Vitality Health
Women's Wellness Center

PATIENT INFORMATION - FEMALE BIOTE		
Name:		Date of Birth:
Address:		**City:**
State / Zip		
Cell Phone		**Addl Phone**
Email Address (Required to access patient portal):		
Gender	**Female Male**	**Married Single Widowed Divorced**
Ethnicity	**Not Hispanic or Latino**	**Hispanic or Latino**
Race	White Black or African American	Native American Asian Other
PREFERRED PHARMACY		
Pharmacy Name		Phone:
Pharmacy Address		
INSURANCE INFORMATION		
Insurance Co Name		
Policy No		GROUP:
RESPONSIBLE PARTY		
Card Holder Name		DOB
SSN		
Address		
City		State/Zip
Phone		Cell Phone
Relationship to Patient	Spouse Child of Card Holder	
SECONDARY INSURANCE		
Insurance Co Name		
Policy		Group No
Guarantor Name		Date of Birth
EMERGENCY CONTACT		
Cell Phone		
PRIMARY PHYSICIAN INFORMATION		
Name		
Address		
Phone		Fax

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HEALTH HISTORY

Name: _____

Reason for today's visit:_____

Have you been diagnosed with any of the following:

	Diabetes		Arthritis		Anxiety
	Hypothyroidism		Osteoporosis		Bipolar
	High Blood Pressure		COPD		Cancer
	High Cholesterol		Asthma		Kidney disease
	Stroke		Lupus		Liver disease (Hepatitis)
	Heart attack		Migraines		
	Heart Arrhythmia (Afib)		Seizures		
	Blood clots (Leg, Arm, Lung)		Depression		

SURGICAL HISTORY

Date	**Details**

ALLERGIES (Please List)

Medciations only and Reaction

MEDICATIONS

Please list all prescribed medications.

Medication	Dose	How often	Prescribing Provider	Reason

FAMILY HISTORY

☐ I WAS ADOPTED

Family Member	Alive/Deceased	Age/Age at death	Illness
Father			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke
Mother			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke
Siblings			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke
Children			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke

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GYN History

Do you still get menstrual periods.? ☐ No ☐ Yes---------- What year was your last menstrual cycle? _____ Do you have hot flashes or night sweats? Yes No Do you experience vaginal dryness? Yes No Is sexual intercourse painful? Yes No Do you use hormone therapy? Yes No If yes, what type?_____	Age of first menses_____ First day of your last menstrual periods? _____ Do you have a period every month? ☐ Yes ☐ No If no please explain: Total days of bleeding: # days of heavy bleeding: Menstrual pain/cramps: Mild Moderate Severe Do you take medication to help with cramping? Yes No Tylenol Advil Motrin Alleve Midol Other
Day/Month/Year of last Annual exam: _____ I have never had an Annual Exam	Have you ever been diagnosed with an STD / STI? Chlamydia Gonorrhea Trichomonas Herpes HIV Hepatitis B / C Syphilis Genital Warts
Have you ever had an abnormal PAP smear? ☐ Yes ☐ No Year_____	Treatment (If Any) LEEP Cone Biopsy Colposcopy
Date of last Mammogram _____ ☐ I have never had a Mammogram	Result ☐ Normal ☐ Abnormal If abnormal, please explain: _____ Do you perform self-breast exams? ☐ Yes ☐ No
Total number of pregnancies	Total living children
# Full term deliveries	# Abortions
# Miscarriages	# Ectopic pregnancies
# C-sections	
☐ Hysterectomy Year:_____ Reason:_____ Type: Abdominal Vaginal Laparoscopic Robotic	Have you every had an ovary removed? ☐ Yes ☐ No Left Right Both
☐ Endometrial / uterine ablation? Yes No	Year: _____
☐ Tubal sterilization Yes No Year:	

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SOCIAL HISTORY

MARITAL STATUS ☐ M ☐ S ☐ D ☐ W PARTNER	ARE YOU SEXUALLY ACTIVE? ☐ YES ☐ NO ☐ MEN ☐ WOMEN ☐ BOTH ☐ PREVIOUSLY NOT NOW
DRINK ALCHOHOL ☐ YES ☐ NO ☐ FORMER HOW MANY DRINKS/WEEK	DO YOU EXERCISE ☐ YES ☐ NO
DO YOU SMOKE ☐ NO ☐ CURRENT SMOKER HOW MANY CIG/DAY_____ FOR _____ YEARS	☐ FORMER SMOKER HOW MANY CIG/DAY_____ FOR _____ YEARS
HAVE YOU USED ANY IN THE LAST YEAR? ☐ MARIJUANA ☐ HEROIN ☐ COCAINE ☐ OTHER	DO YOU USE ANY OTHER SUBSTANCES? ☐ YES ☐ NO IF YES, WHAT TYPE _____

HEALTH SCREENINGS

Have you ever had a Bone Density/DEXA? ☐ Yes ☐ No Month/Year of last Bone Density/DEXA? _____ Result ☐ Normal ☐ Abnormal If abnormal, please explain: _____	Have you ever had a colonoscopy? ☐ Yes ☐ No Month/Year of last colonoscopy? _____ Result ☐ Normal ☐ Abnormal If abnormal, please explain:_____
Have you ever been tested for diabetes? ☐ YES ☐ NO Month/year of last Diabetes test? _____ Result ☐ Normal ☐ Abnormal If abnormal, please explain _____	Have you ever had a cholesterol test? ☐ Yes ☐ No

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Women's Hormone Health Questionnaire				
SYMPTOMS	**NONE**	**MILD**	**MODERATE**	**SEVERE**
Physical Exhaustions (fatigue, lack of energy, stamina, or motivation				
Sleep Problems (difficulty falling asleep or sleeping through the night)				
Irritability (mood swings, feeling aggressive, angers easily)				
Anxiety (Feeling overwhelmed, feeling panicky, or feeling nervous)				
Decline in drive or inters (loss of 'zest for life', feeling down or sad				
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)				
Difficulties with memory (concentration, finding the right word, or retaining information)				
Vaginal Dryness or difficulty with sexual intercourse				
Sexual problems (Change in desire, activity, orgasm and/or satisfaction)				
Sweating (night sweats or increased episodes of sweating)				
Hot Flashes (burst that starts in chest and lasts for short duration)				
Hair loss, thinning or change in texture of hair				
Feeling cold all the time, having cold hands or feet				
Headaches or migraines (increase in frequency or intensity)				
Weight (difficulty losing weight despite diet/exercise)				
Bladder problems (difficulty in urinating, increased need to urinate, incontinence				

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE & CONSENT TO USE & DISCLOSE HEALTH INFORMATION

This acknowledgement of notice and consent authorizes Women's Wellness Center to use and disclose health information about you for treatment, payment, and health care operations purposes. Notice of Privacy Practices: Women's Wellness Center has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change.

Acknowledgement and Consent: I have received the Notice of Privacy Practices for Women's Wellness Center. Women's Wellness Center is authorized to use and disclose health information about me to (i.e., spouse, parent, primary physician):

Signature of Patient/Patient Representative

X_____ Date _____

I request that payment of authorized Medicare and/or insurer benefits be made to me or on my behalf to Women's Wellness Center for services furnished to me by said provider. I authorize to release to my insurance company any medical information needed to determine the benefits or benefits payable to related services. I understand that if, under my insurance guidelines, a necessary service is determined to be non-covered, and I will personally be responsible for payment. I understand I am financially responsible for any amount denied or partially paid by the Third Party Insurance Carrier. I authorize release of medical information for treatment, payment, and healthcare operations.

Signature of Patient/Patient Representative

X_____ Date _____

COMMUNICATIONS & MESSAGES

LEAVING MESSAGES

Vitality Health
Women's Wellness Center

I authorize messages, to include all lab/imaging results and appointment reminders be left at this phone number: Please make sure your voicemail is available so that we can contact you.

PHONE NUMBER: _____

SENDING TEXT MESSAGES

I authorize messages, to include all lab/imaging results and appointment reminders and office announcements be **sent via text** at this cell phone number:

CELL PHONE NUMBER: _____

Signature of Patient/Patient Representative

_____ Date _____

ADDITIONAL AUTHORIZATION REQUIRED BY YOUR INSURANCE COMPANY

I understand that if my insurance doesn't approve of any medications or procedures recommend by the provider, that additional effort and paperwork for prior authorization will be required by myself and by the office staff. This may require the patient to be the point of contact for the transaction for additional information. This effort can take up to 10 business days to put into action. Please make sure your voicemail is available so that we can contact you.

Signature of Patient/Patient Representative

_____ Date _____

PERSCRIPTION REFILLS

Please allow 5-7 business days to refill any current prescription that does not require prior authorization

NAME OF PREFERRED PHARMACY _____

ADDRESS OF PREFERRED PHARMACY _____

PERFERRED PHARMACY PHONE NUMBER _____

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PAYMENT POLICY

Payment of all co-pays is due at the time of service. As a service to you, our office will bill your insurance company. Being a participating provider with most insurance companies, the insurance companies require that we collect these fees, as they are terms of your health care contract. Additionally, patients are ultimately responsible for all balances. For your convenience, we accept credit cards including Visa, MasterCard, American Express, and Debit Cards. Due to the constant changes in health insurance, it is your responsibility to know your health coverage. If you should have any questions regarding if a certain procedure is covered, it is to your advantage to call your insurance company and find out exactly what your contract covers. Their customer service representatives will be happy to assist you. Our mission is to provide you with the highest quality gynecological care possible. We are constantly trying to control our costs while conforming to the standard fee schedules approved by most major insurance companies. Our receptionist will need to verify your insurance coverage prior to every visit.

1. Your medical insurance card and personal identification must be presented to the receptionist at each visit. The medical insurance is needed for lab work if you are using insurance for labs.

2. Any outstanding balances are required be paid before your office visit or procedure unless prior payment arrangements have been made.

3. Your insurance is a contract between you and the insurance company. While we accept the reimbursement rates of many insurance companies, we are not a party to your contract and do not determine which are medically necessary services that they cover and which they do not.

4. Our relationship and treatment responsibility are with/to you. We will attempt to notify you whenever we know a test or service is not covered. There will, however, there may be times when we cannot determine this. Whether covered or not, you are ultimately responsible for payment of the services received.

5. We require payment in full on the date of service for co-pay and offices charges defined under your policy as your responsibility.

6. We expect you to call us if you are not able to make it your appointment. For your convenience, we make every attempt, to remind you of your appointment. Your appointment is a reservation of the offices', staff and doctor's time and resources. A charge of $50 for office visits will be made for appointments that are not cancelled 24 hours in advance. A charge of $150 for any cancelled or no-show surgical procedure.

We realize that on occasion, temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance. I have read and understand the terms listed above.

X_____ Date _____

Signature of Patient/Patient Representative

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HIPPA FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. The implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharIng of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information that is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room. etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to offIce policy and new technology that you might find valuable or informative

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies Or insurance payers in normal performance of their duties

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request changes in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I DO HEREBY CONSENT AND ACKNOWLEDGE MY AGREEMENT TO THE TERMS SET FORTH IN THE HIPPA INFORMATION FORM AND ANY SUBSEQUENT CHANGES IN THE OFFICE POLICY. I UNDERSTAND THAT THIS CONSENT SHALL REMAIN IN FORCE FROM THIS TIME FORWARD.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM

PRINT NAME _____

SIGNATURE _____DATE _____