PATIENT REGISTRATION FORM

Patient name: (last)_____(first)_____(middle)_____

Street Address:_____

City, State, Zip Code:_____

Email Address:_____ Language:_____

Date of Birth:_____SS#:_____

Race:_____ Ethnicity:_____

Phone# (home)_____ (cell)_____

EMERGENCY CONTACT

Name:_____Relation:_____

Number:_____

PRIMARY INSURANCE INFORMATION

Insurance Company Name:_____

Street Address:_____

City, State, Zip Code:_____

Insurance Phone #:_____

Responsible Party Name: (last)_____(first)_____

Street Address:_____

City, State, Zip Code:_____

Phone# (home):_____(cell):_____

Date of Birth:_____ (SS#)_____

Subscriber ID#:_____ Group ID#:_____

Copay:_____ Effective Date:_____

PERSONAL ACCOUNT ACCESS (photo ID required)

- ☐ I am 12-17 years of age and request access to my own medical record information.
- ☐ I am 12-17 years of age and grant Read Only Access to my medical records to the authorized user listed below.
- ☐ I am 12-17 years of age and grant Full Access to my medical records to the authorized user listed below.
- ☐ I am 18 years or older and request access to my own medical record information.
- ☐ I am 18 years or older and grant Read Only Access to my medical records to the authorized user listed below.

AUTHORIZED USER ACCESS (legal documents and photo ID required)

- ☐ I am 18 years or older and request Read Only Access to a medical record.
- ☐ I am 18 years or older and request Full Access to a patient medical record.
- ☐ I have legal paperwork for POA/Guardian/Adoption/Ward of the State or County for this patient.
- ☐ I am the parent of a minor patient aged 11 or younger and possess their birth certificate.

PATIENT INFORMATION (Please Print)

Patient Name:_____
First Name Middle Name Last Name

Patient DOB:_____ Phone:_____
MM/DD/YYYY

Email address where patient portal messages will be sent:_____

I hereby authorize COMPLETE WOMEN'S HEALTHCARE to use/disclose individually identifiable health information to the *FollowMyHealth* patient portal for my online access to COMPLETE WOMEN'S HEALTHCARE health care information.

Patient Signature:_____ Date:_____

AUTHORIZED USER INFORMATION (Please Print)

Authorized User Name:_____

Authorized User DOB:_____ Relationship to Patient:_____

Authorized User email address where portal messages will be sent:_____

Address:_____

Phone#:_____(home) _____(cell)

Authorized User Signature:_____ Date:_____

For Front Desk Use Only:

Photo ID/Copies of Legal Documents Verified By:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. It is our right to change our privacy practices as the laws permit. We will amend this Notice before any significant changes and will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date the changes were made. You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Our office will promptly notify affected individual(s) in the event of a breach of their PHI.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential using it only for the following purposes.

- **Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

- **Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or other persons you choose to involve in your care, only if you consent that we may do so.

- **Payment:** We may use and disclose your health information to seek payment for services we provide to you. The disclosure involves our business office staff and may include insurance organizations or other businesses that may be involved in the process of mailing statements and/or collecting unpaid balances.

- **Emergencies:** We may use or disclose your health information to notify or assist in notification of a family member or anyone responsible for your care in the case of any emergency involving your care. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

- **Healthcare Operations:** We will use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under custody of law enforcement.

- **Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to our health and safety or that of others.

- **Public Health Responsibilities:** We will disclose your health care information to report problems with product reactions to medication, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

- **Marketing Health-Related:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

- **National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to voicemail messages, postcards or letters.

NOTICE OF PRIVACY PRACTICES

YOUR PRIVACY RIGHTS AS OUR PATIENT

- **Access:** Upon written request, you have the right to inspect and get copies of your health information(and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $25.00. If you want copies mailed to you postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for fee and/or explanation of our fee structure.

- **Amendment:** You have the right to amend your healthcare information if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.
- **Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made to your healthcare information. When we make a routine disclosure of your information to a professional for treatment and/or pertinent purposes, we do not keep a record: therefore these are not available. You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released.

- **Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do , we will abide by our agreement. (Except in emergencies) Please contact our Privacy Officer if you want to further restrict access to your healthcare information. This request must be submitted in writing. You also have the right to request restrictions for services paid out-of-pocket.

HEALTH INFORMATION EXCHANGE ADDENDUM

Generally, a HIE is an organization that regional providers participate in to exchange patient information in order to facilitate health care, avoid duplication of services(such as tests) and to reduce the likelihood that a medical error will occur. By participating in a HIE, the provider may share certain health information with other providers that participate in the HIE(each a "Participating Provider") or participants of other health information exchanges. All Participating Providers of a HIE agreed to a set of standards relating to their use and disclosure of health information available through the HIE. These standards are intended to comply with all applicable state and federal laws. This health information includes, but is not limited to:

- General laboratory results including microbiology
- Pathology test results including biopsies, Pap smears, etc.
- Radiology results including x-rays. MRIs, CT scans, etc.
- Results of outpatient diagnostic testing including GI testing, cardiac testing, neurological testing, etc.
- Health Maintenance documentation
- Problem list documentation
- Allergy list documentation
- Immunization profiles
- Medication lists
- Progress notes
- Consultation notes
- Discharge instructions
- Inpatient operative reports
- Emergency Room visit discharge summary notes
- Urgent Care visit progress notes

HIE "OPT OUT" OPTION

- If you opt-out, your health information will no longer be accessible through the HIEs in which the Provider participates, however, your opt-out does not affect health information that was disclosed through a HIE prior to the time that you opted-out.
- Regardless of whether you choose to opt-out, your health information will still be provided to the HIEs in which the provider participates, however, if you choose to opt-out, the HIEs will not exchange your health information with other providers. Also, you cannot choose to have only certain providers access your health information.
- All participating providers who provide services to you will have the ability to access your information, however, participating providers that do not provide services to you will not have access to your information.
- Information available through a HIE may be provided to others as necessary for referral, consultation, treatment and/or the provision of other treatment related healthcare services to you. This includes providers, pharmacies, laboratories, etc.
- Your information may be disclosed for payment related activities associated with your treatment by a Participating Provider and your information may be used for healthcare operations related activities by Participating Providers.
- You may opt-out at any time by notifying the provider. A form and a list of Participating Providers may be obtained at the front desk or online at emoryhealthcare.org/ehealthexchan

NOTICE OF PRIVACY PRACTICES

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

CONTACT INFORMATION

Practice Name: COMPLETE WOMEN'S HEALTHCARE

Telephone: 770-622-9810 **Fax:** 770-622-9811

E-mail: WOMENSCAREONLINE.COM

Address: 634 Peachtree Parkway Suite 200
Cumming, GA 30041

RECEIPT OF NOTICE OF PRIVACY PRACTICES & HIE WRITTEN ACKNOWLEDGEMENT FORM

I have received a copy of the Complete Women's Healthcare Privacy Practices & HIE Notice.

_____ _____

Signature of Patient Date

PATIENT CONSENT FORM

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgement of the attending provider or their assigned designees

I fully understand this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand the COMPLETE WOMEN'S HEALTHCARE will use and disclose my information for the purpose of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its content.

_____ _____

Patient (or responsible party) Signature Date

MEDICARE PATIENTS: I authorize COMPLETE WOMEN'S HEALTHCARE to release information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to COMPLETE WOMEN'S HEALTHCARE.

_____ _____

Patient (or responsible party) Signature Date

FINANCIAL AND PAYMENT POLICY FORM

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. The following is a statement of our financial policy that we would like you to read and sign as evidence of your agreement prior to any treatment.

We must emphasize that as your physician our relationship is with you, not your insurance company. We file the insurance claim as a courtesy to our patients, but all charges are your responsibility from the date rendered. Not every service is a covered benefit in all contracts. Some insurance companies arbitrarily select your health insurance policy and its requirements for coverage including pre-authorizations of services. We are not responsible for knowing the requirements of your specific plan.

It is your responsibility to contact your insurance carrier to confirm that our office participates in your plan. If you receive services from our office and we are not on your plan, you will be responsible for payments in full for our fee(s).

If you are unable to provide us with current insurance information (a current insurance card or written documentation of coverage from your insurance carrier), or if you do not provide us with the correct insurance information and claims are denied, you will be required to pay for any services you receive. When you have provided us with the corrected insurance information, we will file a claim with your insurance carrier and reimburse you once we have received their payment. Please be aware, if too much time has passed your insurance may not cover your services and you will be required to pay for services.

COMPLETE WOMEN'S HEALTHCARE is not a participating provider of Medicaid, you will be responsible for payment in full if you are insured with them. Patient responsible balances are expected to be paid within 30 days. Failure to pay a balance will result in collection actions. If a patient's balance is turned over to a collections agency an additional 30% of the balance will be added to the account.

DEDUCTIBLE, CO-INSURANCE AND CO-PAYS

All deductibles and co-pays are due at the time of services. We accept cash, checks, Visa and Mastercard. If payment is not received on the date of service, a $20.00 administration fee may apply. All unpaid balances will accrue a monthly 5% late charge if not paid in full after 60 days or not set up on an acceptable payment plan.

LABS

We use PathGroup for all laboratory services. All labs are billed separately through PathGroup and you will receive a separate statement for any laboratory services not covered by your insurance. If your insurance requires us to use a specific lab, it is your responsibility to let us know at the time of the visit.

RETURN CHECK FEES

FINANCIAL AND PAYMENT POLICY FORM

Checks returned for non-sufficient funds will be charged a $30.00 administration fee in addition to the patient balance.

HMO, MANAGED CARE AND PPO PLANS

Specific plans may require referrals from primary care physicians. It is your responsibility to provide a current referral form at the time of your visit. You are financially responsible for any services provided without a referral form.

COPY OF RECORDS/ FORMS

Copy of records requests require approximately 2 weeks to complete. A $25.00 charge is applied for each request. Records less than 20 pages will be faxed; records over 20 pages will be mailed. A $25.00 administrative fee is charged for forms and letters completed by our office. This includes any verification of pregnancy letters and /or forms for disability, return to work letter, etc. This is a one-time fee payable before forms are completed. This fee will not be submitted to your insurance.

MISSED APPOINTMENTS

If you are unable to keep your scheduled appointment please notify our office at least 24 hours in advance of your appointment time. Failure to do so will result in a $25.00 no show charge. After 3 no shows on your account you will be dismissed from the practice.

CANCELED SURGERIES

There is a $100 cancellation fee for scheduled surgeries that are canceled less than 48 hours.

I have read and understand this financial agreement of COMPLETE WOMEN'S HEALTHCARE. I accept and acknowledge this financial and payment policy by signing below.

Patient Signature:_____

Date:_____

COMPLETE WOMEN'S HEALTHCARE

Consent for Release of Personal and Health Information

Patient Name:_____

Date of Birth:_____

Address:_____

Phone #:_____

This consent form allows personal and health information to be shared via telephone call with the person being authorized. I authorize the use or disclosure of personal and health information by Complete Women's Healthcare as described below:

- Any and all personal and health information Complete Women's Healthcare maintains.
- Personal and health information regarding the treatment for the following condition:_____
- Personal and health information covering the period of time_____to _____
- Other(Please specify and include dates)_____

_____

This information may be disclosed to, and used by, the following individuals or organizations:

1. **Name:**_____ **Relationship:**_____
   Address:_____
2. **Name:**_____ **Relationship:**_____
   Address:_____
3. **Name:**_____ **Relationship:**_____
   Address:_____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and send my written revocation to Complete Women's Healthcare. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that I do not have to sign this authorization. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

Signature of Patient or Guardian:_____ **Date:** _____

COMPLETE WOMEN'S HEALTHCARE

New Patient Medical History Form

Please complete the following information accurately as possible. Your answers on this form will help your provider understand your medical concerns and conditions better. If you cannot remember specific details, please give best estimates.

Name :_____ Date:_____

Birthdate:_____ Age:_____

Primary Care Physician:_____ Preferred Lab:_____

Preferred Pharmacy:_____ Pharmacy Number:_____

Reason for Visit: *Please Check*

- ☐ Annual - Well Woman Exam Check Up
- ☐ Problem - Please List:_____

Gynecology (Female) History:

First day of most recent period:_____ Cramping: none mild medium strong severe

Age of first period:_____ Flow: none light medium heavy clots

Number of days between each period:_____

How many days do periods last?_____

Current Contraception:

☐ Pills	☐ Abstinence	☐ Ring	☐ Patch	☐ foam/spermicides
☐ None	☐ Partner vasectomy	☐ Hysterectomy	☐ Implant	☐ Tubes tied/plugged
☐ Condoms	☐ Withdrawal	☐ Rhythm	☐ Menopause	☐ Same gender sexual partner
		☐ Depo-provera	☐ IUD	

Are you in menopause? *Yes No*

Do you use/have you ever used Hormone Therapy? *Yes No Currently*

Gynecology (female) Problems (past and present): *Please circle all that apply*

Abnormal pap smear (year:_____)	Endometrial (uterine) Ablation	Genital Herpes	Warts
Endometriosis	Laser/LEEP/Freezing of Cervix	Chlamydia	
HPV	Abnormal mammogram	Gonorrhea	

Pregnancy History:

Number of times pregnant: _____

Number of miscarriages: _____

Number of abortions: _____

Number of premature births: _____

Number of on-time births: _____

Number of living children: _____

Pregnancy History (*including abortions or miscarriages*):

	GA Weeks	Length of Labor	Birth Weight	Sex M/F	Type of Delivery	Anesthesia	Place of Delivery	Pre-Term Labor	Comments/ Complications:
1									
2									
3									
4									

Health Maintenance and Modifiers:

Please list dates of last test or treatment: *(please indicate if results were normal or abnormal)*

Pap Smear: _____

Mammogram: _____

Bone Density: _____

Colonoscopy: _____

Cholesterol/Lipid Screen: _____

Sexual Activity:

Sexual Preference:	❑ Men	❑ Women	❑ Both	❑ Unsure
Have you ever been in a sexual relationship?	❑ Yes	❑ No		
Are you currently in a sexual relationship?	❑ Yes	❑ No		
New sexual partner in the last year?	❑ Yes	❑ No		
Current sexual partner:	❑ Male	❑ Female		
Prevention of Sexually Transmitted Infection:	❑ Abstinence	❑ Condoms	❑ Monogamy	
Do you want testing for STIs?	❑ Yes	❑ No		

Safety:

Is violence at home a concern for you?	❑ Yes	❑ No
Have you ever been abused?	❑ Yes	❑ No

Personal Past Medical History:

❑ No Medical Problems

Asthma	Yes	No
Anemia	Yes	No
Blood Clotting Disorder	Yes	No
Cancer	Yes	No
Mental Disorder	Yes	No
Diabetes	Yes	No
Heart Disease	Yes	No
Gallbladder Problems	Yes	No

Other Problems/Further Details

_____
_____
_____
_____
_____
_____

High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Intestinal Problems	Yes	No
Kidney Problems	Yes	No
Liver Disease	Yes	No
Migraine	Yes	No
Osteoporosis	Yes	No
Stomach Problems	Yes	No
Stroke	Yes	No
Thyroid Problems	Yes	No
Infections	Yes	No
Skin Conditions	Yes	No

Past Surgical History: *Please list ALL surgical procedures with dates performed.*

Year	Type of Surgery	Doctor that performed

Vaccine History:

❑ Hepatitis A	❑ Meningococcal	❑ HPV (Gardasil)	❑ Singles	❑ MMR
❑ Hepatitis B	❑ Flu	❑ COVID	❑ TDAP	❑ Pneumovax

Allergies: (Medications/Foods)

Medication/Food Name	Allergic Reaction Type

Medications: Current regularly taken prescribed medications by healthcare providers.
(If you have a list please attach.)

Medication Name	Strength	Frequency	Prescribing Doctor

Supplements: Supplements, Vitamins, etc.

Supplement	Reason for use

Social:

Your Occupation: _____

Your Employer: _____

Relationship Status: single engaged domestic partner married separated divorced widowed

Name of spouse/partner: _____

Alcohol: Average number of drinks _____/day or _____/week or none

Any concern about personal alcohol misuse or abuse? Yes No

Tobacco: Do you smoke? Yes No Past

If yes, how many cigarettes per day? _____ for how long? _____ Quit date _____

Recreational Drug Use: Yes No Past

Caffeine: Yes No _____ cups/day or _____ cups/week

Calcium: ❑ none ❑ milk/dairy ❑ dietary ❑ supplements

Vitamin D: ❑ none ❑ irregular ❑ regular ❑ supplements

Exercise: ❑ none ❑ irregular ❑ regular ❑ aerobics ❑ weight bearing

Family History:

List of Family Members (parent, grandparents,sibling,aunt,uncle,children)

Bleeding Disorder	Yes	No
Blood Clotting DX	Yes	No
Diabetes	Yes	No
Cancer	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Stroke	Yes	No
Kidney Problems	Yes	No
Mental Illness	Yes	No

Review of Systems: *Please indicate any recent problems*

General:	☐ excessive fatigue ☐ night sweats ☐ hot flashes	☐ unexplained weight change (gain/loss) ☐ heat or cold intolerance	
Breasts:	☐ change in skin ☐ lumps	☐ nipple discharge ☐ breast pain	
Respiratory:	☐ unexplained cough	☐ shortness of breath	☐ wheezing
Gastrointestinal:	☐ vomiting (more than 2 weeks) ☐ blood in stool ☐ persistent nausea ☐ bloating (more than 2 weeks)	☐ chronic diarrhea ☐ chronic constipation ☐ abdominal pain	
Genital/Urinary:	☐ vaginal discharge ☐ leaking of urine ☐ blood in urine	☐ vaginal odor ☐ pain with urination ☐ problems with sex	☐ urgency
Skin:	☐ new or changing skin lesions		
Neurologic:	☐ intense headaches, new onset		
Cognitive/Emotional:	☐ depression ☐ inability to concentrate	☐ anxiety ☐ lack of focus	☐ poor sleep
Heme-Lymph:	☐ easy bruising or bleeding	☐ enlarged lymph nodes	
Cardiovascular:	☐ chest pain	☐ palpitations	

Patient Signature/ Date: _____