Ladies First Health Care

Registration Form

PATIENT INFORMATION

NAME:	Last	First	M.I.
Date of Birth:	Have you ever been seen by a Doctor under a previous name? ☐ NO ☐ YES If YES, please give previous name:		
Marital Status: M S W D	Email Address: **for office use only we NEVER share your email**		
Social Security Number:	Primary Care Physician/Location:		
Street Address:	City:	State:	Zip:
Phone: Home	Cell	Work	
Emergency Contact: Name	Relation	Phone Number	
If you are a dependent on your insurance policy please provide the name, date of birth and gender of the subscriber on the policy:			

DEMOGRAPHICS

Gender:	Gender Identity:	
Preferred Languages:	Primary	Secondary
Race: **Check all that apply**	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other Race: _____ ☐ Unknown ☐ Decline to Specify	
Ethnicity:	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to Specify	

FOR OUR INFORMATION

What is your Preferred Pharmacy?	Name	Street/City
How did you hear about us?		
What is your preferred method of contact?	☐ Home Phone Call ☐ Cell Phone Call ☐ Mail ☐ E-Mail/Patient Portal Messaging	
Reminder calls/texts/emails are sent automatically from our system 1 week, 2 days and 90 minutes prior to appointments that have not been confirmed. A staff member will also call you 1 business day prior to your appointment if it has not been confirmed. **Do you wish to opt out of automated calls/texts/emails?** YES NO		

Please read, sign and date the reverse side of this form.

Ladies First Health Care

Health Questionnaire

PATIENT INFORMATION

NAME:	Last	First	M.I.
Date of Birth:	Age:	Primary Care Physician/Location:	
Gender:		Gender Identity:	

GYNECOLOGICAL HISTORY

Date of Last Menstrual Period (First Day):		Age Period Began:		Length of Periods:	Length of Cycles (time between periods):
Are you sexually active? ☐ Yes, currently ☐ Never ☐ In the past but not now	Number of Sexual Partners:	Lifetime	Currently	Gender of Sexual Partners: **Circle All That Apply**	Female Male Trans Other: _____
What do you currently use for birth control:					
What have you used in the past for birth control:					
Date of Last Pap Smear:				Results:	
Date of Last Mammogram:				Results:	
Date of Last Colonoscopy:				Results:	

Check any/all items below that you currently experience and/or have a history of:

☐Abnormal Pap	☐ Infertility	☐ Hot Flashes	☐ Pelvic Pain
☐Abnormal Periods	☐ Endometriosis	☐ Vaginal Dryness	☐ Nipple Discharge
☐STI's	☐ Uterine Fibroids	☐ Mood Swings	☐ Ovarian Cysts
☐PID	☐ Breast Disease	☐ Sexual Problems	☐ Pelvic or Bladder Prolapse
☐Cervical cautery or freezing	☐ Female Cancer(s)	☐ Night Sweats	☐ Urinary Incontinence

PREGNANCY HISTORY

Are you currently pregnant?		Are you trying to get pregnant?	
Number of:	Pregnancies	Miscarriages	Abortions
Please list each delivery:	**if you need more room, please use the space at the end of this packet**		

Type of Delivery (Vaginal or C-Section)	*Year*	*Any Complications*

Ladies First Health Care

Health Questionnaire

MEDICAL HISTORY

Do you experience: **Check all that apply**

☐ Depression/Anxiety	☐ Blood in Urine	☐ Weight Loss	☐ Painful Urination
☐ Sleep Interruptions	☐ Heart Palpitations	☐ Bowel Changes	☐ Persistent Cough
☐ Temp. Intolerances	☐ Chest Pain	☐ Rectal Bleeding	☐ Sinus Problems
☐ Fainting Spells	☐ Swelling of Ankles	☐ Vomiting Blood	☐ Easy Bruising

Do you or have you ever had: **Check all that apply**

☐ Blood Transfusions	☐ Heart Disease	☐ High Blood Pressure	☐ Urinary/Bowel Problems
☐ Epilepsy/Seizures	☐ Heart Murmur	☐ Psychological Issues	☐ Pulmonary Embolism
☐ Lung Disease	☐ Migraines	☐ Thyroid Disease	☐ Arthritis/Back Problems
☐ Varicose Veins	☐ Kidney Disease	☐ Gallbladder Disease	☐ Stroke
☐ Diabetes	☐ Lupus	☐ Bleeding Problem	☐ Asthma
☐ Cancer	☐ Sickle Cell Trait	☐ Blood Clots	☐ Neuro. Disease (Aneurysm)

Allergies:	
Allergen	Reaction

Medications:			
Medication	Dose	Medication	Dose

Surgeries: **excluding deliveries listed on the previous page**		
Procedure/Reason	Year	Facility

Please print your First and Last name and Date of Birth: _____

This ensures all pages are loaded to the correct patient

Ladies First Health Care

Health Questionnaire

SOCIAL HISTORY

Who lives with you?				
Marital Status: M S W D		Family Problems? Y N	Spousal Problems? Y N	
Occupation				
Occupational Concerns: **Circle** Stress Hazardous Substances Heavy Lifting Other_____				
Please tell us about your use of the following:				
Tobacco	☐ Current ☐ Past	Type:	Amount:	How Long:
Alcohol	☐ Current ☐ Past	Type:	Amount:	How Long:
Drugs	☐ Current ☐ Past	Type:	Amount:	How Long:

In the last 12 months have you had issues with any of the follow? **Check all that apply**

☐ Having enough food for yourself/family ☐ Homelessness/Housing ☐ Transportation

☐ Paying for Necessities (ie. Utilities, Diapers, Feminine Products, etc.) ☐ Physical/Emotional/Sexual Abuse

If so, would you like a referral to resources? Y N What is your most urgent issue?

FAMILY HISTORY

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

Use this box to tell give details of the items you checked above, please make sure to list types of cancer and ages of diagnosis if known:

Please print your First and Last name and Date of Birth: _____

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Ladies First Health Care

Health Questionnaire

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? **Circle**				
	Not at all	**Several days**	**More than half the days**	**Nearly every day**
Little Interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have notices. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
If you experienced any of the above, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
For provider use			**TOTAL:**	

Please use this space for anything you could not fit in the spaces provided or for any other pertinent issues/ history you would like to discuss with your provider:

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____

Please print your First and Last name and Date of Birth: _____

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Ladies First Health Care

"Where Your Health Comes First"

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. **Outstanding Balances:** Patients with outstanding balances will be required to pay on their account PRIOR to being seen. Patients with a balance exceeding $200.00 will not be permitted to schedule future appointments until the balance has been paid to below $200.00.

_____ 9. **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.

_____ 10. **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 for a fee of $100.00, at which point you will be responsible for all collection and attorney fees.

_____ 11. **Missed Appointments:** If you miss an appointment or fail to give 24 hours' notice, your account will be charged $20.00 for each appointment.

_____ 12. **Returned Check:** A fee of $25.00 will be assessed to your account each time a check is returned.

_____ 13. **Payment Methods:** We accept cash, check, and money orders. Any payments made by credit/debit card via phone or mail will be charged a $2.00 processing fee. After your card information is used for payment processing it is destroyed and NEVER given out to third parties.

_____ 14. **Lab Billing:** All lab work billing issues must be initially addressed with 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, if you do not inform a staff member and your labs are sent to Quest Diagnostics, YOU ARE RESPONSIBLE FOR ALL CHARGES INCURRED!

I have read and I understand the above financial policy.

_____ _____

Signature of Patient or Representative **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.

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.

6. AGREEMENT TO SURESCRIPTS

I understand and consent to Ladies First Health Care viewing and utilizing my prescription history via Surescripts for the purpose of making future medication prescriptions and coordinating prescriptions with my other providers to minimize drug-to-drug reactions and over prescribing.

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.

_____ _____

Signature of Patient or Legal Representative | Relationship, if other than patient

_____ _____

Signature of Witness | Date

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 _____