Premier
Women's Health

Patient Registration Form

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

Today's Date	Last Name		First Name	Middle Name
Date of Birth	Sex	Age	Social Security #	Driver's License No.
Preferred Pharmacy			Marital Status	
Home Address	City		State	Zip
Home Telephone Number		Cell Phone Number		Work Phone Number
Email		Preferred Method of Contact		Employer
NOTIFY IN CASE OF EMERGENCY				
Name		Phone Number		Relationship
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES				
Name	Date of Birth	Social Security #		Phone Number
Address	City	State	Zip	
INSURANCE INFORMATION				
Primary Insurance		Subscriber	Date of Birth	Social Security #
Policy #		Group #		
Secondary Insurance		Subscriber	Date of Birth	Social Security #
Policy #		Group #		
How Did You Hear About Us?	Doctor	Friend	Internet (what source)	

Patient Health History

Date: _____

Name_____ DOB: ___/___/___

Reason for today's visit (Please list all symptoms):

_____

_____

_____

Past Medical History

Illnesses: Have you ever had any of the below illnesses? Please check all that apply.

	Date / Details:
ADD	_____
A-Fib	_____
Abnormal Pap	_____
Asthma	_____
Blood Transfusions	_____
Bronchitis	_____
Cancer (Specify)	_____
Colitis	_____
Congestive Heart Failure	_____
COPD	_____
Coronary Artery Disease	_____
Diabetes (Type I or II)	_____
Emphysema	_____
Gall Bladder Disease	_____
Epilepsy	_____
Heart Disease	_____
Heart Attack	_____
Hepatitis	_____
High blood pressure	_____
High Cholesterol	_____
HPV	_____

	Date / Details:
Hyperthyroidism	_____
Kidney Stones	_____
Mononucleosis	_____
Mental Disorder	_____
Neurological Disorder	_____
Osteoporosis	_____
Osteopenia	_____
Phlebitis	_____
Pneumonia	_____
Stroke	_____
Tuberculosis	_____
Ulcer	_____
Urinary Infection	_____

Sexually Transmitted Infection

_____

Other:

_____

_____

Preventative Health Maintenance

1.) Date of last pap smear? _____
Was your last pap smear normal? Yes No

2.) Date of last Colonoscopy? _____
Was your last colonoscopy normal? Yes No

3.) Date of Last Bone Density Test? _____
Was your Bone Density normal? Yes No

4.) Date of last Pelvic Ultrasound? _____
Was your last Pelvic Ultrasound normal?
Yes No

5.) Date of last mammogram? _____
Was your mammogram normal? Yes No

6.) Do you perform regular Self Breast Exams?
Yes No

Past Surgical History

	Date/ Details:		Date/Detail:
Appendectomy	_____	Lumpectomy (R, L, both)	_____
Breast Augmentation	_____	Mastectomy (R, L, both)	_____
C – Section	_____	Removal of Tube/Ovary	_____
D & C	_____	Thyroid Operation	_____
Gall bladder	_____	Tonsillectomy	_____
Hysterectomy	_____	Tubal ligation	_____
Laparoscopy	_____	Varicose vein operation	_____

Other Previous Surgeries :

_____

_____

_____

List of Physicians Currently Overseeing Your Care:

_____

_____

_____

Medications

Please list all current medications.

Medication	Dose	Frequency

Allergies

Medication Allergies:

_____

_____

_____

Food Allergies:

_____

_____

Family History

Has anyone in your immediate family been diagnosed with the following disease :

(Please indicate who, whether maternal or fraternal side of the family, and type)

Cancer (Type) _____
Bleeding Disorder _____
Diabetes _____
Heart Disease _____
High Blood Pressure _____
Other: _____

_____

_____

Reproductive History

Age Menarche: _____

Cycle Interval: _____# days

Menses Duration: _____ # days

Flow: (please circle) Heavy Medium Light

Last Menstrual Period (Date): _____

Menopause Status (pre/peri/post): _____

Menapause Age:_____

Method of Birth Control: _____

Clots: Yes No

Breakthrough Bleeding : Yes No

Have you had Hormone Replacement Therapy?
Yes No

Pregnancies

Total Pregnancies	Full Term	Premature	Abortion	Miscarriage	Ectopic	Multiple	Living

Date of Delivery	Boy or Girl	Weight	Vaginal or C-Section	Complications	Location	Physician	Other Info

Social History

Alcohol Use Every Day Some Days Former Never Amount Used: _____ Age Start: _____ Age Stop: _____

Drug Use Yes Describe: _____

Tobacco Use Every Day Some Days Former Never Amount Used: _____ Age Start: _____ Age Stop: _____

Marital Status Dating Divorced Engaged Married Not dating Remarried Single Separated Widowed

Employment (Occupation) _____ Unemployed Homemaker Student Retired

FINANCIAL POLICY

Your clear understanding of our Financial Policy is important to our professional relationship. Premier Women's Health, PLLC (PWH) is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Please ask if you have any questions about our fees, Financial Policy or your responsibilities.

To establish your financial account with PWH, you must first complete our Patient Registration Form and return it to the Front Office staff. It is YOUR responsibility to notify us of any changes.

In our effort to better serve you and to alleviate unnecessary billing confusion over patient balances we require you to pay all of your co-payments, deductibles, and co-insurance at the time of service.

We accept the following forms of payment: cash, checks and all major credit cards. As a convenience to our patients, we will assist you with applying for care credit for certain procedures, surgeries and/or deliveries.

The parents (or guardians) of minors treated at PWH are financially responsible for full payment of the minor's account.

INSURANCE

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, co-insurance, covered charges, secondary insurance and/or coordination of benefits, "usual and customary" charges, pre-existing conditions, etc., other than to supply factual information as necessary.

Insurance companies require that all claims must be submitted within a specified time of service. If there are any changes to your insurance policy, you must notify us and update your Patient Registration Form or you may be financially responsible for any amounts denied by insurance.

If your insurance company has not paid the full balance for any office visit, procedure, surgery or delivery within sixty (60) days; PWH may deem the balance your responsibility. We will mail you a statement every 30 days at which time any unpaid balances are due and payable upon receipt. If payments of any remaining balances have not been made within ninety (90) days of receiving your first statement, your entire balance may be sent to an outside collection service. You will be responsible for any additional expense of collections, including but not limited to, collection service fees and attorney's fees.

All prior balances must be paid in full prior to entering into an OB Addendum or Surgical Addendum.

PPO/HMO

Each time you make an appointment with any provider at PWH, it is your responsibility to make sure your provider and PWH are currently under contract with your plan. Verification of your plan is required; therefore, you must show your current card to our Front Office Staff at check in for each visit. If we are not currently a participating provider in your Insurance Plan, you are responsible for full payment of your visit at the time of service.

MEDICARE/MEDICAID

The federal government requires that all Medicare/Medicaid claims be filed directly by PWH. Therefore, you must show your current Medicare/Medicaid card to our Front Office Staff at check in.

By signing below, you acknowledge that you have received a copy of this notice. You further acknowledge that you have read and understand the information contained in this Financial Policy.

_____
Signature

_____
Patient Name

_____
Date

PATIENT PRIVACY NOTICE
Health Information Portability and Accountability Act (HIPAA)

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Your privacy and safeguarding your medical information are critical concerns to us here at Premier Women's Health, PLLC. The Federal Government's Health Information Portability and Accountability Act (HIPAA) requires that every patient receive notification about how the details of their current or past health condition (Protected Health Information or PHI) are disclosed to those outside our practice. We agree with this policy, and will do our utmost to protect personal information about you that our practice may have in your record. Although our policy is to disclose information only after receiving a written release from you, or from someone legally responsible for you, we will disclose information to persons or organizations outside the practice under certain conditions. These circumstances include but are not limited to, filing insurance claims, communicating with other doctors or organizations (hospitals, labs, health care agencies and governmental agencies), or performing those tasks necessary to conduct your medical care.

Given the complexity of modern medicine, and the insurance industry, there are a number of appropriate circumstances in which we will need to disclose or use your PHI without your specific written consent. These uses are best described in terms of the following categories:

For Treatment: In order to undertake, coordinate, or complete a patient's treatment we may need to disclose PHI to nurses, pharmacists, doctors, lab technicians, X-ray technicians and other individuals involved in your care.

For Health Care Operations: We may use or disclose your PHI to others in connection with review of our practice carried out as part of a quality assurance programs or record reviews conducted by outside insurance agencies or governmental agencies responsible for regulating medical practices or insuring compliance with existing regulations. If these reviews are conducted, we will make every attempt to protect your identity and the anonymity of our patients while complying with the review. However, sufficient material may need to be disclosed that could possibly reveal your PHI.

Appointment Reminders or Verification: We may need to disclose PHI about you in connection with appointment reminders by phone or by mail. Simply by identifying ourselves as a caller, other persons may learn that you are under our care. We will make every effort to be discreet, but your information may need to be used to remind you of an appointment, or verify to others that you have an appointment.

Individuals Involved in your Care: Our practice may disclose PHI to friends or family members who are involved in our patient's care. Information will be disclosed with the intent of insuring the accurate conduct of care, or to answer questions about appropriate delivery of care.

Research/Medical Literature: Our doctors participate in research, which may involve collection and use of your PHI in connection with a study, journal article, or educational program. Before using your information a valid authorization to do so will be specifically requested from you. You are under no obligation to participate in any research being conducted.

As Required by Law or to Avert a Serious Threat to Health or Safety: PHI may be disclosed or used when required by public law. An example of this is the requirement to release specific patient information when certain kinds of communicable diseases are discovered.

For Payment: Our practice may use or disclose PHI to third-party payers (insurance companies or Government Agencies) so that we may receive payment for treating you.

By signing below, you acknowledge that you have received a copy of this notice. You further acknowledge that you have read and understand the information contained in this HIPAA Privacy Notice.

_____
Signature

_____
Patient Name

_____
Date

Premier Women's Health
Cancellation and No Show Policy

www.mspwh.com

14231 Seaway Road
Suite 3004
Gulfport, MS 39503

Telephone: (228) 206-1905
Fax: (220) 206-1917

Premier Women's Health's goal is to provide excellent medical care to our patients in a timely manner. To better serve the needs of our patients, beginning _____, a Cancellation and No Show Policy will be enforced. This will allow us to better accommodate patients that need to be seen by our providers. **Please read each paragraph below and initial to the left acknowledging your understanding of our office policies.**

_____ **Appointments:** We require that you call and give our staff at least 24 hours (1 business day) notice to cancel or reschedule your appointment. If the appointment is not cancelled or rescheduled at least 24 hours (1 business day) in advance you will be charged a $40.00 fee for the missed visit. Arriving 15 minutes late without prior notice to your appointment is considered a late cancellation and is subject to the same $40.00 fee.

_____ **In-office procedure appointments:** We require that you call and give our staff at least 72 hours (3 business days) notice to cancel or reschedule the in-office procedure appointment. If the appointment is not **cancelled or rescheduled** at least 72 hours (3 business days) in advance you will be charged a $150.00 fee.

_____ **Surgeries:** We require that you call and give our staff at least 48 hours (2 business days) notice prior to your **Pre-Operative Appointment** (Pre-op) to cancel or reschedule your scheduled surgery. If the surgery is not cancelled or rescheduled at least 48 hours (2 business days) in advance you will be charged a $200.00 fee.

_____ **Rescheduled appointments/surgeries**: If an appointment/surgery has been rescheduled for two consecutive times, the fee will be applied to the type of rendered service and the third rescheduled appointment will result in pre-payment for rendering services. If you fail to keep the third rescheduled appointment and/or surgery date you could be dismissed from the practice.

All fees must be paid in full prior to scheduling your next appointment and/or surgery. This is nonrefundable and will not be covered by your insurance company.

By signing below, you acknowledge that you have read and understand the policies. I also understand that such terms may be amended periodically by the practice.

_____ _____

Patient Signature **Date**

_____

Print Name (please print)

_____ _____

Relationship to patient if signing on their behalf **Date**

Patient Authorization Form

I authorize Premier Women's Health to speak with and/or leave information about my visit and/or financial information to the following individuals:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name (Printed)_____

Patient Signature _____

Date _____

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www.mspwh.com