

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.

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Patient Information

Ms / Mrs <small>Circle One</small>	First Name	MI	Last Name	
Address		City	State	Zip Code
Home Telephone <small>Preferred #</small>	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 your 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 QUESTIONNAIRE

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 syphilis)? _____

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. 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 testing done 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 prevention 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 _____ also, 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**- 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 if your plan does global maternity. 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, 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 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. 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 if your spot can not be filled. This fee will range from \$20.00 to \$100.00 depending on the type of appointment or procedure. After the 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

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 first 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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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.



Women's Health For Life, Inc.

1005 Bellefontaine Ave., Suite 175
Lima, OH 45804
(419) 227-2727
Fax (419) 227-2737

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

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

_____ DOB

_____ Date

Parent/Guardian of Minor Patient

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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www.womenshealthforlife.com

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 _____

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/Diphtheria/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 _____