

CAPITAL WOMEN'S CARE, LLC.

Please update the information below, sign the form, and return the form to the front desk. Thank you.

Patient Information					
Today's Date:		Patient Medical Record Number		Referring Physician	
Appointment Info		Name		Marital Status	Gender
Date of Birth		Social Security #			
Address		Apartment #		City State Zip	
Home		Cellular		Ext	
Guarantor/Financially Responsible Party					
Guarantor Name		Date of Birth		Social Security Number	
Home Phone		Address		City State Zip	
Day Phone		Employer		Employer Address	
Occupation					
Primary Insurance Information					
Have you applied or intend to apply for Medical Assistance? (Circle your answer)				Yes	No
Not Sure					
Insurance Company		ID		Group	
Address		City State Zip «Patient Primary City, State Zip»		Phone	
Policy Holder Name		Policy Holder Date of Birth		Policy Holder Social Security	
Policy Holder Employer		Patient Relation to Policy Holder		Insurance Effective Date	
Secondary Insurance Information					
Please note, insurance companies require you to notify them of other insurance. They may not pay the claim for this visit if the information is not in their system.					
Insurance Company		ID		Group	
Address		City State Zip		Phone	
Policy Holder Name		Policy Holder Date of Birth		Policy Holder Social Security	
Policy Holder Employer		Patient Relation to Policy Holder		Insurance Effective Date	
Personal Representative Authorized To Access Protected Health Information					
Name		Phone		Relationship to Patient	
1. Financial Responsibility: I certify that the information I have provided regarding my insurance coverage is correct and I authorize Capital Women's Care to verify insurance coverage and benefits allowed in accordance with my insurance plan's coverage. I authorize that the payments be made directly to Capital Women's Care for all medical insurance benefits which are payable under the terms of my insurance policy for services provided. I agree to pay any copayment, coinsurance, or deductible as required by my insurance for the terms and regulations of my insurance plan. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at 25% of the debt, and all costs and expenses including reasonable attorneys' fees, we incur in such collection efforts			3. Release of Medical Information for Billing: I hereby authorize Capital Women's Care to submit a claim and a copy of medical records related to such services, to my insurance company, health and welfare fund, Medical or Medicaid for medical services provided to me or my dependent. I also authorize Capital Women's Care to provide a copy of this release and a copy of medical records related to such services if requested by the payor. Further, I authorize Capital Women's Care to release medical information to my consulting or primary physician to assist with continuity of care. This release will expire one year from the date my signature below, unless I cancel this release in writing prior to that date.		
Capital Women's Care may impose a no-show fee of \$35.00 for appointments not cancelled 24-hours in advance.			4. Receipt of Privacy Notice: I have been given the opportunity to review the Capital Women's Care Notice of Privacy Practices which provides a detailed description of how my Protected Health information (PHI) is used and disclosed.		
2. Payment in full at time of service: I understand that if Capital Women's Care does not participate with my insurance or I do not have insurance, payment is due in full at the time of service.			5. Non Covered Services: I agree to pay for medical services provided to me or my dependant which are not covered by the benefits in my insurance plan.		
I AGREE TO THE ABOVE STATED CONSENT					
Signature of Patient or Legal Guardian:			Date:		

CAPITAL WOMEN'S CARE, LLC.

Patient Information

Name	Patient Medical Record Number	Today's Date:	Appointment Info
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How did you learn about our Practice? (Circle all that apply)
Patient Referral Other Referral Website/Internet Ad//Radio/TV Other _____

Patient Ethnicity, Race and Religion and Gender Details (Please circle your response) - For Medical Decision Making Purposes Only

Ethnicity: Hispanic/Latino or Not Hispanic/Latino Will Discuss with Provider Current System Selection:

Race: Asian, Black or African American, White, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander
Hispanic or Latino, Indian, Multi Racial Will Discuss with Provider Current System Selection:

Religion: _____ Will discuss with Provider Current System Selection:

Gender Identity: Choose not to Disclose Female Female-to-Male Genderqueer Male Male-to-Female Will discuss with Provider
Current System Selection:

Sexual Orientation: Choose not to Disclose BiSexual Lesbian, Gay, Homosexual Straight or Heterosexual
Will discuss with Provider Current System Selection:

Preferred Pronoun: Decline to Answer He, Him, His Other She, Her, Hers They, Them, Theirs Ze, Hir
Will discuss with Provider Current System Selection:

Patient Allergies (Please include your reaction to each Allergy)

Allergen	Reaction

Patient Medications (Please include dosage for each medication)

Medication	Dosage

Patient Preferred Pharmacy

Pharmacy Name	Pharmacy Phone
Street Address	City State Zip

Patient Communication

Capital Women's Care physicians are dedicated to helping our patients live healthy lifestyles. Your physician would like the opportunity to communicate with you via patient portal, email, and telephone about preventive health services such as well woman exams or other health promotion information. Also, there may be other messages we would like to send our patients, such as the announcement of new physicians or contract changes with insurance companies.

Patient Portal: The portal is the preferred communication method for all adults 18 years or older. This method requires an active email address and enrollment in the portal.

Email: Capital Women's Care makes this commitment to our patients about the collection of email information.

1. They will be for Capital Women's Care use only. They will not be sold to any other entity.
2. The patient's privacy will be protected. The email address will not be used to communicate any personal health information or in any manner inconsistent with the Health Insurance Portability and Accountability Act (HIPAA)
3. Emails to our patients will be one way communications and, therefore, will not allow for conversations between the patient and physician/staff.

Telephone: As a service to our clients, we provide a courtesy appointment reminder and possibly other important calls that may be placed using a pre-recorded message. By providing your cell phone number, you consent to receiving such calls at this number.

All health related questions should continue to be addressed to the appropriate Capital Women's Care staff. Additional comments and questions on our privacy policy as it relates to electronic communications, should be directed to the Capital Women's Care Compliance Officer at privacy@cwcare.net or 301-340-8339, ext 201

Patient Name: _____ Email Address: _____

Patient Signature: _____ Date: _____



Revision Date:

NEXTGEN MOBILE SOLUTIONS CONSENT FORM

I hereby authorize the **Capital Women's Care** Providers to use their phone to send and receive images related to my OB/GYN care via a secure, HIPAA-compliant application ("App") managed by **NextGen Mobile Solutions**. The images will be taken using the **NextGen Mobile Solutions App**, stored for a brief time on the App and not the Provider's phone, then uploaded to the NextGen EHR system which houses patient chart details.

I understand that the images captured through the App are Protected or Personal Health Information ("PHI"), and the HIPAA Privacy Rule provides federal protections for PHI held by covered entities such as Capital Women's Care and permits the disclosure of PHI needed for patient care and other important purposes.

I hereby authorize Capital Women's Care and its related entities to use the images captured via the **NextGen Mobile Solutions App** as described above. This Authorization is valid for twelve (12) months from the date of signature of this request. I understand that 1) this Authorization may be revoked by me at any time by written notification to this Capital Women's Care, except to the extent that action has been taken in reliance upon this Authorization; 2) Information released pursuant to this Authorization may be subject to re-disclosure due to a Medical Records Release request and may no longer be protected by the Federal HIPAA Privacy Rule; 3) Capital Women's Care may not condition my treatment based on whether or not I sign this Authorization; and 4) I understand that I will receive a copy of this Authorization.

PATIENT INFORMATION

Patient Name (Print): _____

Former Name (if applicable): _____

Social Security Number: _____

Telephone Number (Primary): _____

Birth Date: ____/____/____

Email Address: _____

Signature of Patient/Legal Representative

Relationship to Patient, if not signed by Patient

Date

CWC Internal Use Only	
Upon Completion, Upload to Patient's Chart (Document Management/ICS Tool)	
Date Request was Received: _____	
Date Request was Granted: _____	



CAPITAL
WOMEN'S
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PATIENT HISTORY FORM

Name _____

Date of Birth _____

Date _____

Age: _____ Marital Status: _____ Occupation: _____ Primary Care Provider: _____

Reason for your visit today: _____

Current Contraception: None Tubal Ligation IUD Mirena® Nuva Ring® Patch Natural Family Planning Depo Provera Condoms
 Diaphragm Vasectomy Pills - Brand: _____

If Postmenopausal, are you on Hormone Replacement Therapy? Yes No Have you ever been on HRT? Yes No

Medication Allergies: None _____

List all prescription medications you are currently using: None _____

List all non-prescription medications or supplements you are currently using: None _____

What was the first day of your last menstrual period? _____

When was your last mammogram? _____

Do you perform breast self-exams monthly? Yes No

When was your last PAP test? _____

Do you have a history of Sexually Transmitted Disease? Yes No

Have you had 5 or more sexual partners? Yes No

Was your age at first intercourse under 16? Yes No

Were you exposed to DES before your birth? Yes No

Have you ever had an abnormal PAP smear?..... Yes No

Do you exercise regularly? Yes No

Do you use seat belts? Yes No

Do you smoke? Yes No

How much? _____

Do you drink alcohol? Yes No

How much & how often? _____

Do you use any recreational drugs? Yes No

What & how often? _____

Surgeries or Hospitalizations: None

Type of surgery or reason for hospitalization	Date	Doctor	Hospital or Facility
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pregnancies (include losses and terminations)

Year	Male/Female	Weight	Vaginal or Section	Complications

Do you have or have you ever had...

- | | | | |
|---|--|--|--|
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic lung condition <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral valve prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcohol abuse <input type="checkbox"/> Yes <input type="checkbox"/> No | High cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures/Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug/substance abuse <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis/liver disorder/Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Bowel trouble <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood clots in legs/lung/heart <input type="checkbox"/> Yes <input type="checkbox"/> No | Transfusion reactions <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney stones <input type="checkbox"/> Yes <input type="checkbox"/> No | Autoimmune diseases (lupus, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No | Anesthetic reactions <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Thyroid disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression, anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No | Eating disorder <input type="checkbox"/> Yes <input type="checkbox"/> No |

Cancer Yes No If yes, Type, Date and Treatment: _____

Other disease? _____

Please list any major illnesses that have occurred in your family. Is there a family history of...

- | | | | |
|---|--|---|--|
| Breast Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ovarian Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Coronary artery disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Colon Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | High cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: _____ | |

Capital Women's Care, LLC

Use and Disclosure of Protected Health Information

Section I: PATIENT ACKNOWLEDGEMENT & CONSENT FORM

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Capital Women's Care, LLC, Capital Women's Care Specialty Center, LLC and ENK Surgery Center, LLC may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices states that we reserve the right to change terms described. Should this happen we will display the new policy and effective date at each of our Capital Women's Care Locations.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you.

*By signing below, you acknowledge receipt of our **Notice of Privacy Practices**.*

Patient's Signature

Date

Print Full Name

Section II: CONSENT FOR USE AND DISCLOSURE OF INFORMATION

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Capital Women's Care, LLC for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits for related services. I agree to provide all reference and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

Patient's Signature

Date

Print Full Name

Section III (Optional):

PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED

Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

Name of Authorized Person or Entity

Relationship

Phone #

Name of Authorized Person or Entity

Relationship

Phone #

Section IV: AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL

Capital Women's Care physicians and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Health care Information that we may possibly disclose on your home, work, or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, and surgical posting/scheduling information.

_____ (Initial) Yes, I agree to allow Capital Women's Care physicians and healthcare staff to leave messages that include Protected Healthcare Information on all three communication devices: home, work and cell phone.

_____ (Initial) I agree to allow Capital Women's Care physicians and healthcare staff to leave messages that include Protected Healthcare Information on the following: Please initial next to the applicable communication devices: _____ home number, _____ work number or _____ cell number.

_____ (Initial) No, I do not agree to allow Capital Women's Care physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.

Patient's Signature

Date

For CWC Internal Use Only

Section V: UNABLE TO OBTAIN NOTICE RECEIPT ACKNOWLEDGEMENT

Option 1: I could not obtain a signed Notice Receipt Acknowledgement from the patient for the following reason:

Option 2: I attempted to obtain a signed Notice Receipt Acknowledgement from the patient on ___/___/___, but was unable for the following reason:

CWC Employee Signature

Date

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact the HIPAA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.



CAPITAL
WOMEN'S
CARE

Asha Barrett, MD
Roy M. Brooks, MD
Andrew B. Block, MD
Eric Ashkin, MD
Lauren F. Ng, MD
Anne Seifert, CNM
Tussing, Meredith, WHNP

Patient Name: _____ Date: _____

PRENATAL QUESTIONNAIRE

Will you be 35 years or older at the time of your delivery? YES NO

Have you had previous complications in past pregnancies? YES NO

Explain: **Example: Shoulder Dystocia**

Are you or the baby's father...

Eastern European Jewish ancestry? YES NO

African American ancestry? YES NO

Is there anyone in you or your baby's father's family with:

Inherited anemia? (i.e., thalassemia) YES NO

Spina Bifida or anencephaly? YES NO

Congenital heart problems? YES NO

Down's syndrome? YES NO

Tay Sachs or Canavan? YES NO

Sickle Cell disease or trait? YES NO

Hemophilia or blood disorders? YES NO

Muscular Dystrophy? YES NO

Cystic Fibrosis? YES NO

Mental retardation/autism YES NO

Other inherited or genetic disorders? YES NO

Have You

Have you had three or more spontaneous miscarriages? YES NO

Have you ever had **shoulder dystocia** with a past delivery? YES NO

Were fertility drugs used in this pregnancy? YES NO

Have you had blood type problems in a previous pregnancy? YES NO

Updated 8.13.2021

Prenatal Questionnaire Continued
Page 2

Patient Name: _____

Date: _____

Have you ever been treated for any sexually transmitted disease? (Syphilis, Gonorrhea, Herpes, Hepatitis, etc.)	YES	NO
Do you smoke?	YES	NO
Do you use recreational drugs?	YES	NO
Do you use alcohol?	YES	NO
Have you been exposed to any chemicals or toxic substances?	YES	NO
Have you ever had any blood clots or phlebitis?	YES	NO
Have any family members ever had a blood clot?	YES	NO
Are you a vegetarian or had any nutritional deficiency?	YES	NO
Have you had a stillborn infant?	YES	NO
Do you weigh more than 200 pounds?	YES	NO
Have you had recurrent urinary tract infections?	YES	NO
Have you had a prior premature delivery?	YES	NO
Have you ever had an incompetent cervix?	YES	NO
Do you have any heart problems?	YES	NO
Do you take antibiotics when you have dental work?	YES	NO
Have you ever been rejected as a blood donor?	YES	NO
Have you ever had liver disease or live with someone with Hepatitis B?	YES	NO
Do you own or care for a cat or exotic bird?	YES	NO
Have you ever had a bleeding or clotting problems?	YES	NO
Have you ever had ulcerative colitis or Crohn's Disease?	YES	NO
Have you been the victim of domestic or sexual violence?	YES	NO
Do you have a history of depression?	YES	NO
Do you have a history of postpartum depression?	YES	NO
Have you ever had a latex allergy?	YES	NO
Are you a Jehovah's Witness?	YES	NO
Would you refuse blood or blood products transfusion to save you or your baby's life?	YES	NO

Prenatal Questionnaire Continued
Page 3

Patient Name: _____

Date: _____

Answering all of the above questions with a "NO" will not guarantee you with a perfect outcome for your pregnancy. You may be in a higher or lower risk group depending on your answers. Even under the best of circumstances, there are less than ideal outcomes that are out of our control.

I have read all of the above questions and answered them to the best of my ability. All questions answered with "YES" have been discussed with me to my satisfaction.

Patient Signature

Date

Physician Signature

I desire further testing or counseling for _____

Patient Signature

Date