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

Capital Women's Care may impose a no-show fee of $35.00 for appointments not cancelled 24-hours in advance.

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.

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 physicaian 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.

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.

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

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: __________________________

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 ❑ Yes ❑ No
Asthma ❑ Yes ❑ No
Stroke ❑ Yes ❑ No
Ulcers ❑ Yes ❑ No
Heart disease ❑ Yes ❑ No
Chronic anemia ❑ Yes ❑ No
Thyroid disorder ❑ Yes ❑ No

High blood pressure ❑ Yes ❑ No
Mitral valve prolapse ❑ Yes ❑ No
Seizures/Epilepsy ❑ Yes ❑ No
Tuberculosis ❑ Yes ❑ No
Bowel trouble ❑ Yes ❑ No
Kidney stones ❑ Yes ❑ No
Bleeding disorder ❑ Yes ❑ No

Chronic lung condition ❑ Yes ❑ No
Alcohol abuse ❑ Yes ❑ No
Drug/substance abuse ❑ Yes ❑ No
Hepatitis/liver disorder/Jaundice ❑ Yes ❑ No
Blood clots in legs/lung/heart ❑ Yes ❑ No
Autoimmune diseases (lupus, etc.) ❑ Yes ❑ No
Depression, anxiety ❑ Yes ❑ No

Osteoporosis ❑ Yes ❑ No
High cholesterol ❑ Yes ❑ No
Rheumatic fever ❑ Yes ❑ No
Blood transfusion ❑ Yes ❑ No
Transfusion reactions ❑ Yes ❑ No
Anesthetic reactions ❑ Yes ❑ No
Eating disorder ❑ Yes ❑ 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 ❑ Yes ❑ No
Ovarian Cancer ❑ Yes ❑ No
Colon Cancer ❑ Yes ❑ No

Thyroid disorder ❑ Yes ❑ No
Coronary artery disease ❑ Yes ❑ No
High cholesterol ❑ Yes ❑ No

Osteoporosis ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No
Other: ______________

Stroke ❑ Yes ❑ No
High blood pressure ❑ Yes ❑ No

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 in formation 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 Pro tected 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.

Family History Questionnaire

MRN#____________

Name ________________________________ Date of Birth __________ Date: ________________

I HAVE HAD HEREDITARY FAMILY CANCER GENETIC TESTING: ❑YES ❑NO

If YES, Please Indicate your RESULTS: ❑ Negative ❑Positive, Gene:_____

******If you have already had cancer genetic testing done, you DO NOT need to fill out this questionnaire***

Based on the family history information you provide here, you MAY be appropriate for genetic testing and your provider MAY be able to change your medical management to improve your care. Please circle yes to those that apply to you and/or your family. Consider these family members when completing the form (Both Maternal AND Pternal sides of the family):

Mother/Father/Sister/Brother/Children = **1st Degree Blood Relatives**
Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Blood Relatives**

			Specify Relative(s):	*Age of Diagnosis:*
Breast Cancer before age 50	YES	NO	________	________
Ashkenazi Jewish Ancestry with breast cancer at any age	YES	NO	________	________
Ovarian Cancer at any age	YES	NO	________	________
Breast Cancer in both breasts (Bilateral) at any age	YES	NO	________	________
3 Breast Cancers on the same side of the family at any age	YES	NO	________	________
Male Breast Cancer at any age	YES	NO	________	________
Pancreatic Cancer at any age	YES	NO	________	________
Uterine Cancer before age 50 (or before 65 in YOURSELF)	YES	NO	________	________
Colorectal Cancer before age 50 (or before 65 in YOURSELF)	YES	NO	________	________
3 or more of the following cancers on the same side of the family: Uterine, Colorectal, Stomach	YES	NO	________	________
Have you been personally diagnosed with Breast Cancer	YES	NO	________	________
Do you plan to become pregnant in the next year?	YES	NO	________	________

Patient Signature: ____________________________ **Provider you are seeing today:** ____________

FOR OFFICE USE ONLY

Patient is a candidate for genetic testing: YES NO.

_____Genetic testing information provided ____Genetic testing Completed ___Genetic testing Decline

Provider's Signature:__________________________________