WOMEN'S HEALTH SERVICES
PATIENT PROFILE

PATIENT INFORMATION

Patient Name:			Home Phone #:
Date of Birth:	Social Security #:	Marital Status:	Cell Phone #:
Street Address, City, State & Zip:			Family Doctor:
			What doctor sent you to our office?
Ethnicity (please circle): Hispanic or Latino Non-Hispanic		Gender: Male Female	Race (please circle): African American Asian American Indian Alaskan Native Caucasian Hispanic Native Hawaiian or other Pacific Islander
Email Address:		Preferred Language:	

PATIENT EMPLOYMENT

Employed Not Employed Retired Disabled Student (circle one)

Employer:	Employer Complete Address:	Employer Phone #:

EMERGENCY CONTACT

Name:	Relationship:	Phone:

PERSON RESPONSIBLE FOR PAYMENT (GUARANTOR)

Name:	Social Security #:	Relationship:	Phone:
Complete Address:			

INSURANCE(s): (You must provide all insurance cards and information to receptionist.)

Name of Primary Insurance:	Policy Holder's Name & Date of Birth:	Policy Holder's Social Security #:
Name of Secondary Insurance:	Policy Holder's Name & Date of Birth:	Policy Holder's Social Security #:

PHARMACY INFORMATION:

Name of Pharmacy:	Pharmacy Street Address, City, State & Zip:	Pharmacy Phone:

INSURANCE AUTHORIZATION, MEDICAL RECORD & MEDICATION HISTORY AUTHORIZATION, & PHOTO CONSENT: I authorize and request my insurance company to pay insurance benefits directly to the physician or physician group. I understand that my medical record is available for continuity of care by Infinity Birthing Center, Infinity Family Practice and Women's Health Services. I understand that I am financially responsible to pay all co-insurances, co-payments, or balances for services rendered by the medical providers. I understand and agree to reimburse your company for the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts. I understand that it is my responsibility to contact my insurance company to verify benefits for services rendered by the providers. I grant permission to Infinity Birthing Center, Infinity Family Practice, and/or Women's Health Services to post photographs of myself and/or my children as taken by staff photographer(s) or provided by me to them as well as permission to post written comments that I provide to them regarding their services on social media, their website, and marketing materials. By signing this consent form you are agreeing that the medical providers can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all the above, I hereby provide informed consent for providers to enroll me in the eprescribe program.

Patient Signature:	Date:
Guardian Signature if Patient is a minor:	Date:

We offer the following methods of payment: Cash Check Debit Card MasterCard Visa American Express Discover Care Credit

**** Do you have a living will? Yes No ** Do you have a durable power of attorney? Yes No**

**** Would you like more information about advanced directives? Yes No**

Revised 6/23/2015

Intake Clerk: _____

New Patient and/or Annual Exam Questionnaire Date of Birth: _____

Please answer the following questions:

1. What is your main reason for seeing us today? _____
2. Who is your primary care physician? _____ 3. Doctor's name that referred you to our office? _____
4. How did you hear about us? _____ 5. How many pregnancies have you had? _____
6. How many miscarriages? _____ 7. When was your last menstrual period? _____
8. How many full term deliveries have you had? _____

Are you currently experiencing any of the following? Check Yes or No

Allergy/Immunology

- ☐Yes ☐No Anaphylactic Reaction
- ☐Yes ☐No Swelling
- ☐Yes ☐No Drug allergy
- ☐Yes ☐No Food allergy
- ☐Yes ☐No Latex Allergy

Cardiovascular

- ☐Yes ☐No Irregular Heart Beat
- ☐Yes ☐No Chest Pain/Pressure
- ☐Yes ☐No Difficulty Breathing
- ☐Yes ☐No Edema
- ☐Yes ☐No Exercise Intolerance

Constitutional

- ☐Yes ☐No Fatigue
- ☐Yes ☐No Fever
- ☐Yes ☐No Night Sweats
- ☐Yes ☐No Weight Gain
- ☐Yes ☐No Weight Loss

Dermatological

- ☐Yes ☐No Skin Infection
- ☐Yes ☐No Cyst
- ☐Yes ☐No Hair Infection
- ☐Yes ☐No Herpes Simplex

Ear/Nose/Throat/Back

- ☐Yes ☐No Dizziness
- ☐Yes ☐No Ear Discomfort
- ☐Yes ☐No Reflux
- ☐Yes ☐No Headache
- ☐Yes ☐No Hoarseness

Endocrine

- ☐Yes ☐No Chills
- ☐Yes ☐No Hot Flashes

Eyes

- ☐Yes ☐No Eyeglasses/contacts
- ☐Yes ☐No Visual disturbance

Gastrointestinal

- ☐Yes ☐No Abdominal Pain
- ☐Yes ☐No Bloody Stool
- ☐Yes ☐No Constipation
- ☐Yes ☐No Diarrhea
- ☐Yes ☐No Gas & Bloating
- ☐Yes ☐No Nausea
- ☐Yes ☐No Vomiting

Genitourinary/Nephrology

- ☐Yes ☐No Breast Complaint
- ☐Yes ☐No Painful Urination
- ☐Yes ☐No Genital Lesion
- ☐Yes ☐No Bloody Urine
- ☐Yes ☐No Hypertensions
- ☐Yes ☐No Menopausal Symptoms
- ☐Yes ☐No Menstrual Irregularity
- ☐Yes ☐No Urinate Frequently at Night
- ☐Yes ☐No Pap Smear Abnormality
- ☐Yes ☐No Pelvic Pain
- ☐Yes ☐No Pregnancy
- ☐Yes ☐No Urinary Frequency
- ☐Yes ☐No Loss of Bladder Control
- ☐Yes ☐No Urinary Urgency
- ☐Yes ☐No Vaginal Discharge

Hematologic/Lymphatic

- ☐Yes ☐No Abnormal Bleeding/Bruising
- ☐Yes ☐No Anemia

Musculoskeletal

- ☐Yes ☐No Back Pain
- ☐Yes ☐No Muscle Weakness
- ☐Yes ☐No Osteoporosis
- ☐Yes ☐No Shoulder Pain
- ☐Yes ☐No Stiffness

Neurologic

- ☐Yes ☐No Fainting
- ☐Yes ☐No Dizziness
- ☐Yes ☐No Difficulty Walking
- ☐Yes ☐No Memory Loss

Psychiatric

- ☐Yes ☐No Anxiety
- ☐Yes ☐No Depression
- ☐Yes ☐No Suicidal thoughts
- ☐Yes ☐No Emotional Issues
- ☐Yes ☐No Hallucinations

Respiratory

- ☐Yes ☐No Asthma
- ☐Yes ☐No Shortness of Breath
- ☐Yes ☐No Wheezing
- ☐Yes ☐No Smoker
- ☐Yes ☐No Cough

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM (Turn Sheet Over)

For Internal Use Only

	Nurse	Provider
BMI	☐	☐
HTN	☐	☐
Mammography	☐	☐
Smoker	☐	☐

Did you add this to your diagnosis?

Updated 11/2015

Medical History:

1. Are you experiencing any medical problems?
   A. _____
   B. _____
   C. _____
   D. _____
2. List any previous surgeries you have had and the year that they were performed:
   A. _____
   B. _____
   C. _____
   D. _____
3. List any allergies to medications:
   A. _____
   B. _____
   C. _____
   D. _____

Family History:

Please list any close relative with a history of the following:

Social History:

	Relative/ Age at diagnosis		Relative/ Age at diagnosis
Breast Cancer		High Blood Pressure	
Ovarian Cancer		Diabetes	
Uterine Cancer		Heart Disease (heart attack,	
Colon Cancer		stroke, bypass surgery)	

1. Do you smoke? If so how many packs per day? _____
2. Do you drink alcohol or take any drugs? _____

Medications:

Please list all medications and dosages that you are currently taking below

Medication	Dosage	Number of Times Per Day

Patient Signature: _____ Date: _____

Women's Health Services of the Cumberlands, Inc.
Michael P. Casal, M.D., FACOG
Morlee Burgess, DO Aileen Treto, MD
Mary Beth Dunn, CNM Ashli Randolph, CNM Shelley Schumacher, CNM

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or healthcare operations, in order to provide healthcare that is in your best interest. Your record is available for continuity of care by Infinity Birthing Center, Infinity Family Practice, and Women's Health Services.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physician and not patients), and may have to disclose personal health information for purposes of treatment, payment or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI, you may update your PHI release at any time; however, you may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice. A copy of this notice is also available to you. You may request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Date of Birth: _____

Signature: _____ Date Signed: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS.

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly value patients.

Request/Permission To Release PHI

I hereby request and give permission to Women's Health Services to release my Personal Health Information (PHI), which includes, but is not limited to, medical information, lab information, personal information, billing and insurance information to the person(s) named below.

Person(s) for information to be release to: _____

Relationship to person(s) allowed to have your PHI: _____

Women's Health Services

Receipt of Notice of Privacy Practices Written Acknowledgement Form.

I, _____, have received a copy of Women's Health Services's *Notice of Privacy Practices.*

_____ _____

Signature of Client Date

Women's Health Services

OBSTETRICS & GYNECOLOGY
Michael P. Casal, M.D. FACOG
Morlee Burgess, DO ♦ Aileen Treto, MD
Mary Beth Dunn, CNM ♦ Ashli Randolph, CNM ♦ Shelley Schumacher, CNM
1080 Neal Street, Suite 200, Cookeville, TN 38501
931-520-1529 Cookeville Office

Thank you for choosing us as your health care provider. We are committed to providing you with quality healthcare, while keeping your healthcare costs as low as possible. In order to do that, we must adhere to the following financial and payment policy that you need to review and sign in agreement and understanding.

Patient Information

- Each patient is responsible for providing our office with accurate personal information (complete mailing address and telephone numbers).

- Each patient is responsible for providing our office with accurate insurance information at each visit.
  - This includes bringing up-to-date insurance card(s) to each appointment and providing the personal information of the person who carries the insurance (for example, parent or spouse date of birth and social security number if they are the one who carries the policy).
  - This includes reporting all insurances on which they have coverage. (For example, if you have Medicare insurance or commercial insurance and a Tenncare insurance, you must tell us all of them). Failing to provide full information can be considered insurance fraud.

Insurance, Payment, Deductibles & Account Balances

- Some services we provide may not be covered by your insurance carrier. It is a patients' responsibility to know their own insurance benefits. You will be financially responsible for non-covered services when provided.

- We are required by our insurance contracts to collect all co-payments at the time of service. We accept cash, check, debit, Visa, Mastercard, Discover, American Express & Care Credit. Please be advised there is a 3% convenience fee for processing payments via credit or debit card on payments of $250 or more.

- If a patient does not have active health insurance coverage on a date of service, you will be required to pay for your office visit in full on the date of service.

- If a patient has an existing account balance, payment will be expected in full before treatment continues unless other arrangements have previously been approved.

- It is the patient's responsibility to pay account balances already processed by their insurance in a timely manner. If account balances are not paid within 90 days, the account may be sent to a collection agency where the patient will be additionally responsible for collection fees. Once sent to a collection agency, it will report as bad debt on your credit report by that agency and cannot be removed from that agency until the account is paid in full.

- It is our policy that all patients scheduled to undergo surgery must pay 100% of their estimated financial responsibility for that surgery on or before their pre-operative visit 1 to 3 days prior to the surgery. A financial representative from our office will contact you with this information.

- If you are an obstetrical patient, a financial representative from our office will contact you with cost estimates and payment policies.

- To better assist our patients, we have partnered with a reputable consumer financing company called Care Credit. This firm offers a consumer healthcare credit account that is just for health related expenses like the ones occurring here. Care Credit can work with you on payment terms letting you stretch out payments to be more affordable to your budget and is accepted at dozens of physician offices in the area. To learn more about Care Credit, you can pick up a brochure in our office, you can log on to www.carecredit.com, or you can meet with one of our financial representatives.

Labs

- Laboratory Corporation of America (LabCorp) is our primary source for processing lab specimens. If your insurance requires us to use a lab other than this, it is the patients' responsibility to let us know at the time of the visit.

Administrative Fee for Copay Not Paid at Time of Service

- There will be an administrative fee of $15 applied to account balances if a patient does not pay a copay on a given date of service when a copay was applicable. .

Return Check Fees

- Payments returned for non-sufficient funds will be charged $35 in addition to the account balance.

Copy of Records

- Copy of records requests require approximately 2 weeks to complete. A $25 charge is applied for each individual's request. These records can be mailed or picked up by the patient. If records are being sent to another physicians' office, the charge will not apply.

FMLA Forms

- FMLA forms requests require approximately 2 weeks to complete. There is no charge for the completion of these forms. All account balances must be current in order for forms to be completed.

Disability and/or Other Insurance Forms

- Disability and/or other insurance forms require approximately 2 weeks to complete. A $25 charge is applicable for each set of forms and must be paid before forms are released. All account balances must be current in order for forms to be completed.

****As a reminder, it may be considered insurance fraud if you do not tell us about any other insurances you may have if you are a TennCare insured patient.**

I have read, understand and accept the terms of the two-page financial and payment policy as outlined above.

_____ _____

Patient Name, printed Patient, Date of Birth

_____ _____

Patient Signature Date