Doctor's of Women Health Center

Patient Information Form

This information is confidential. We appreciate your cooperation in filling out this form in its entirety.

Please Print Clearly

Your Full Name: Date:

Home Address: City/State/Zip:

Phone: (Home) Work: Cell:

Birthdate: Age: Birthplace:

Married: Single: Widowed: Divorced: Separated: Email:

Maiden Name: Social Security #: Driver's License #:

Who referred you to us?

Your Employer: Occupation:

Your Work Address: City/State/Zip:

Spouse/Responsible Party Information:

Name: Relationship:

Home Address: City/State/Zip:

Birthdate: Social Security #: Employer:

Person to contact in case of an emergency:

Relationship: Phone:

Doctor's of Women Health Center

Patient Information Form

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR BILLING COSTS, WE REQUEST THAT YOUR PATIENT RESPONSIBILITY BE PAID AT THE CONCLUSION OF EACH VISIT, or are on the Obstetrical Care Fee Schedule. If you cannot pay at time of service, you must discuss other payment arrangements PRIOR to your visit, with our Billing Department. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.

I/We hereby assign all medical benefits, to include major medical benefits to which I am entitled, including MediCare, private insurance, and other health plans to DOCTOR'S OF WOMEN HEALTH CENTER, INC.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed: _____

Patient: Date:

Signed: _____

Responsible Party: Date:

POS Reorder # 1605771

DOCTORS OF WOMEN HEALTH CENTER
62 Corporate Park, Suite 100
Irvine, CA 92606
949-559-1911 Fax: 949-559-4071

Dear Patient:

As physicians of Doctors of Women, we feel it is very important that you receive all laboratory results including blood work, Pap smears, mammograms, etc. It is standard procedure for our office to notify our patients by either phone or mail of their results. However, in the unlikely event that a laboratory result is not received by our office, standard procedure for notification of our patients may not take place. We therefore ask our patients to share in the responsibility of obtaining their laboratory results by calling for results if not notified within 2 weeks for Pap smear, mammogram, culture results, routine blood work and 24 to 48 hours for all STAT or emergent laboratory work. Your physician or nurse practitioner will let you know during your visit what testing will be done so you are aware of what results are pending. Your health care is our number one priority.

Thank you for partnering with us in your care.

Sincerely,
Doctors of Women

If my called ID blocks Doctors of Women's number, I understand that you will not attempt to leave a message.

I will take responsibility for calling for my laboratory results if not notified in a reasonable amount of time.

_____ _____
Patient Signature Date

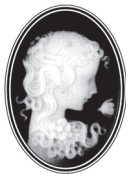
AUTHORIZATION TO LEAVE MESSAGES

I give my permission for the staff of Doctors of Women to leave messages regarding my health care, normal test results, appointments, or authorizations.

If a family member answers the phone, I give Doctors of Women permission to leave your name and phone number.

_____ _____
Patient Signature Date

_____
Print Name



Gynecology Health History

ID No.: _____

Today's Date: _____/_____/_____

PATIENT IDENTIFICATION *(Please print)*

Patient's Name: _____

Address: _____

_____

Home Telephone No: ( ) _____

Work Telephone No: ( ) _____

Reason for Seeing Doctor _____

Date of Birth: _____/____/____ Age: _____ Religion: _____

Marital Status: ❑ S ❑ M ❑ D ❑ SEP ❑ W Race: _____

Education: _____ years Occupation: _____

Employer: _____

Type of Insurance: _____ Policy #: _____

Referring Physician: _____

Primary Physician: _____

1. CURRENT MEDICATIONS ❑ None

_____

_____

_____

2. MEDICATION ALLERGY / SENSITIVITY

List all medications allergic to: ❑ None

_____

_____

_____

MEDICAL HISTORY *(Check the appropriate box)*

Have you or any members of your family had:	You	Your Family
3. High Cholesterol	❑	❑
4. Heart Disease	❑	❑
5. Rheumatic Fever	❑	
6. High Blood Pressure	❑	❑
7. Asthma	❑	
8. Tuberculosis	❑	
9. Diabetes	❑	❑
10. Thyroid Problems	❑	❑
11. Liver Disease	❑	
12. Stomach, Bowel or Gall Bladder Problems	❑	
13. Kidney or Bladder Problems	❑	
14. AIDS (HIV)	❑	❑
15. Hepatitis (type____)	❑	❑
16. Anemia or Blood Disorder	❑	❑
17. Blood Transfusion	❑	
18. Allergies	❑	
19. Breast Problems	❑	❑
20. Cancer	❑	❑
21. Infertility	❑	
22. Female or Sexual Problems	❑	
23. Chlamydia	❑	
24. Gonorrhea	❑	
25. Herpes (HSV)	❑	
26. Syphilis	❑	
27. Birth Defects or Inherited Diseases	❑	❑
28. Sexual Abuse or Domestic Violence	❑	❑
29. Other Medical Problems	❑	❑
30. **No Known Medical Problems**	❑	❑

31. HOSPITALIZATIONS List those operations/serious illnesses that have required hospitalization. If more than six, check this box. ❑ *Do not include pregnancies here.*

Month/Year	Illness or Operation	Complications Yes	No
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑
/		❑	❑

SUBSTANCE USE *(Check only those you use)*

32. Alcohol ❑
Type _____
Amt/day _____

33. Tobacco ❑
Type _____
Amt/day _____

34. Caffeine ❑
Type _____
Amt/day _____

35. Non-Prescribed Drugs ❑
Type _____
Amt/day _____
Type _____
Amt/day _____

36. Street Drugs ❑
Type _____
Amt/day _____
Type _____
Amt/day _____

37. PREGNANCY HISTORY *(Complete all information)*

# of Pregnancies	# of Premature Births	# of Miscarriages	# of Spontaneous Abortions	# of Induced Abortions	# of Living Children

# of Term Births	Born Month/Year	Baby's Sex	Weight at Birth	Weeks Pregnant (Term=40Wks)	Hours in Labor	Type of Delivery	Type of Anesthesia	Complications Yes	No
1	/		lbs. oz.					❑	❑
2	/		lbs. oz.					❑	❑
3	/		lbs. oz.					❑	❑
4	/		lbs. oz.					❑	❑
5	/		lbs. oz.					❑	❑

38. MENSTRUAL HISTORY

First Day of Last Menstrual Period ____/_____/_____

Menarche (Age at First Period)	Interval (No. of Days Between Periods)	Length of Period
years	days	days

Abnormalities: ❑ Excessive Bleeding ❑ Discharge ❑ Pain ❑ None

39. CONTRACEPTIVE HISTORY

Type		Dates Used
Oral Contraceptive	❑	_____
Type(s) _____	❑	_____
_____	❑	_____
IUD	❑	_____
Diaphragm	❑	_____
Norplant	❑	_____
Sponge	❑	_____
Spermicide	❑	_____
Condoms	❑	_____
Other _____	❑	_____

Sterilization ❑ Male ❑ Female

LIFESTYLE

	Yes	No
40. Did your mother take DES or any other hormones when pregnant with you?	❑	❑
41. Have you ever had a Pap test?	❑	❑
If Yes: Date of your last Pap test? ____/____/____		
Have you ever had abnormal Pap test results?	❑	❑
42. Are you sexually active?	❑	❑
43. Do you have one partner or	❑	one
many partners	❑	many
44. Is intercourse painful for you?	❑	❑
45. Do you do a monthly well breast exam?	❑	❑
46. Have you ever had a mammogram?	❑	❑
If Yes: Date of your last mammogram? ____/____/____		
47. Do you exercise on a regular basis?	❑	❑

If Yes: Type of exercise _____

Hours per week exercise _____

Check and detail positive findings below. Use reference numbers.

Signature: _____

DOCTORS OF WOMEN

62 Corporate Park #100 Irvine CA 92606

Privacy Officer-Office Manager 949-428-3402

I hereby acknowledge that I received a copy of this medical practice's **Notice of Privacy Practices** (URL: http://www.doctorsofwomen.com/privacy.html). I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

_____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

❒ Parent or guardian of minor patient

❒ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

_____

Firmado: _____ Fecha: _____

Imprimir Nombre: _____ Teléfono: _____

Si no está firmada por el paciente, por favor indique la relación:

❒ El padre o tutor del paciente menor de edad

❒ Tutor o curador de un paciente incompetente

Nombre y dirección del paciente: _____

_____

_____

Doctors of Women Health Center

Requests For Confidential Communication of Protected Health Information

Name: _____

D.O.B. _____

I give DOCTORS OF WOMEN permission to release any information (appointments, results, treatment, and all questions) regarding my protected health to the following only (i.e. mother, father, husband, other.):

Name: _____

Relationship: _____

Phone #: _____

Name: _____

Relationship: _____

Phone #: _____

_____

Patient Signature Date

DOCTORS OF WOMEN

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature	Date	Physician Signature

Doctors of Women

Dear Valued Patient,

With all the changes in Healthcare we feel the need to communicate the following information regarding your insurance healthcare coverage:

1) Doctors of Women does not quote or guarantee coverage for services provided by our practice

2) Doctors of Women bills your insurance company as a courtesy on your behalf for services provided however this does not imply that you will have no out of pocket costs associated with your care

3) Doctors of Women are legally bound by our PPO and HMO contracts to collect your co-pay at the time service is rendered. We do not bill patients for co-pays

4) Doctors of Women provides a courtesy service of verifying your benefits and eligibility. We rely on the information provided by your insurance company to be current and complete, however we do not guarantee that the information provided by your insurance company is accurate.

5) Ultimately, it is the patient (Insured's) responsibility to know the plan coverage and limitations of their own health insurance policy.

6) Doctors of Women do not guarantee that your insurance will be considered "In-Network" with your plan or policy. If you are unsure if services rendered here will be covered by your insurance, please call your member services department directly and give them our
Tax ID # 33-0580598 and ask them to verify if we are "In" or "Out" of network.

7) For Obstetrical patients, someone from our office will discuss with you your financial responsibilities, which will need to be paid to our office by the 6th month of your pregnancy. Failure to pay your financial responsibility will result in being discharged from the practice.

8) For Surgical patients, someone from our office will discuss with your your financial responsibilities, which will need to be paid to our office prior to your surgery.

We acknowledge that dealing with Healthcare coverage issues can be confusing as well as frustrating. Doctors of Women makes every attempt to verify the specifics of your coverage, however, as physicians specializing in your healthcare needs, any assistance our office provides to obtain insurance information is simply as a courtesy and not an obligation.

We thank you in advance for understanding our role in your Healthcare. We invite you to partner with us by obtaining your individual insurance plan coverage specifics prior to receiving services with our organization.

Thank you kindly for your cooperation with this matter.

_____ _____

Patient Signature Date

DOCTORS OF WOMEN

Prior Authorization Policy

As your physician we make every effort to ensure that you receive the safest, most effective and reasonably priced prescription drugs, treatments, laboratory tests and imaging studies we feel is best suited for your healthcare. We must also abide by regulations set by your insurance companies and government agencies. Over the last year, many health insurance companies or plans are requiring Prior Authorization or approval for an increasing number of drugs, treatments, imaging studies and laboratory tests.

As this is an additional and labor-intensive service our nursing staff completes, Doctors of Women will begin charging a fee of $25.00 per authorization fee for medications. This cost is an out-of-pocket expense to you and is not covered by insurance. You can be assured that your provider will take every step necessary to provide you with cost effective treatments and alternatives. We will fully evaluate your medical needs, and if appropriate, recommend a medication that does not require Prior Authorization. Prior authorizations for drugs required as a result of telephone requests from patients will always be charged a $25.00 fee. Please note: **this still does not guarantee approval from your insurance company.**

Please feel free to contact our office at 949-559-1911 with any questions.

Patient Name: _____

Patient Signature: _____ Date: _____