Ladies First Health Care | **Patient Information** | "Where your Health Comes First"

Patient Data

Date:

Last Name	First Name	Middle Name	
Street Address		Email Address *for patient portal use only*	
City	State	Zip	Home Number: Cell Number:
Birthdate	Social Security Number	Gender	Marital Status
Employer		Occupation	
Employer Street Address			
City	State	Zip	Work Phone Number
Emergency Contact Person	Relationship	Home Phone Number: Cell Phone Number:	

Guarantor – Required if patient is under 18 y/o

Last Name	First Name	Middle Name	
Street Address			
City	State	Zip	Home Number: Cell Number:
Birthdate	Social Security Number	Gender	Relationship to Patient
Employer		Occupation	
Employer		Employer Street Address	
City	State	Zip	Work Phone Number

Demographic Information

Race

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Pacific Islander ☐ White

☐ Other Race _____ ☐ Unknown ☐ Declined to Specify

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino

☐ Declined to Specify ☐ Unknown

Preferred Languages Primary: Secondary:	Preferred Pharmacy

For Our Information

Family Doctor	How Did You Hear About Us?
Have You Ever Been Seen By a Doctor Under a Previous Name? ☐ NO ☐ YES if YES, please give previous name	What is your preferred method of contact? ☐ Primary Phone Number ☐ Mail ☐ E-mail/Patient Portal Messaging

Please present all insurance cards and proper identification and read and sign the reverse side.

Ladies First Health Care

Patient Information Form

NAME: Last _____ First _____ Middle _____

Age _____ Birthdate _____ Primary care physician _____

GYNECOLOGICAL HISTORY

Last Normal Menstrual Period (First Day) _____

Age Period Began _____ Length of Periods _____ Length of Cycles _____

Present Birth Control: _____ IUD _____ Pill _____ Vasectomy _____Condoms _____ Diaphragm _____Other

Past Birth Control: _____ IUD _____ Pill _____ Vasectomy_____ Condoms _____ Diaphragm _____Other

Last Bone Scan-Date _____ Result _____

Last Pap Smear-Date _____ Result _____

Last Mammogram-Date _____ Result _____

_____ abnormal Pap	_____ infertility	_____ female cancer	_____ sexual problems
_____ abnormal periods	_____ endometriosis	_____ hot flashes	_____ nipple discharge
_____ venereal disease	_____ fibroids	_____ vaginal dryness	_____ pelvic pain
_____ PID	_____ breast disease	_____ mood swings	_____ night sweats

_____ cervical cautery or freezing

PREGNANCY HISTORY

Are you currently pregnant? _____ Are you trying to become pregnant? _____

Number of pregnancies _____ Miscarriages _____ Abortions _____

Number of children _____ Ages _____

Type(s) of Delivery/Complications _____

MEDICAL HISTORY

DO YOU EXPERIENCE:

Yes / No	Yes / No	Yes / No	Yes / No
___/___ depression	___/___ blood in urine	___/___ weight loss	___/___ urine leakage
___/___ sleep interruptions	___/___ heart palpitations	___/___ bowel changes	___/___ painful urination
___/___ temp. intolerance	___/___ chest pain	___/___ rectal bleeding	___/___ persistent cough
___/___ fainting spells	___/___ swelling of ankles	___/___ vomiting blood	___/___ sinus problems

DO YOU HAVE OR HAVE YOU EVER HAD:

Yes / No	Yes / No	Yes / No
___/___ Blood Transfusions	___/___ Heart Disease/Murmur	___/___ High Blood Pressure/Stroke
___/___ Epilepsy/Seizures	___/___ Migraines	___/___ Depression/Psychological Illness
___/___ Lung Disease (TB/Asthma)	___/___ Shortness of Breath	___/___ Pulmonary Embolism
___/___ Varicose Veins	___/___ Kidney Disease	___/___ Thyroid Disease
___/___ Diabetes	___/___ Hepatitis/Liver Disease	___/___ Gallbladder Disease
___/___ Eating Disorder	___/___ Easy Bruising	___/___ Bleeding Problem
___/___ Cancer	___/___ Lupus	___/___ Arthritis/Back Problems
___/___ Asthma	___/___ Sickle Cell Trait	___/___ Blood Clots
___/___ Urinary/Bowel Problems	___/___ Sickle Cell Diseases	

Allergies / Reactions	Current Medications

Surgery - Hospitalization		
Year	**Hospital**	**Procedure/Reason**

PERSONAL HISTORY

Martial Status M S W D Who lives with you? _____

Occupation _____

Occupational Concerns:

_____Stress _____Hazardous Substances _____Heavy Lifting _____Other

(Circle) Current or Past Tobacco Use

Type _____ Amount _____ How Long _____

(Circle) Current or Past Alcohol Use

Type _____ Amount _____ How Long _____

(Circle) Current or Past Drug Use

Type _____ Amount _____ How Long _____

Spousal Problems? _____

Family Problems? _____

FAMILY HISTORY	Father	Mother	Mother's Parents	Father's Parents	Brothers/ Sisters	Children	Aunts/ Uncles
Heart Disease							
High Blood Pressure							
Stroke							
Cancer/Type							
Diabetes							
Thyroid Disease							
Menopause Problems							
Mental Illness							

I certify that the above information is correct to the best of my knowledge. I will not hold my practitioner or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature Date

_____

Reviewed by Date

LADIES FIRST HEALTH CARE, P.C.

Notice of Privacy Practices
Acknowledgement of Receipt

By signing below, I acknowledge that I have received or been offered the Notice of Privacy Practices from Ladies First Health Care, P.C.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

FOR OFFICE USE ONLY:

Documentation of failure to obtain signed acknowledgment

On _____, this Acknowledgement of Receipt of Notice of Privacy
Date
Practices was presented to _____. The
Patient Name
patient refused to provide a signature when requested.

Please read and complete this form prior to your appointment. Upon arrival provide this form to the front desk.

Ladies First Health Care

"Where Your Health Comes First"

Saqib M. Ahmad M.D., F.A.C.O.G.
Board Certified Obstetrics and Gynecology

Patient Financial Policy

It is a goal of Ladies First Health Care to provide the best care on your behalf. It is also our desire to assist you in the financial arrangements related to your care. Therefore, it is important for you to fully understand our patient, insurance, credit, and collections policies. **We ask that you initial next to each number and sign this statement once you have carefully read the following information.**

Thank you for your cooperation!

_____ 1. **Payment Responsibility:** The patient or legal guardian is responsible for all charges that are incurred. Payment is expected promptly following receipt of monthly statement.

_____ 2. **Insurance Contract:** Your insurance contract is an agreement between you and your insurance carrier. As a courtesy to you, our office is able to file your insurance claims for you. Your doctor's bill is an agreement between you and this office. You are ultimately responsible for payment of your bill regardless of the status of your insurance claim.

_____ 3. **Insurance Verification:** Your insurance is verified prior to your appointment. If the policy is inactive, the patient is responsible for all charges incurred. All information is subject to verification.

_____ 4. **Partial Insurance Coverage:** If your insurance only covers a portion of a service, you are responsible for the difference.

_____ 5. **Assignment of Benefits:** Our office will bill your insurance if you supply all necessary information such as proof of identification and insurance cards. It is the patient's responsibility to know what their insurance benefits cover. If you have an HMO insurance we can assist you in acquiring a referral from your Primary Care Physician. If they refuse to issue one, or the referral is not finalized by your appointment date, you will not be seen.

_____ 6. **Discounts:** By Federal Law and Managed Care Contract Laws, we are required to collect all co-pays and deductibles for each service. Therefore accounts cannot be reduced or discounted.

_____ 7. **Refunds:** Overpayments will be refunded once all active and past dues accounts are paid in full. Refunds of less than $5.00 will not be processed unless specifically requested.

_____ 8. **Delinquent Accounts:** Patients that have unpaid delinquent accounts and/or accounts that have been sent to collections may be discharged for financial negligence at the discretion of office management.

_____ 9. **Referral for Outside Collection:** If we do not receive payment in full by 90 days from the date of service or you do not maintain a payment arrangement as outlined by a staff member and signed by you, we reserve the right to refer your account to an outside collections agency where you will be responsible for all collection and attorney fees.

_____ 10. **Missed Appointments:** If you miss an appointment or fail to give 24 hours' notice, your account will be charged $20.00 for each appointment.

_____ 11. **Returned Check:** A fee of $25.00 will be assessed to your account each time a check is returned.

_____ 12. **Payment Methods:** We accept cash, check, and money orders. We also accept credit/debit cards but payments over $500.00 may be charged a 5% processing fee.

_____ 13. **Lab Billing:** All lab work billing issues must be initially addressed with Quest Diagnostics as we cannot see their system. We cannot answer billing questions. We can ONLY reconcile diagnosis coding and it must be at the instruction of Quest Diagnostics. If you require lab work to go to a different lab than Quest Diagnostics you must let the staff know prior to having blood drawn, a Pap smear, culture collection or biopsy completed

I have read and I understand the above financial policy.

_____ _____

Signature of Patient or Representative **Date**

Ladies First Health Care
TREATMENT AGREEMENT

1. **CONSENT TO TREATMENT**
   I hereby voluntarily request, consent to and authorize Ladies First Health Care (LFHC) and its physicians, employee(s), their associates, assistants, or other practitioners under their orders to treat me at LFHC office, and to provide medical and surgical treatment, including, but not limited to, diagnostic procedures, x-rays, and administration of medications, as is deemed necessary and advisable. In cases of birth, this consent shall extend to my child/children. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments and examinations in LFHC office.
2. **PATIENT'S PERSONAL POSSESSIONS**
   LFHC is not responsible for any patient's clothing, valuables or other personal belongings left with/by patient. I hereby release LFHC from any liability for any and all personal possessions which I choose to keep with me during my office visit.
3. **RELEASE OF INFORMATION**
   I hereby authorize LFHC, or its designee, to release information, in written form, by phone, or facsimile machine, contained in the patient's medical records. I specifically authorize the release of drug and alcohol abuse records in accordance with Federal regulations and or communications made by me to a social worker or psychologist and/or records pertaining to communicable diseases. I further specifically authorize the release of information regarding: Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), Acquired Immunodeficiency Related Complex (ARC) to:
   (a) any third party payor, employer, or insurance company (including but not limited to Medicare, Medicaid, maternal and infant health, Blue Cross/Blue Shield, commercial health insurers, automobile no fault insurers, workers' disability compensation insurers and health maintenance organizations) which are responsible in whole or in part for paying the patient's bill so that LFHC may receive payment or reimbursement for the services provided to the patient.
   (b) any health care facility, physician, durable medical equipment supplier or other ancillary services provider to which the patient is referred or transferred or to which referral transfer is contemplated for the purpose of facilitating continuity of the patient's health care, and
   (c) any independent auditors hired or retained by any and all third party payors, private health insurers and or any employer providing health insurance benefits to the patient, applicable to the patient's office visit, for the purpose of enabling these independent auditors to analyze charges made for services rendered to the patient.
   (d) The release authorization shall be effective only so long as is necessary to accomplish the purpose for which it is given. With respect to substance abuse information (if any), this consent may be revoked at any earlier time unless LFHC has release information in reliance upon it.
4. **ASSIGNMENT OF INSURANCE BENEFITS**
   I hereby assign, transfer and set over unto Ladies First Health Care as its interest may appear all benefits now due or becoming due to me by virtue of the present office treatment.
5. **AGREEMENT TO PAY FOR SERVICES**
   I understand that I am liable and responsible for any health insurance deductibles and coinsurance portions of my bill. I also understand that I am responsible to pay for all services to be rendered to the patient whether signing as an agent or as patient.

The undersigned certifies that (s)he has read the foregoing or that it has been read to him/her, and that (s)he understands the same and consents thereto, and that (s)he is the patient or the duly authorized representative or agent of the patient to sign this form and consent thereto.

I further understand that my treatment may require more than one occasion of service, therefore, this consent shall carry full force and effect from the date of signature until I am discharged from further treatment.

I further understand and acknowledge that an HIV test may be performed upon myself, and in cases of birth, my child/children, without written consent in the event that a health professional, other health facility employee or emergency first responder (as defined in Act 419 of 1994) sustains a percutaneous mucous membrane, or open wound exposure to my, or in cases of birth, my child/children's blood or other body fluids.

Date: _____ _____

(Signature of Patient or Legal Representative)

_____ _____

(Signature of Witness) (Relationship, if other than patient)

If patient is unable to sign, or is a minor, complete the following.

Patient is: 1.) a minor ____ years of age OR 2.) is unable to sign because _____