of service. Please make sure you check with your insurance before having any testing performed to be sure it is a covered benefit. We do not do retro determination of benefits. All charges are your responsibility from the date services are rendered to you. If your claim is not paid after 90 days, you will be billed and it will be your responsibility to pay. ____

E- **Yearly Exam –** Most insurance companies pay for one annual visit in a 12 month period. This includes preventative services at your family doctor as well as our office. Please let our staff know if you have had a prevention visit this calendar year to avoid duplication of services. Visits outside the frequency limitations on your plan will be your responsibility to pay _____ additionally, if you have a problem addressed at a yearly visit that is outside the scope of a preventive service, this will be billed separately to your insurance. If denied on same date of service or if a copayment applies you will be billed for this. We will provide this service the same day as a courtesy to you; however you will be responsible for payment. ____

F- **Surgeries**- Our billing department will check with your insurance company for coverage on the procedure you are having done. We will estimate how much your responsibility to pay will be. A deposit is required prior to surgery if deductibles are not met, as well as a payment agreement for any remaining patient balance. Checking your benefits does not guarantee payment. You are ultimately responsible for payment. If your insurance company does not pay within a reasonable time, you will be billed for services. Self-pay patients must pay for the procedure, in its entirety, before it can be done. We do accept cash, check, major credit cards and care credit as forms of payment. ___

G- **Obstetrical Services**- After your first OB assessment visit, we will contact your insurance company and verify your benefits. Our fee for your maternity care will be billed to your insurance company AFTER your delivery if your plan does global (all inclusive) maternity billing. You will have an estimate for any expected out of pocket costs. This fee includes all of your regularly scheduled prenatal visits, the delivery and your six week postpartum checkup. HOWEVER, ultrasounds, non-stress tests, lab and non-pregnancy related office visits are billed separately and will require separate copayments/deductibles. We will set you up on a payment plan for your estimated out-of-pocket expense. You can pay it all at once or make payments. Any amounts for non-included services will be billed to you separately. We will reimburse you for any over payment that we may receive. You MUST notify our office immediately of any changes in your insurance plan or benefits. We must have satisfactory payments on your account each month or it may impact the practice's ability to continue to provide care for you. Should your plan be a non-global plan, we will do our best to split bill your care to maximize your benefits. ___

H- **Broken Appointments**- Our office does charge for any broken appointment. A broken appointment is failure to call to cancel or reschedule at least 4 hours prior to your appointment time. This fee will range from $20.00 to $100.00 depending on the type of appointment or procedure scheduled. In the event of a third missed appointment you will be dismissed from the practice. ___

I- **Additional fees you should know** Leave of absence forms $10.00, Return Check fee of $35.00, Phone consultation without an appointment $25.00, Work or School Physicals $40.00, Tax Statement $10.00, Refill or new prescription outside of an appointment $10.00, After hours or weekend visits in office are an additional fee of $75.00, Emergency visits during office hours in the office are an additional fee of $45.00. Rebilling fee (if applicable) 3% of total patient balance on account after 90 days _____

AUTHORIZATION AND ASSIGNMENT

By signing below, I acknowledge acceptance of all of the above terms of payment as outlined in this agreement and initialed by me.

I authorize the release of any medical or other information necessary to process my medical claims as requested by my insurance. I also authorize and request that payment of benefits be made directly to Women's Health For Life, Inc. I understand that this authorization will remain until I withdraw the authorization in writing. I have read and understand the above Financial Policy and all of my questions have been answered. I understand that changes can be made to this at any time and I will be notified. I understand that this is a legal document and can be submitted in the event of collections. I also understand that payment of all services rendered is ultimately my financial responsibility in all cases and must be paid in a timely fashion. I also understand that diagnosis codes or procedure codes cannot and will not be changed just to receive payment for services rendered. Codes will only be changed in the result of an error by the providers at Women's Health for Life, Inc. and after complete review by our coding department. By signing this authorization it is a blanket authorization for those reviews of my medical record should they be necessary.

For Questions regarding this notice, please contact:
Business Office at 419-224-0084

Patient or Responsible Party (PLEASE PRINT) Date of Birth

Signature of Patient/Responsible Party if patient a minor

Staff Reviewer Signature

Updated 02/22/2018