



**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: \_\_\_\_\_



## **Patient Financial Policy**

We have developed these financial policies to promote confidence and understanding between our patients and practice. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment at Elite Women's Care Center.

### **Payment for Service**

- Unless either you and your health insurance carrier have made other arrangements in advance, full payment is due at the time of service. For your convenience, we accept VISA, MasterCard, Discover, and American Express. **PERSONAL CHECKS ARE NOT ACCEPTED.**
- Co-payment is due at the time of service. No payment arrangements are made for co-pay amounts.
- All surgical procedures **REQUIRE** a \$150.00 nonrefundable deposit before booking.
- Delinquent accounts will be sent to collections after 90 days. Patient will be responsible for collection fees in addition to office charges.

### **Your Insurance**

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill these plans for which we have an agreement with and will collect the authorized co-payment, deductible, or co-insurance amount at the time of service. It is part of the insurance contract to collect your responsibility amount at your appointment.
- It is the responsibility of the patient to have their insurance card with them at the time of their visit. Failure to do so could result in the visit, treatments, or testing not to be covered by your plan.
- It is the responsibility of the patient to present valid government issued identification at each visit.
- It is the responsibility of the patient to provide us with current insurance information at each visit.
- It is the responsibility of the patient to verify that our office is "in-network" with your insurance company.

### **Obstetrics Patients**

- Please refer to your insurance benefits to be familiar with your particular coverage and limitations.
- Patients are required to pay their estimated co-insurance, deductible, or total OB fee by their 24<sup>th</sup> week of pregnancy, unless otherwise noted.
- Most insurance companies only cover 3 ultrasounds per pregnancy. At times, additional ultrasounds are required. It is the patient's responsibility to pay for the ultrasound at the time of service.
- For elective circumcisions, there will be a \$150.00 deposit due no later than the 28th week of pregnancy. The deposit will be applied to the charge if the insurance does not pay. A statement will be issued to the patient, as this is only a deposit. This does not cover the full charge.



### **Patient Attendance**

- There will be a \$25.00 charge to the patient for NO SHOW office visit appointments.
- There will be 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 cancel your appointment within 24 hours.

### **FMLA**

- Our office charges a \$25 fee for all FMLA or disability forms. The fee is based on a per incident charge.
- Please allow 5-7 business days for all forms to be completed.

### **Medicaid Coverage**

Please be advised that our office accepts certain Texas Medicaid/ CHIP plans for pregnancy only. These plans are Traditional Medicaid, Molina, Amerigroup, and Community Health Choice. We are not contracted with any other Medicaid/ CHIP plans. If you receive care from any providers employed by Elite Women's Care Center and have any plan besides those which we are contracted with, you are considered out of network, and subsequently you will be financially responsible for your care. If you have any commercial insurance (i.e. BCBS, Aetna, United Healthcare, etc.) at the time of your appointment, regardless of having an active or pending Medicaid plan, you must notify our staff and provide us with the policy information prior to being seen. As required by State law, we will file your claim with your private insurance first and Medicaid as a supplementary payer. It is necessary to provide this information to prevent inaccurate billing and to avoid your personal, financial liability after care has been established.

IT IS IMPORTANT THAT YOU PROVIDE US WITH ALL INSURANCE INFORMATION AT EACH VISIT IN ORDER FOR US TO ACCURATELY BILL. The omission of any additional insurance other than your Medicaid plan makes accurate billing difficult. Please understand that this is also considered fraudulent. Elite Women's Care Center does not support any such activity. Any deliberate and/ or fraudulent actions will be grounds for discharge from our practice and you will be financially responsible.

### **Laboratory Fees**

Charges for any type of lab work will be billed by our contracted laboratory, LabCorp. This includes blood work, pap smears, cultures, and pathology. LabCorp will bill the insurance that you have provided us and then bill you for any remaining balance. These charges are separate from any charges you pay for in our office. Please contact the lab for any invoices received related to laboratory fees.

X \_\_\_\_\_  
By signing this form, the patient acknowledges receipt of the EWCC payment policy

\_\_\_\_\_  
Date



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, P.A.*

**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/](http://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    | HIGH BLOOD PRESSURE   | NEUROLOGICAL DISEASE  |
| ASTHMA       | HIGH CHOLESTEROL      | OSTEOPOROSIS          |
| BREAST TUMOR | INTESTINAL BLEEDING   | PARALYSIS             |
| DIABETES     | KIDNEY INFECTION      | PNEUMONIA             |
| HEART ATTACK | KIDNEY STONE          | RHEUMATIC FEVER       |
| HEART MURMUR | MIGRAINE HEADACHES    | THROMBOEMBOLIC EVENTS |
| HEPATITIS    | MITRAL VALVE PROLAPSE | 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:**

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

PATIENT NAME \_\_\_\_\_

AGE \_\_\_\_\_



**SURGICAL HISTORY**

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

<u>PROCEDURE</u>		<u>COMPLICATIONS</u>	<u>SURGEON/HOSPITAL</u>
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  
DAYS APART

21-35 DAYS APART

MORE THAN 36

HOW MANY DAYS DOES YOUR PERIOD LAST (CIRCLE ONE)

LESS THAN 2 DAYS  
10 DAYS

2-5 DAYS

5-7 DAYS

7 -10 DAYS

MORE THAN

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  
WARTS

CHLAMYDIA/GONORRHEA/SYPHILIS/HERPES

GENITAL

PELVIC INFECTIONS

TUMOR OF THE UTERUS OR OVARIES

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

<u>NAME</u>	<u>DOSAGE</u>	<u>FREQUENCY</u>	<u>NAME</u>	<u>DOSAGE</u>	<u>FREQUENCY</u>

PATIENT NAME \_\_\_\_\_

AGE \_\_\_\_\_



**LIST ALLERGIES TO MEDICATION/FOOD** ARE YOU ALLERGIC TO LATEX?  YES  NO

<u>MEDICATION/FOOD</u>	<u>REACTION</u>	<u>MEDICATION/FOOD</u>	<u>REACTION</u>

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**

<u>CANCER</u> TYPE: _____	<u>FAMILY RELATION</u>	<u>HIGH CHOLESTEROL</u>	<u>FAMILY RELATION</u>
<u>CONGENITAL DISEASE (INHERITED)</u>	<u>FAMILY RELATION</u>	<u>KIDNEY DISEASE</u> TYPE: _____	<u>FAMILY RELATION</u>
<u>DIABETES</u> TYPE: _____	<u>FAMILY RELATION</u>	<u>MENTAL RETARDATION</u>	<u>FAMILY RELATION</u>
<u>HEART DISEASE</u> TYPE: _____	<u>FAMILY RELATION</u>	<u>OSTEOPOROSIS</u>	<u>FAMILY RELATION</u>
<u>HIGH BLOOD PRESSURE</u>	<u>FAMILY RELATION</u>	<u>TWINS</u>	<u>FAMILY RELATION</u>

PATIENT NAME \_\_\_\_\_

AGE \_\_\_\_\_



HAVE YOU EVER HAD AN ABNORMAL 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 PRESCRIPTION?  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 \_\_\_\_\_