

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: _____

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.



Roy M. Brooks, M.D.
 Asha Barrett, MD
 Andrew B. Block, M.D.
 Julie G. Glass, M.D.
 Eric Ashkin, MD.
 Ronald D. Jacobs, M.D.
 Gayle F. Friedman, M.D.
 Lauren F. Ng, M.D.
 Tussing, Meredith, WHNP
 Anne Seifert, CNM

ANNUAL HEALTH HISTORY UPDATE

Name: _____ Age: _____ Date: _____

Telephone Number: _____ Email: _____

Have you had any other well exam within the past year at another doctor's office? Yes No Date: _____

Primary Care Physician or Provider: _____

You are scheduled for your annual history examination today. We would like you to complete the below information to help assist us with ensuring we have the most update to date information pertaining to you and your medical care.

MEDICATIONS / ALLERGIES

Current medications with dosing

Do you have an allergy to Latex? Yes No

Do you or have you developed any medication allergies? Yes No

If you answered yes, please list the medication and reaction

MENSTRUAL HISTORY

Are you menopausal? Yes No

If you answered yes, please skip the following questions

1ST day of your last period _____ Was it normal? Yes No

Have your cycles been regular? Yes No

SIGNS AND SYMPTOMS

Do you have any of the following:

- | | | | | | |
|-------------------------|---------------------------|--------------------------|---------------------------|---------------------------|--------------------------|
| Abnormal Bleeding | <input type="radio"/> Yes | <input type="radio"/> No | Bleeding between periods | <input type="radio"/> Yes | <input type="radio"/> No |
| Pelvic Pain or Cramping | <input type="radio"/> Yes | <input type="radio"/> No | Mood Swings / Fatigue | <input type="radio"/> Yes | <input type="radio"/> No |
| Are you sexually active | <input type="radio"/> Yes | <input type="radio"/> No | Do you have a new partner | <input type="radio"/> Yes | <input type="radio"/> No |
| Painful intercourse | <input type="radio"/> Yes | <input type="radio"/> No | Pain with urination | <input type="radio"/> Yes | <input type="radio"/> No |
| Urinary Frequency | <input type="radio"/> Yes | <input type="radio"/> No | Vaginal Discharge / Odor | <input type="radio"/> Yes | <input type="radio"/> No |



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Tussing, Meredith, WHNP
Anne Seifert, CNM

Name: _____ Date: _____

CONTRACEPTION METHOD

What method are you currently utilizing (please circle)

Nothing Condoms Tubal Ligation IUD (Indicate Brand & Date of Insertion) _____ Vasectomy
Ring Depo-Provera Patch Pill (Indicate Brand) _____

SOCIAL HISTORY

Do you smoke? Yes No Do you drink? Yes No
If so, how much _____ If so, how much _____
Do you exercise? Yes No
If so, how much _____

ADDITIONAL TESTING

Have you ever had a Mammogram? Yes No Have you ever had Bone Scan? Yes No
If so, when _____ If so, when _____
Have you ever had a Colonoscopy? Yes No Have you ever had a Cholesterol Screen? Yes No
If so, when _____ If so, when _____

FAMILY HISTORY

Have there been any new medical issues among your immediate family since your last visit? Yes No
If so, please explain _____

OTHER

Is there anything else you wish to discuss with your provider at today's visit?

Patient's Name (Please print)
Patient Name (Please Print)

Signature
Signature



CAPITAL
WOMEN'S
CARE

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: _____ | |