Shelby Women Health, LLC
Patient Information Sheet

Demographic Information: **Date:**_____

Last Name:_____ First Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Date of Birth:_____ Age:_____Social Security #: _____-_____-_____
Personal Cell Phone:_____ Home Phone:_____ Work Phone:_____
Personal Email Address: _____ Initial: _____

Emergency Contact:_____ Relationship:_____
Emergency Contact Number:_____
Occupation:_____ Referred by:_____

Legal Guardian (if Applicable)
Full Name_____
Relationship to patient_____ Contact Number_____

Primary Insurance:
Primary Insurance Company: _____
Member ID #_____ Group#_____
Name on card (if different from above) _____
Relationship to patient_____ Effective Date:_____
Secondary Insurance: (If Applicable)
Primary Insurance Company: _____
Member ID #_____ Group#_____
Name on card (if different from above) _____
Relationship to patient_____ Effective Date:_____
Guarantor: _____

Authorization to leave messages on your voicemail

_____ Yes, in the case that Shelby Women Health staff is unable to reach me, I give authorization to leave voice mails. Preferred number:_____

_____ NO, I do not give authorization

I certify that the above information is true and that I have not withheld any information.

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____

New Patient Registration Sheet

Reason for today's visit: Annual Exam__New Pregnancy__Other:_____
Primary Care Doctor:_____ Referring Doctor:_____
Current contraception (including condoms and any form of sterilization):_____
Current medication (If Applicable):_____
Pharmacy Name and Location:
_____

List any Medication allergies (If Applicable):_____No Known Drug Allergies___
List date of last Pap Smear:_____ Results: Normal__Abnormal Cells__+HPV___
List date of last Mammogram (If Applicable):_____Results: Normal___Abnormal___
List date of last Colonoscopy (If Applicable):_____

Obstetrical History (including miscarriages and terminations):
Total number of pregnancies: _____
Number of vaginal deliveries:_____ Number of C-sections:_____
Number of living children:_____Number of deceased children:_____
Have you had any miscarriages:_____ When: _____
Have you had any terminations:_____ When: _____

DATE	CHILD'S SEX	BIRTH WEIGHT (LBS OR KG)	VAG/C-SECTION	COMPLICATIONS

Surgical History not including C-Sections:

DATE	SURGERY	HOSPITAL	COMPLICATIONS

Check if you are or have in the past experienced any of the following:
Aids___ HIV___ Anorexia___ Bulimia___ Anxiety___ Depression___ Arthritis___ Asthma___ Chlamydia___ Gonorrhea___ Trichomoniasis___ Diabetes___ Genital Warts___ Herpes___ High Blood Pressure___ Lupus___ Multiple Sclerosis___ Blood Clot___ Seizures___ Stroke___ Thyroid issues___ Ulcers___Cancer___(List Type):_____
Please list any other conditions not mentioned:
_____

Menstrual History:
Age of onset:_____ Date of first day of last period:_____ ___Cycle length_____
Check if you experience any of:
Heavy Flow_____ Bleeding between periods_____ Bleeding after intercourse_____
Other_____

New Patient Registration Sheet

Social History:

Are you sexually active: Yes___No___Virgin___ Do you have multiple sexual partners: Yes___No____
Do you smoke: Yes___No___ (Circle) Cigarettes, Marijuana, Hookah Quantity/Frequency:_____
Do you use street drugs: Yes___No___ What kind:_____ How often:_____
Do you drink alcohol: Yes___No___Quantity/Frequency:_____
Do you wear seat belts: Yes___No___
Do you regularly exercise: Yes___No___Frequency:_____
Are you being physically, sexually or emotionally hurt or abused:_____

Family History:

Have you or anyone in your family had any of the following medial conditions:

CONDITION	MEMBER	RELATIONSHIP	AGE DIAGNOSED
Cancer (List Type)			
High Blood Pressure			
Heart Disease			
High Cholesterol			
Osteoporosis			
Diabetes			
Substance Abuse			
Mental Illness			
Other:_____			

Review of Systems: (Check all that apply)

Constitutional: Weight loss_____ Weight gain_____ Fatigue_____ Sweating_____ Fever_____
Eyes: Blurred vision_____ Vision loss_____ Spots_____
Ear/Nose/Throat: Ringing in ear_____ Sore throat_____ Bleeding gums_____
Cardiac: Chest pain_____ Palpitations_____ Swelling _____ (Location of swelling)_____
Respiratory: Wheezing_____ Cough_____ Shortness of breath_____
Gastrointestinal: Constipation_____ Diarrhea_____ Bloating_____ Bloody Stools_____
Genitourinary: Painful Urination_____ Vaginal dryness_____ Hot flashes_____ Night sweats_____
Muscle: Joint pain_____ Muscle cramps_____ Weakness_____
Skin: Rash_____ Dryness_____ Lesions_____
Breast: Lump_____ Discharge_____ Pain_____
Neuro: Headaches_____ Tremors_____ Seizures_____ Weakness_____
Psych: Anxiety_____ Depression_____ Insomnia_____ Memory Loss_____ Moodiness_____
Endo/Lymph: Excess thirst_____ Hair loss_____ Nosebleeds_____ Swollen glands_____ Bruising_____

PATIENT SIGNATURE _____ **DATE** _____

We would like to thank you for choosing Shelby Women Health as your OBGYN medical provider. We have written this policy to keep you informed of our current **office policies**.

New Patient Registration Sheet

Office Hours: Our office is open **Monday-Thursday** from **9:00AM-5:00PM**; **Fridays** from **9:00AM-6:00PM**. Keep in mind the schedule may and will change at any time and appointments may need be to rescheduled due to the nature of our patients care. The physician may at times need to leave to the hospital.

Appointments and cancellations: While we do accept walk-ins, it is always best to schedule an appointment first to avoid issues with your insurance and having to wait. **Missed appointments without 24 hour notice will be charged $25.00, EFFECTIVE: October 2016.**

After hours and emergencies: For serious emergencies, call 911 immediately. If you call the office after hours, you will go to voice mail where you will be advised to call 911 or have the option of calling the doctor.

Treatment of Minors: Patients under the age of 18 must be accompanied by a parent or guardian, no exceptions. **Parent or guardian has to be over the age of 18, with valid identification, valid contact information and needs to sign a minor consent form approving treatment.**

Test Results: If you have diagnostic testing, i.e. labs, ultrasounds, MRI, please schedule an appointment within 7-10 days to go over the results with your physician. You will be subject to your copay/coinsurance for **EVERY** office visit. The office will not call you for results if there are no abnormalities in your results. We will call to set up a follow-up appointment for any diagnostic testing with flags or abnormalities, **however we will not discuss this over the phone**.

Prescriptions and Refills:

- The best time to get a **prescription refill is at your appointment**. Do not wait until you are out; refills require the doctor's authorization and may take a day before it can be authorized.
- Some medications have potential side effects that must be monitored. **We require check-ups every 3 or 4 months for these medications.** Be sure to keep those follow-up appointments.
- Don't call after hours for prescription refills. There is no access to your chart and we may not be able to help you.

Dismissal: If you are **"dismissed"** from the practice it means you can ***no longer schedule appointments, get medication refills or consider us to be your doctor.*** You have to find a doctor in another practice. Reasons for dismissal include: *failure to keep appointments, noncompliance and failure to pay your bill.* A certified letter will be mailed to your last known address notifying you of your dismissal.

By signing this form, you confirm that you have read and understood the policies of our office.

PATIENT SIGNATURE _____ **DATE** _____

Please make sure you read and fully understand our financial policy. If you have any questions, please approach our front office or call us at 301-982-9333.

New Patient Registration Sheet

Insurance: Shelby Women Health is contracted with several insurance companies; ***it is your responsibility*** to know whether the provider is participating with your network or if you have out-of-network benefits. While we do file a claim on your behalf, ***it is your responsibility*** to know what **services are or are not covered under your plan**. To completely and accurately process your claims, we must have your complete insurance coverage information! **Please supply us with secondary or tertiary insurances if you have them**. We will update/confirm your insurance information on every visit; **bring your insurance card to every office visit**. ***You will be responsible for fees not covered by your health plan.*** That could include: ***copay's, coinsurance, deductibles and any non-covered fees or previous balance.*** **Please be prepared to pay your portion at EVERY visit. If you have a a deductible over $500, you will be responsible to pay for the office visit, *prices may vary*.** We cannot know each patients benefits and exclusions; contact your insurance for this information.

Upon billing your insurance, you may receive a statement for any balance due. For your convenience, we accept credit cards (*Visa, Discover and MasterCard*) and cash. We also accept payment by phone.

Self-Pay: At the moment we only accept OB self-pay. **You are expected to pay in full on your visit**. A charge of **$2,500,** for vaginal deliveries is expected to be paid *before 30 weeks*. Typically we charge half the amount on your first visit. The amount for a C-section is **$3,000**. **Ultrasounds and blood work are not included.** This price will cover prenatal as well as 2 postpartum visits and the delivery. **Hospital fees are not included.**

Payment arrangements: Patients who are preparing for births and surgeries may make scheduled payments. We will only apply the amount your insurance deems you responsible for and refund any unused payments.

Medical Records: We will provide you with a copy of your medical records upon request. There is a fee of **$25.00** associated for the handling and copying of medical records.

Other fees: A **$25.00** fee will be assessed **for every missed visit that was not cancelled in advance.** There will be a charge of **$25.00** for completing any ***medical forms, such as letters and FMLA paperwork.*** Please allow us ***7-10 business days*** to complete your forms.

Billing and Collections: *Your bill is your responsibility*. If you believe there to be a mistake contact your insurance company. You are expected to make complete payment ***within 30 days*** of receiving the bill. Call our office to make payment arrangements. **Should you fail to pay your balance within 30 days, you could be dismissed from the practice.** *After **90 days**, it will be sent over to our collection agency. **Once it is sent out, you may no longer contact the office with billing arrangements.***

By signing this form, you confirm that you have read and understood the policies of our office.

PATIENT SIGNATURE _____ **DATE** _____

Shelby Women Health, LLC

Patient Consent for Use and Disclosure of Protected Health Information

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other health-care providers involved in my treatment);

Obtaining payment from third party payers (e.g. my insurance company);

The day-to-day health-care operations of your practice.

I understand I have the right to review a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

PATIENT/GUARDIAN NAME _____

PATIENT SIGNATURE _____ **DATE** _____

Missed Appointments

Effective October 01, 2016, patients will incur a $25.00 dollar fee for missed appointments without a 24-Hour notice.

By signing below, I agree to pay the fee of $25.00 dollars due to a missed appointment. I acknowledge that I may be billed for any missed appointment's without prior notice.

Name: (Printed)_____

(Signature)_____

Date_____