Parkside Women's Centre
Annual Medical Update

Date: ____________

Name:______________________________Phone #____________________

Please help us update your records by providing us with the following information. Please fill in the blanks.

Your age: __________
What medical concerns did you have this year? _________________________
____
First day of your last normal period: _____First day of the previous period: ___
Are your periods regular? ___________ How many days in a cycle? _________
How heavy is the bleeding? __________ How many days of bleeding? ________
Are your periods painful? ____________

Are you sexually active? _________ Do you have pain with intercourse? _______
What do you do to prevent pregnancy? ________________________________
If birth control pills, what brand? ___________________________________
Are you satisfied with this method? __________________________________

Name of family physician? ____
Do you smoke? ___________________ How much? ____________________
Do you exercise? _________________ What type? ____________________
Have you had any medical problems in the past year, e.g., *surgery, accidents, or medical problems*? If so, please explain. ______________________________
____
Have you had any blood work, labs or x-rays in the past year? If so, please list?
____
Have you had a mammogram? If so, when and where was it performed? _______
___________ Are you doing a self breast exam? _______ Every month? ______

Are you taking any medications? If so, please list.________________________
____
Are you allergic to any medications? If so, please list. ____________________
____
Have there been any significant change in the medical condition of close blood relatives, e.g., *cancer heart- attack, stroke* ?
____

You are being seen today for your annual well woman exam. It will billed to your insurance as a preventative exam. Most insurances pay for one preventative exam a year. Please inform Dr. Hoover or our staff at the time service if you do not want it billed as a preventative service.

Thank you for taking the time to provide this information.

Parkside Women's Centre
For all the seasons of your life...

PATIENT INFORMATION

Please Print

Today's Date ____/____/____

Name: ________________________________

Address: ________________________________

City: ________________ State: ________ Zip Code: ____________

Home Phone: ( ) - ________ Work Phone: ( ) - ________ Cell: ( ) - ________

(Please check the preferred number you would like to be reached at: HOME ☐ WORK ☐ CELL ☐)

E-Mail: ________________________________

Date of Birth: ____/____/____ SSN #: ____-____-____ Marital Status ________

Primary Care Physician's Name: ________________________

Who referred you to our office: ________________________

In Case of Emergency Please Contact: ________________________

Phone: ( ) - ________ Relationship: ________________

GUARANTOR INFORMATION: (If patient is a minor)

Responsible Party/ Guarantor Name: ________________________

Address: ________________________________

Guarantor Birth date: ____/____/____ Employer Name: ________________

Occupation: ________________ SSN #: ____-____-____

INSURANCE INFORMATION

PRIMARY

Insurance Carrier: ________________________________

Guarantor on Policy ________________________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Insured's Employer: ________________ Insured's Birth date: ____/____/____

Insured's SSN #: ____-____-____ Plan Effective Date: ____/____/____

Annual Deductible Amount: $______.____ Co-Pay Amount: $______.____

Has patient's deductible been met for this year? ☐ Y ☐ N

SECONDARY INSURANCE

Insurance Carrier: ________________________________

Guarantor on Policy ________________________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Insured's Employer: ________________ Insured's Birth date: ____/____/____

Insured's SSN #: ____-____-____ Plan Effective Date: ____/____/____

Annual Deductible Amount: $______.____ Co-Pay Amount: $______.____

Has patient's deductible been met for this year? ☐ Y ☐ N

Client Financial Policy

This document serves as a guide to help clarify your role & responsibility both as a health care consumer & active client of Parkside Women's Centre. Thank you for choosing us for your medical care.

1. **Assignment of Benefits:** As Parkside Women's Centre is a contracted provider with various Preferred Provider Organizations (PPO's) we will file the necessary forms for you and accept payment directly from your health plan. Your signature allows us to directly bill for services rendered on your behalf. Please note that we will file your insurance as a courtesy, any balances unpaid by your insurance is your responsibility.

2. **Co-Payments/Collections:** The portion of healthcare cost for which you are financially responsible is expected to be paid in full at the time of service. As required by your plan, we will collect all co-payments & submit all health forms to your carrier for you. Any balance left on your account will need to be paid in full within 120 days to avoid the balance being sent to an outside collection agency. You are responsible for any fees incurred from the collection agency. You further understand that your credit may be affected and we reserve the right to pursue legal action, which may include property liens.

3. **Form Completion Policy:** To help defray the costs incurred due to the increasing amount of time staff and providers must spend on fulfilling requests for various forms we have enforced a $10.00 charge per form. If additional information is needed that cannot already be found in the chart in order to complete the form, a scheduled visit may also be required. Once all pertinent information is available, the form will be completed within 5 business days of being submitted to our office.

4. **Surgery & OB Deposits:** We ask that you pay a $200.00 surgery deposit or OB deposit. Once your insurance has been billed and the insurance has paid their part, your $200.00 surgery deposit or OB deposit will be applied to any remaining balances owed by you the patient. If your insurance plan pays at 100% for your medical treatment we will gladly refund your deposit back to you. You further understand that failure to notify Parkside Women's Centre of intent to cancel within 48 hours of the scheduled procedure, all or part of your surgical deposit may be forfeited.

5. **Cancellation Policy:** Kindly give 24 hours notice when the need arises to cancel an appointment. Failure to do so may result in a **$25.00 non-refundable** cancellation charge that will be payable before you reappoint with our office. It is our policy to dismiss patients who routinely fail to keep their appointments.

6. **Prescription Replacement Fee:** Effective 1/1/08 we have implemented a replacement prescription fee of $5.00. This payment cannot be billed to your insurance company and you must pay for this service when picking up the new prescription.

7. **Filing Medicaid as a Secondary Insurance:** As a policy, we do not file Medicaid as a secondary insurance. As a courtesy, will file your primary insurance and balance bill you for any charges that your primary should not pay. You will be responsible for paying any co-insurance, deductible or out of pocket expenses incurred.

8. **Medicaid Family Planning:** If you have Family Planning Medicaid and are seen for a non-family planning reason (example: medical condition) you will be billed for any services not covered by Medicaid.

Authorization to Release Medical Records

I authorize Parkside Women's Centre to release any medical information pertinent to my care to any outside physicians, labs and/or insurance companies. I further understand that any person(s) that receives this information will not release any medical information obtained without further authorization singed by me.

Consent for Treatment

The undersigned consents for treatment by Parkside Women's Centre. This treatment may include, but not limited to, office visits, laboratory testing, injections, pelvic exams, breast exams, minor surgical procedures and other procedures directly related to patient care. The undersigned understands that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk. The undersigned acknowledges that no guarantees have been made as to the results of examination and/or treatment.

Privacy Practices

The undersigned acknowledges receipt of Parkside Women's Centre Notice of Privacy Practices.

By signing below, I fully understand Parkside Women's Centre policies and accept full responsibility thereof.

____ _______________

Patient, Parent or Guardian ***Date***

If Parent or Guardian, minor's name:________________________________

Authorization for Release of Protected Health Information

Medical Provider's Name: ______________________________

Street Address: ______________________________

____

Phone and Fax: ______________________________

Patient Name at time of treatment:

____

Date of Birth: ____________ Social Security Number: ____________

Street Address: ____________ City/State/Zip code ____________

Telephone #: ____________ Account # ____________

I authorize the <u>above named provider</u> to release my protected health information to:

Recipient Name: **Parkside Women's Centre**
Dr. Judith Hoover

Street Address: **PO Box 5669**

City/State/Zip code: **Aiken, SC 29804** **Phone: 803-649-7746**

<u>Fax information to</u>: 803-649-7730

Information for treatment period: From (date) ________ to (date) ________

Information to be released: (Please check all that apply)

□ Patient History Forms	□ Operative Notes	□ Lab tests
□ Office notes	□ Imaging / CDs	□ Hospital reports
□ Pathology reports	□ Imaging reports	□ Other- specify

This information is being requested for the following purpose (s): ______________________

Sensitive Information: I understand that my record may include information relating to AIDS or HIV, psychiatric care, psychological assessment, behavioral and/or mental health services, sexually transmitted diseases, alcohol and/or drug abuse and this information will be released.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing to the above medical provider and that the revocation will not apply to information already released based on this information.

Expiration: I understand that this authorization will expire 12 months after signed unless an earlier date is specified here: ________

Services: I understand that refusal to sign this authorization cannot be used as a reason for denial of services or benefits.

______________________________ ____________

Signature of Patient or Legal Representative **Date**