

Women's Health Services
Patient Information Form
1001 N. Waldrop Suite 505
Arlington, TX 76012 817-277-9415

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Your Doctor's Name: _____

Patient Information

Patient Name: _____
Last First MI Maiden

Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Date of Birth: _____ SS#: _____ Driver's License: _____

Patient Employer: _____ Work Address: _____

Spouse/Guardian Information

Spouse/Guardian Name: _____ Cell/Work Phone: _____

Date of Birth: _____ SS#: _____ Driver's License: _____

Employer: _____ Work Address: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Primary Insurance

Insurance Company: _____ Phone #: _____

Name of Insured: _____ DOB: _____

Self _____ Spouse _____ Parent _____ Other _____ Co-pay Amount: _____

Insured's Employer: _____ Claim Address: _____

ID #: _____ Group #: _____ Insured SS#: _____

Secondary Insurance

Insurance Company: _____ Phone #: _____

Name of Insured: _____ DOB: _____

Self _____ Spouse _____ Parent _____ Other _____ Copay Amount: _____

Insured's Employer: _____ Claim Address: _____

ID #: _____ Group #: _____ Insured SS#: _____

Insurance Authorization and Assignment: I authorize WHS to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to WHS. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on her discretion to access my chart for utilization management review.

Date: _____ Signature: _____

WHS Patient Health History Questionnaire

Name: _____ Date: _____

Account #: _____ Who is your Primary Care Physician? _____

Date of last Pap smear: _____

Have you ever had an abnormal Pap smear? Yes No

At what age did you first start your period? _____

What was the first day of your last menstrual period?

Are your periods: Regular Irregular

Do you often skip periods? Yes No

Do you have heavy bleeding with your periods?
Yes No

Do you have pain with your period? Yes No

Mild Moderate Severe

Do you have pain during or after intercourse?
Yes No

Do you need birth control? Yes No

What form of birth control do you currently use?

How many children do you have? _____

How many miscarriages have you had? _____

Are you trying to become pregnant? Yes No

Do you have cyclic breast pain? Yes No

Do you have a history of breast lumps? Yes No

Do you have any nipple discharge? Yes No

Do you have a family history of breast cancer?
Yes No

Have you ever had a mammogram? Yes No

When was your last mammogram? _____

Do you have any history of sexually transmitted
disease? Yes No

If yes, please list: _____

Do you lose urine with heavy lifting, sneezing, or
coughing? Yes No

Do you experience bladder symptoms of urgency,
frequency, or pain? Yes No

Do you smoke? Yes No

If so, how many packs per day? _____

How much alcohol do you consume weekly/daily?

Family History: (If yes, please circle)

Cancer (type _____) Diabetes Heart Disease High Blood Pressure Stroke

List all of your ALLERGIES: _____

List your PREVIOUS SURGERIES: _____

List your CURRENT MEDICATIONS: _____

List your CURRENT MEDICAL PROBLEMS: _____

Date: _____ Patient's Signature: _____

Women's Health Services Acknowledgement of Receipt of Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand that Women's Health Services reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at the appointment.

Patient Name (PRINT)

Date of Birth

Patient/Legal Rep. Signature

Date

Relationship to Patient

Witness

Date

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Women's Health Services to share my protected health information with:

Name

Relationship

Name

Relationship

Name

Relationship

Name

Relationship

Women's Health Services Financial Responsibility Statement

Our primary mission is to provide you with quality, cost effective medical care. We are continually working to adapt to the way that health care is financed and delivered. We believe that it is important to make sure there is a good understanding with our patients regarding patient and insurance financial responsibility. We hope this explanation will be helpful to you with respect to this.

- You must present your insurance card at each visit.
- You must pay the copay, deductible, or coinsurance at the time of service.
- If you receive services that are not covered by your plan or you are no longer insured, you will be expected to pay for your services at the time in which services are rendered.
- We will certainly bill your insurance company for any remaining balance due, but there is no guarantee that this difference will be paid by the insurance company.
- Should an insurance company send you the check for payment for the services rendered for your care, and you did not remit this payment to us at the time of your service, then you are responsible to send the check received for the services and explanation of benefits to our office.
- If your insurance company does not pay the claim within 60 days, you are expected to pay this bill.
- In circumstances where we have a participating provider agreement with your insurance company for an agreed upon negotiated rate for our services, an adjustment will be made in the amount of the difference between this rate and our normal fees at the time we receive payment from your insurance company.

- Your insurance may refuse payment of a claim for the following reasons:
 - This is a pre-existing illness that is not covered by your plan.
 - You have not met your full calendar year deductible.
 - The type of medical services required in not covered by your plan.
 - Your health care was not in effect at the time of services.
 - You have other insurance that must be filed first.

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to offer our services to file your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies your claim for any of these or other reasons, our office is not responsible for the bill. It is your responsibility, as a patient, to pay the amount in full.

We value you as a patient, and our first priority is to provide you with the best possible health care.

Sincerely,

The Physicians at Women's Health Services

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance carrier(s).

Patient/Legal Representative Signature

Date

Print Patient/Legal Representative Name

Women's Health Services Consent for Treatment

By signing this consent, I am authorizing my physician(s) to perform and/or order another person to perform all exams, tests, procedures, and any other care deemed medically necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Women's Health Services unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick (any such test shall be conducted pursuant to Women's Health Services infection disease protocol); 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure is to inform you that you may be tested, at the expense of Women's Health Services, if any of these situations occur during your treatment period.

Patient/Legal Rep. Signature

Date

Authorization for Release of Information

I hereby authorize Women's Health Services to furnish information pertinent to my medical condition including but not limited to the diagnosis, treatment, and care offered or rendered to me while a patient at Women's Health Services to the following entities: 1) to the insurer(s), including Medicare, to which my medical bills have been assigned for payment; 2) to consultants outside Women's Health Services who I may be referred to for care; 3) to employees of Women's Health Services for conducting quality assurance and compliance activities. I understand that my records may be released to the state and federal courts on issuance of a subpoena without my permission. I understand that my medical information will not be released to any persons other than those listed without my expressed written permission.

For the purpose of this release, "medical information" shall mean copies of all medical records, test, x-ray reports and/or other materials in the possession of Women's Health Services relating to my medical condition and proposed or actual treatment. I understand that by signing this consent I am also authorizing release of any information contained within the medical records which may be related to AIDS and/or HIV antibody or antigen testing to the above mentioned persons.

By signing this consent for release of medical information, I agree not to hold Women's Health Services, their agents and employees liable for any unfavorable outcomes as the result of releasing this information. I realize that the release of my medical information may be necessary before my insurer will cover the cost of my medical treatment, and that by failing to authorize this release of this information, I may be required to pay the entire bill at the time of service.

Patient/Legal Rep. Signature

Date

Patient Name (please print)

Date of Birth

Women's Health Services
Dr. Joan Bergstrom
Dr. Dawnette Pepler
Dr. Angela Watson

I understand that Women's Health Services does not accept assignment from my insurance company for injections. (Example: hormone shot, birth control injection, etc.) I also understand that a payment of \$15.00 is due at the time of the injection is received and services are rendered.

Patient Signature

Date

**Women's Health Services
Well Woman and Additional Services Statement**

I _____ understand that my insurance will be billed a separate claim for additional services provided to me during my annual well woman exam if I choose not to come back for another visit. Example: a problem visit, ultrasound, bone density, biopsy, etc.

All these services listed above, must be approved by the physician at the time of my service if time permits. I also understand once my insurance processes the additional claim (for the extra services provided to me on the same date of service as my well woman exam) that I may owe an additional co-pay, deductible, coinsurance, etc.

I understand these charges will be my responsibility to pay once my insurance processes the paperwork for the claim, if the insurance does not cover the additional charges.

Patient/Guardian Signature

Date

Witness

Date