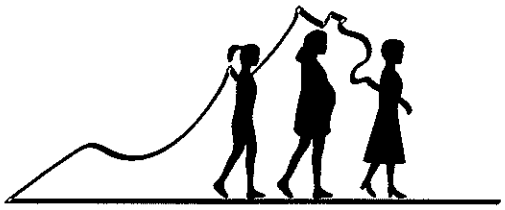
PATIENT INFORMATION



DEMOGRAPHICS

Date _____ Office Mechanicsville Forest
Tappahannock Midlothian

Name _____
Last First Middle

Date of Birth Age SSN

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Nationality/Language: _____ **E-mail:** _____

Address _____
Street

_____
City State Zip Code

Home Telephone _____ Work Telephone_____ Cellphone _____

Referred by: _____ Primary Care Physician _____

Employed YES NO

If **YES**, employer's name: _____

If **MARRIED**, please fill out the following information regarding your spouse

Name _____
Last First Middle

SSN _____ DOB

Employment Information: _____

Nationality/Language:

In case an **EMERGENCY**, please notify: _____

Telephone Number Home/Cell/Work

If you **DO NOT** want test results mailed or phoned to your home, where should we contact you with result:

Address _____

Telephone Number Home/Cell/Work

INSURANCE INFORMATION

Do you have medical insurance? YES NO
Do you have medical insurance through your employer? YES NO
If YES, employer's name _____
Are you the subscriber of the medical insurance? YES NO

If NOT, please complete subscriber's following information

Name _____

Date of birth _____ SSN _____

Your relationship to subscriber: Spouse Child Other _____

Employer _____

PRIMARY INSURANCE

Insurance Company Name _____

Street and/or PO Box _____

City, State and Zip Code _____

Subscriber ID# _____ Group# _____

SECONDARY INSURANCE

Insurance Company Name _____

Street and/or PO Box _____

City, State and Zip Code _____

Subscriber ID# _____ Group# _____

I hereby authorize the release of medical information to insurance carriers and/or other physicians, and also for benefits to be paid directly to Dominion Women's Health, Inc. in the case of a minor, I authorize the filing of the insurance claims. I understand that I am responsible for all charges (including non-covered charges) arising for the treatment of the named patient. Should this account become delinquent, I agree to pay all collection and courts costs, including attorney's fees.

_____ _____

Printed name – Patient/Responsible Party Signature – Patient/Responsible Party

_____

Date

Consent for testing for HUMAN IMMUNODEFICIENCY VIRUS (HIV)

In the event of exposure to my blood or bodily fluids, I consent for the HIV blood test; which may indicate the presence of acquired immunodeficiency syndrome (AIDS). I understand that if I desire to have this test done, I must request it.

I have been informed and understand that the test results will not always predictably indicate that a person has AIDS, will develop AIDS, or is immune to AIDS; but that a positive test can be associated with the transmission of HIV to other persons.

I understand that the results of my HIV testing will become a part of my medical record; further release of information will be done only with my written authorization.

The undersigned certifies that he/she has read and understands the foregoing, has had the opportunity to ask questions, and is the patient, or is the patient's authorized agent or representative.

I consent to HIV testing

_____
Patient/Representative

_____
Date

_____

Release of Medical Records

I, _____ (Please print full name) understand that in the event that I may need a copy of my medical records for any reason (transferring care, personal file, etc.); I will be required to pay a $15.00 fee. My payment will be due before my records will be processed and released. I also understand that there will be a 5 to 7 business day waiting period for my records to be released. The only exception to the fee is if I am referred to another provider by Dominion Women's Health, Inc.

Upon requesting a copy of my records I will be required to complete and sign a Medical Records Release form. This form will grant Dominion Women's Health, Inc. permission to release my records as per my request.

I understand that I may ask any questions if I do not understand the Dominion Women's Health, Inc. Medical Records policy stated above.

_____
Patient/Representative

_____
Date

GUARANTEE OF COLLECTIONS

It is understood and agreed that the undersigned (jointly and separately if more than one) is liable for all charges incurred or to be incurred for medical and/or surgical services rendered or to be rendered by or through Dominion Women's Health, Inc., in connection with the patient named herein. It is further understood and agreed that if medical or hospitalization insurance fails to promptly pay all such charges, the undersigned shall immediately pay the account in full.

The undersigned authorizes the payment of all insurance benefits to Dominion Women's Health, Inc., and authorizes Dominion Women's Health, Inc. to release any information required by any insurance carrier to secure such payment.

If the undersigned fails to pay an account when due and the amount is referred to an attorney for collection, then the undersigned agrees to pay a collection fee of thirty-three and one third percent (33 1/3%) of the balance due and also attorney fees when applicable.

_____ _____

Printed name – Patient/Responsible Party

Signature – Patient/Responsible Party

_____

Date

Dominion Women's Health's witness: _____

Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, _____ (Please print patient name) have been provided a copy of Dominion Women's Health, Inc.'s Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

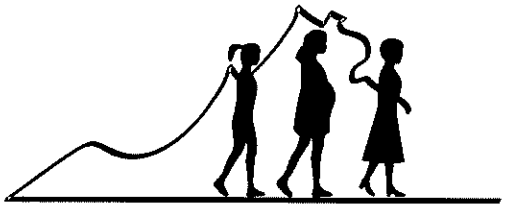
I understand that I may ask questions to Dominion Women's Health, Inc. if I do not understand any information contained in the Notice of Privacy Practices.

_____

Patient/Representative

_____

Date



DOMINION
Women's Health, Inc.

PATIENT FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to building a successful physician-patient relationship with you. Please understand that payment for services is a part of that relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

Patient information
Patient's information will be updated yearly. A signature by the responsible party is required. If there is a change of residence, phone number or insurance information, it is the responsibility of the patient to notify us of the change.

Insurance claims
Our office will file claims with the patient's insurance as a courtesy. It is the patient's responsibility to determine if Dominion Women's Health, Inc. is a contracted provider. In the event the patient has insurance coverage but cannot provide documentation, patient will be considered self pay and payment is due at the time of service. Upon receipt of insurance card, we will submit claims to the insurance company at that time. **Coverage is not a guarantee of payment.**

Authorizations
Our staff will obtain any necessary Pre-certification or Pre-authorization for surgery or any other procedure, and/or testing.

Affiliated Organizations
Depending on what services you have performed and what insurance coverage you have, you may receive bills from another entity (i.e. - LabCorp, Quest and NTD labs, etc.)

Patient Financial Responsibility
Co-payments, deductibles, co-insurance and any medical services not covered by an individual's insurance plan are the patient's responsibility and are **DUE AT TIME OF SERVICE.**

If you do not have insurance coverage all services **MUST BE PAID AT THE TIME OF SERVICE.** Should you require surgery, the surgery must be paid prior to having surgery.

Physicians **DO NOT** discuss any financial issues. Our billing staff is trained to discuss your account and will be happy to help you, but if you need further assistance, our Billing Manager can be consulted as well.

The billing department makes every effort to work with our patients to assist them with payment plans for outstanding balances. The billing department will set-up a monthly payment plan utilizing your credit card for automatic monthly payment and/or payment by check or cash. Our minimum payment plan is $50.00 per month.

We accept cash, checks, money orders, Visa, MasterCard and American Express.

Checks received "paid in full"
It is the policy of the practice not to accept checks marked "Paid in full" since there might be charges still pending with the insurance carrier.

Returned Check Policy
If a check is returned, a note will be made in the account that the specific check payment has been returned and the account is charged with the returned-check processing fee of $35.00. The patient is informed that the office will no longer accept a personal check as a method of payment.

The patient will be notified by mail that she has 5 days to present at the office with cash, money order, certified check or credit card; otherwise the check will be forwarded to the state's worthless check/fraud unit.

Patient Refunds
The following criteria must be met prior to issuing a patient refund: The patient has not been seen in the office for 90 days; there are no outstanding insurance claims on the patient account.

Medical Records and Forms
If you require a copy of your record or a form to be completed, you must pay $15.00 prior to receiving the records or form. Legally we have 30 days after we receive written authorization from the patient to complete the form. Patients requesting FMLA, disability, work, and/or school forms to be completed MUST pay a $15.00 fee prior to the forms being completed and allow 7 business days to be completed.

Collection Agency
Dominion Women's Health, Inc. utilizes an outside collection agency to collect any outstanding balances which do not maintain an active/current payment status with the practice. In the event your account is turned over to the Collection Agency, we will no longer be able to set-up payment plans. All collection account balances must be paid to the collection agency. In addition, a fee of 33.3% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other cost incurred directly or indirectly to collect amounts owed under this agreement (i.e. court costs, attorney fees, etc.)

Should your account be turned over to collection agency, **payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be required at the time services are rendered.**

Appointment Policy - Failure to Show or Cancel
Dominion Women's Health, Inc. appreciates that everyone's time is valuable. For this reason, effective 5/1/16, a fee of $10 for Current Patients & $20 for New Patients will be charged for any appointment that is Not Canceled 24 hours prior to the appointment or a "No Show". This fee is due immediately upon occurrence. Thank you for your understanding & cooperation.

Bankruptcy
If Dominion Women's Health, Inc. is notified of bankruptcy, the patient will be dismissed from our practice and no further appointments are made.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY SET FORTH BY DOMINION WOMEN'S HEALTH, INC., AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

Date	Printed Name	Signature of patient or person acting on Patient's behalf

Dominion Women's Health, Inc. witness: _____

DOMINION
Women's Health, Inc.

Permission to disclose PHI (Private Health Information)

Patient Name _____ Date of Birth _____ Social Security No. _____

By signing this paper below, I give permission to the person(s) listed in the table documented to received Private Health Information or other authorization as listed in the comments section. I understand this form is legally binding and that I may revoke my authorization at any time by submitting my request to change, add, or terminate such permission in writing.

Date of Permission	Name of Individual	Comments/Instructions *(i.e.: may pick up meds)*	Patient/Guardian Initials	Date Permission Revoked	Patient/Guardian Initials
		ALL			

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Identifier/Password: _____ Password Question Hint? _____

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Printed name of Patient or Legal Guardian Relationship (if not self)

DOMINION
Women's Health, Inc.

PATIENT HISTORY

Name: _____ Age: _____ Date: _____

SS#: _____ Marital Status: _____ DOB: _____

Reason for Visit? _____ Referred By: _____

Pharmacy: _____ Pharmacy Phone #: _____

When was the first day of your last menstrual period?

How many times have you been pregnant?

How many liveborn children have you had?

How many pregnancy losses have you had? (Miscarriage, Abortions, Ectopic Pregnancies)?

Do you experience problems with:	Yes	No	
Pelvic or abdominal pain?			
Bleeding between periods?			
Abnormal vaginal discharge?			
Cramps with your periods?			
Hot flashes?			
Depression?			
Anxiety?			
Breast Symptoms?			
Urinary incontinence, burning or frequency?			
Blood in the urine?			
Have you ever had any abnormal Pap smears?			
Previous Mammogram? If yes, when?			
Previous Colonoscopy?			
Are you sexually active?			
Do you have plans to attempt pregnancy THIS year?			
History of Tubal ligation?			
Surgeries? If yes, please list them.			
Have you ever had any sexually transmitted diseases?			
Do you smoke?			How much?
Do you drink alcohol?			How much?
Do you use marijuana, cocaine or other street drugs?			How much?

What prescription or over-the-counter medications do you take on regular basis (including vitamins)?

Are you allergic to any medications?

What do you use for birth control?

Are there any problems or issues you would like to discuss?

Dominion Women's Health, Inc.
Annual Waiver of Liability

At your Annual health care visit, you and your healthcare provider may discuss health issues that are outside the scope of your annual exam. You may be charged for an office visit in addition to your annual exam. Depending on your insurance carrier, you may be responsible for paying a copay, deductible, coinsurance or the office visit in full once processed by your insurance carrier.

Dominion Women's Health, Inc. appreciates that everyone's time is valuable. For this reason, effective 5/1/16, a fee of $10 for Current Patients & $20 for New Patients will be charged for any appointment that is Not Canceled 24 hours prior to the appointment or a "No Show". This fee is due immediately upon occurrence. Thank you for your understanding & cooperation.

_____ _____

Patient's Printed Name Signature of Patient

_____ _____

Patient DOB Date