PATIENT NAME:______________________________

DOB: ____________ SOCIAL SECURITY::______________

ADDRESS: ______________________________

CITY: ____________ STATE: ______ ZIP: ____________

HOME PHONE: ____________CELL PHONE: ____________

EMAIL: ______________________________

SINGLE____ MARRIED_____ DIVORCED_____ WIDOWED______ OTHER____________

EMPLOYER/SCHOOL: ______________________________

EMPLOYER/SCHOOL PHONE NUMBER: ______________________________

ETHNICITY: _____CAUCASIAN ________AFRICAN AMERICAN/BLACK______HISPANIC/LATINO

_____NATIVE AMERICAN______ASIAN______OTHER_________

SPOUSE / GUARDIAN

NAME: ______________________________

DOB: ____________ PHONE NUMBER: ____________

EMERGENCY CONTACT

NAME: ______________________________

PHONE NUMBER: ____________RELATIONSHIP:____________

NEAREST RELATIVE NOT LIVING AT SAME ADDRESS:

NAME: ______________________________

PHONE NUMBER: ____________RELATIONSHIP:____________

PRIMARY INSURANCE INFORMATION

INSURANCE CO.: ____

POLICY #:___________________________GROUP#:________________

POLICY HOLDER NAME: ____

DOB: ______________________RELATIONSHIP:____________________

SECONDARY INSURANCE INFORMATION

INSURANCE CO.: ____

POLICY #:___________________________GROUP#:________________

POLICY HOLDER NAME: ____

DOB: ______________________RELATIONSHIP:____________________

Assignment of Insurance Benefits and Authorization to release Information

I authorize payment of medical benefits to **Elite Women's Care Center, PA** for any and all services not paid in full at the time services are rendered.

I authorize **Elite Women's Care Center, PA** to release any medical information as necessary for the completion of my insurance claims to any insurance carrier, health, or hospital plan.

PATIENT/GUARDIAN NAME (PRINT): ______________________________

PATIENT/GUARDIAN NAME (SIGN):_______________________________

DATE: ____________________

PAYMENT POLICY

- Payment arrangements must be made **prior** to appointment. Arrangements for payment require approval from management. If arrangements are defaulted, all arrangements will be voided and full payment will be due **before** any future services will be rendered.

- Co-payment is due at time of service. No payment arrangements are made for co-pay amounts.

- A statement will be sent within 30 days of the rendered service(s) or immediately after payment from your insurance company is received.

- A late fee of $35.00 will be applied to your account balance after **EACH** 60 day period until the balance is cleared.

- Accounts will be sent to collections after 90 days. Patient will be responsible for collection fees in addition to office charges.

- All major credit cards are accepted / **no checks accepted**

- There will be a $25.00 charge to the patient for **NO SHOW office visit** appointments. There is also a $50.00 charge to the patient for **NO SHOW office procedures.** These charges are not payable by any insurance company. **To avoid additional charges, please call within 24 hours to cancel your appointment.**

- Patient requested paperwork (i.e. FMLA certification) completion is subject to a $25.00 service fee **per form**. Forms will not be released, **by any means**, until fee is paid. Please allow 5-7 business days for completion.

- For **obstetrical services**, the full 100% is due by, no later than, **28 weeks** of pregnancy.

- **Laboratory fees** are separate from physician fees. Please contact the lab for any invoices received related to laboratory fees.

- For **elective circumcisions**, there will be a $150.00 deposit due by 28th week of pregnancy. Deposit applied to charge if insurance does not pay. A statement will be issued to you, as this is only a deposit. **This does not cover the full charge.**

- Proof of monthly payment is required for premium based insurance coverage.

- Patients are responsible for services not covered by their health plan. (i.e. pre-existing, medical necessity, non coverage, etc)

X____

By signing this form, the patient acknowledges receipt of the EWCC payment policy.

It is the intent of Elite Women's Care Center, PA to ensure that our patients are well informed of the office policies and procedures so that we may provide you with the best possible care. We appreciate your business and thank you for allowing us the opportunity to care for you.

All laboratory services, cultures, and pathology are performed by a third party vendor. You are responsible for these services. Elite Women's Care Center is not responsible for any copays, deductibles, or non covered lab services. If you have any questions, please contact your insurance company prior to any services rendered.

Patient's Name (Print) ______________________________ ***Date*** __________

Patient's Signature ______________________________ ***Date*** __________

Health Insurance Portability and Accountability Act Notice

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), as of April 14, 2003 all health care providers are required to provide their patients with a "Notice of Privacy Practice" statement.

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

Elite Women's Care Center, PA is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

TREATMENT – We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment, or health care operations. For example: *It may be necessary to seek consultation regarding your condition from other health care provider's associated with Elite Women's Care Center, PA.*

PAYMENT – We may disclose your health information to your insurance provider for the purpose of payment or health care operations. For example: *An itemized billing statement provided by EWCC to your insurance company may contain medical information including diagnosis, date of injury, condition, and codes that describe the services received.*

WORKER'S COMPENSATION - We may disclose your health information as necessary to comply with State Worker's Compensation laws.

EMERGENCIES – We may disclose your health information to notify or assist in notifying a family member, or the individual responsible for your care about your medical condition in the event of an emergency or of your death.

PUBLIC HEALTH – As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

JUDICIAL PROCEEDINGS – We may disclose your health information in the course of any judicial proceedings.

LAW ENFORCEMENT – We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness, missing person, complying with a court order or subpoena, and other law enforcement purposes.

DECEASED PERSONS – We may disclose your health information to coroners or medical examiners.

ORGAN DONATION – We may disclose your health information to organizations involved in procuring, banking, or transplanting organs or tissues.

PUBLIC SAFETY – We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

SPECIALIZED GOVERNMENT AGENCIES – We may disclose your health information for military, national security, prisoner, and government benefits purposes.

MARKETING – As a courtesy to our patients, we may contact you for the purpose of reminding you of an appointment date and time. If you are not available we may leave a message. No personal information will be disclosed during the attempt to contact you other than the date and time of your scheduled appointment in addition to a request to return the call to our office if you need to cancel or reschedule your appointment.

YOUR HEALTH INFORMATION RIGHTS

- You have the right to request restrictions on certain uses and disclosures on your health information. Please be advised, however, that Elite Women's Care Center, PA is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Elite Women's Care Center, PA amend your protected health information. Please be advised, however, that Elite Women's Care Center, PA is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of denial reason(s).
- You have the right to receive accounting of disclosures of your protected health information made by Elite Women's Care Center, PA.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

Elite Women's Care Center, PA reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Elite Women's Care Center, PA is required by law to comply with this notice. Elite Women's Care Center, PA is required by law to maintain the privacy of your health information and to provide you with this notice of its legal duties and privacy practices with respect to your health information. If you have questions about this notice, or if you would like more information about your privacy rights, please contact: Dr. Torri Pierce at Elite Women's Care Center, PA at 281-579-9900.

COMPLAINTS – Complaints about your privacy rights or how Elite Women's Care Center, PA has handled your health information should be directed to Dr. Torri Pierce at Elite Women's Care Center, PA by calling this office at 281-579-9900.
If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to the Department of Health and Human Services:

- File online at: www.hhs.gov/ocr/hipaa/
- Or mail complaint to HIPAA Complaint, Office for Civil Rights, Region VI U.S. Dept. Health & Human Services, 1301 Young St., Suite 1169, Dallas, TX 75202

THIS NOTICE IS EFFECTIVE AS OF 04/01/2010.

I have read the Privacy Notice and understand my rights contained in this notice.

As indicated by my signature below, I provide Elite Women's Care Center, PA with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Patient's Name (print) ______________________________ Date ______________

Patient's Signature ______________________________ Date ______________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBER

Patient Name (print) ______________________________ DOB:____________

I hereby authorize Elite Women's Care Center to discuss my protected health information with the following friend(s) and/or family member(s):

Name__________________________Relation_____________DOB____________

Name__________________________Relation_____________DOB____________

Name__________________________Relation_____________DOB____________

Name__________________________Relation_____________DOB____________

____ ____________________

Patient signature Date

Elite Women's Care Center, PA

You are scheduled for your yearly well woman exam/preventative health exam today.

(This is a routine checkup). Your insurance plan may only pay for the routine visit, testing of your preventative visit as defined by your plan.

***If you have new or chronic condition that requires additional attention, testing or treatment, there may be a co-pay, deductible, or an extra charge (s) for these services as per your plan.**

*Some tests may not be covered under your preventative benefit coverage which may result in a cost share to you.

*You may wish to consult your health plan regarding your benefits and your health plan reimbursement policies

Thank You

Patient Signature____

Date ____________________

PAST HISTORY: **CIRCLE ALL THAT APPLY**

ARTHRITIS
ASTHMA
BREAST TUMOR
DIABETES
HEART ATTACK
HEART MURMUR
HEPATITIS

HIGH BLOOD PRESSURE
HIGH CHOLESTEROL
INTESTINAL BLEEDING
KIDNEY INFECTION
KIDNEY STONE
MIGRAINE HEADACHES
MITRAL VALVE PROLAPSE

NEUROLOGICAL DISEASE
OSTEOPOROSIS
PARALYSIS
PNEUMONIA
RHEUMATIC FEVER
THROMBOEMBOLIC EVENTS
THYROID PROBLEMS

OTHER HEART DISEASE______________________________

OTHER KIDNEY DISEASE______________________________

INFECTIOUS DISEASE (TB,HIV,ETC)______________________________

OTHER LUNG DISEASE______________________________

OTHER GENETIC/INHERITED DISEASE______________________________

OBSTETRIC HISTORY

___# OF PREGNANCIES
___# OF MISCARRIAGES
___# OF LIVING CHILDREN
___# OF DELIVERIES
___# OF ABORTIONS

PLEASE LIST PREGNANCIES IN CHRONOLOGICAL ORDER:

BIRTH DATE MM/DD/YY	SEX M/F	BIRTH WEIGHT	DELIVERY ROUTE VAGINAL/ C-SECTION/VBAC	ANESTHESIA (IF ANY)	COMPLICATIONS	DOCTOR/HOSPITAL

PATIENT NAME______________________________
AGE________________

SURGICAL HISTORY

LIST ALL PREVIOUS SURGERIES (TYPE AND APPROXIMATE DATE) INCLUDING PLASTIC SURGERY, MINOR SURGERY AND CESAREAN

PROCEDURE		COMPLICATIONS	SURGEON/HOSPITAL
APPENDECTOMY	YES NO DATE:		
CERVICAL CONE/LEEP	YES NO DATE:		
GALLBLADDER	YES NO DATE:		
HYSTERECTOMY (UTERUS)	YES NO DATE:		
LAPAROSCOPY	YES NO DATE:		
OVARIES REMOVED	YES NO DATE:		
TUBAL LIGATION	YES NO DATE:		
OTHER_____________________ (I.E.BREAST BIOPSY, COLONOSCOPY,ETC)	YES NO DATE:		

WILL YOU PERMIT A BLOOD TRANSFUSION FOR MEDICAL REASONS? _____YES ______ NO

AGE OF ONSET OF MENSES ________

WHEN WAS YOUR LAST PAP SMEAR?______________________

WHEN WAS YOUR LAST MAMMOGRAM?___________________

HAVE YOU HAD A HYSTERECTOMY? ______YES ________NO

DO YOU STILL HAVE YOUR OVARIES? ______YES ________NO

IF MENOPAUSAL, AGE OF LAST MENSTRUAL PERIOD________________

FIRST DAY OF LAST MENSTRUAL CYCLE?_____________________

PATIENT NAME____

AGE___________

HOW OFTEN DO YOU GET YOUR PERIOD (CIRCLE ONE)

LESS THAN 20 DAYS APART 21-35 DAYS APART MORE THAN 36 DAYS APART

HOW MANY DAYS DOES YOUR PERIOD LAST (CIRCLE ONE)

LESS THAN 2 DAYS 2-5 DAYS 5-7 DAYS 7 -10 DAYS MORE THAN 10 DAYS

HOW MANY PADS/TAMPONS DO YOU USE ON A HEAVY DAY?____

WHICH FORM OF BIRTH CONTROL (IF ANY) DO YOU USE? ______PILL/PATCH/RING _______IUD_______CONDOM

____DEPO PROVERA _____VASECTOMY _____TUBAL LIGATION/ESSURE ______ OTHER:______________________

DO YOU WANT TO CHANGE BIRTH CONTROL? ____YES ____NO

WHAT BIRTH CONTROL OPTIONS ARE YOU INTERESTED IN?____

DID YOUR MOTHER TAKE **DES** OR OTHER HORMONES WHILE PREGNANT WITH YOU? ____YES ____NO

REGARDING YOUR FEMALE ORGANS: CIRCLE ANY THAT APPLY

ABNORMAL BLEEDING CHLAMYDIA/GONORRHEA/SYPHILIS/HERPES GENITAL WARTS

PELVIC INFECTIONS TUMOR OF THE UTERUS OR OVARIES

LIST ALL CURRENTLY USED MEDICATIONS (PRESCRIPTION,BIRTH CONTROL PILLS, OVER THE COUNTER,HERBAL AND NUTRITIONAL SUPPLEMENT)

NAME	DOSAGE	FREQUENCY	NAME	DOSAGE	FREQUENCY

PATIENT NAME____

AGE_________________

LIST ALLERGIES TO MEDICATION/FOOD ARE YOU ALLERGIC TO LATEX? ____YES ____NO

MEDICATION/FOOD	REACTION	MEDICATION/FOOD	REACTION

WHAT LANGUAGE(S) DO YOU SPEAK, OTHER THAN ENGLISH?
____

SOCIAL HISTORY
MARITAL STATUS:___SINGLE ___MARRIED____DIVORCED ____WIDOWED____LIVING TOGETHER
________OTHER

ARE YOU SEXUALLY ACTIVE? YES____NO____ NUMBER OF PARTNERS IN THE PAST YEAR
____

ALCOHOL USE:YES____NO____ IF YES, DESCRIBE____________________ PREVIOUSLY,BUT NOT NOW____

TOBACCO USE: YES____NO____ PACKS PER DAY:_________________ PREVIOUSLY,BUT NOT NOW____

ARE YOU USING ANY OTHER DRUGS: YES____NO____ IF YES, TYPE OF DRUG(S)___________________________

FAMILY HISTORY

CANCER TYPE : ______________	FAMILY RELATION	HIGH CHOLESTEROL	FAMILY RELATION
CONGENITAL DISEASE (INHERITED)	FAMILY RELATION	KIDNEY DISEASE TYPE: ____________	FAMILY RELATION
DIABETES TYPE: ______________	FAMILY RELATION	MENTAL RETARDATION	FAMILY RELATION
HEART DISEASE TYPE: ______________	FAMILY RELATION	OSTEOPOROSIS	FAMILY RELATION
HIGH BLOOD PRESSURE	FAMILY RELATION	TWINS	FAMILY RELATION

PATIENT NAME____

AGE______________________

HAVE YOU EVER HAD AN ABMORMAL PAP SMEAR? ____YES _____NO

IF YES, TYPE OF TREATMENT____

ARE YOU SEXUALLY ACTIVE? ____YES ____NO

DO YOU HAVE ANY CONCERNS OR DISCOMFORT? ____YES ____NO

IF YES, EXPLAIN____

DATE OF LAST PAP SMEAR______________________ RESULTS ______________________

DATE OF LAST MAMMOGRAM____________________RESULTS______________________

DATE OF LAST BONE DENSITY____________________RESULTS______________________

REASON FOR TODAY'S VISIT

____

____

WHAT CHANGES HAVE THERE BEEN IN YOUR LIFE RECENTLY?

____

____

PHARMACY NAME: ______________________PHONE NUMBER______________________

DO YOU NEED ONE MONTH OR 90 DAY PRESCTRIPTION? ______ONE MONTH________90 DAY

HOW DID YOU HEAR ABOUT US? ______ KATY MAGAZINE ______ ABSOLUTELY KATY ____ PRIOR PATIENT

_____ INTERNET _____ FRIEND/RELATIVE _____ INSURANCE COMPANY _____ PRIMARY CARE/SPECIALIST

PATIENT NAME____

AGE______________