

[PATIENT DATA SHEET]

Provider:
Date:

Women's Health Care Associates, P.A.
135 Newton Sparta Road, Suite 201
Newton, NJ 07860
(973) 383 - 8555

PATIENT INFORMATION

Patient Name: _____
Address Line 1: _____
Address Line 2: _____
City / State / Zip: _____

Social Security #: _____
Birth Date: _____
Patient Age: _____
First Day Last Menstrual Period: _____

Home Phone: _____ Cell: _____

Okay to Use Cell? _____

Is Patient a Student? ___ If Yes, Full or Part Time? ___

Marital Status: _____

EMPLOYER

Employer Name: _____
Work Number: _____

Occupation: _____
Extension: _____

INSURANCE

Primary Insurance: _____

Policy Number: _____

Name on Ins. Card: _____

Co-Pay: _____

Second Insurance: _____

Policy Number: _____

Name on Ins Card: _____

Co-Pay: _____

SPOUSE / PARTNER / GUARDIAN:

Name: _____
Date of Birth: _____ Age: _____
Address: _____

Relationship: _____
Employer: _____
Phone: _____

HOW DID YOU HEAR ABOUT US?

___ Friend ___ Yellow Pages ___ Internet ___ Flyer ___ Newspaper ___ Other _____

OUTSIDE LABS

Outside labs maybe used for testing the following procedures: labwork, cultures, and pap smears. If we participate with your insurance carrier we will send it to the lab they direct us to, otherwise we will send he specimens to labs which we use for the quality of service. Please specify if there is a lab your carrier has an agreement with.

.ab: _____ Phone Number: _____

Pharmacy: _____ Phone Number: _____



Patient Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this practice's Notice of Privacy Practices (NPP). This practice reserves the right to change the terms of this Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain a copy of the current NPP on request.

Signature _____ Date: _____

Relationship to patient (if signed by a personal representative of patient) _____

I authorize the practice to discuss my health care with the following person(s): Please circle.

No One Husband Mother Father Child Other

Name and Relationship must be written in order for us to comply with NPP.



Payment Policy and Financial Agreement

We are committed to providing you with the best possible care. If you have medical insurance we are eager to help you receive the maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our payment policy.

- Payment for all copays, deductibles, and non-covered office services and supplies is due at the time service is rendered, unless payment arrangements have been approved in advance through the business office. If payment is not made upon checking out of the office, a \$15 fee will be applied.
- We accept cash, checks, MasterCard, American Express and Visa (returned checks are subject to additional services charges and bank fees).
- We are happy to submit a claim form to your insurance carrier, but we require appropriate proof of insurance, ID number, and mailing address at each visit. If such information is not provided, full payment will be expected from you.
- When we are a non-participating provider with your insurance carrier, we require payment in full at time of service, and we will submit a claim on your behalf. If the carrier remits payment to us, we will promptly reimburse you the appropriate amount.
- If your insurance carrier requires you to obtain a referral or precertification prior to receiving our services, it is your responsibility to be aware of and to obtain such requirements.
- Surgical procedures may require a deposit, including deductible and/or co-pay. Remaining balances are to be paid within one month of settlement with your insurance company (unless arrangements for pre-payment or a monthly payment schedule have been made in advance.) We pre-approve the surgical procedure with individual insurance carriers to determine benefits, but it is ultimately the patient's responsibility to pre-approve all surgical procedures and to be aware of conditions of approval, such as obtaining second opinion, etc.
- *Effective January 9, 2001, any appointment not kept or cancelled less than 24 hours prior will be subject to a \$25 charge.*

Important- Some plans require patients to obtain referrals and/or preauthorization for services provided at outside facilities (hospitals labs, radiology, etc.) Occasionally, a provider may send a patient to these facilities directly from the office. In such instances, the patient must notify our business office within 24 hours so that they may obtain the necessary referral or preauthorization. *If we are not notified, and subsequently unable to obtain a referral or preauthorization, you will be responsible for the bill.*

Other notes about insurance:

- Medical insurance is a contract between you, your employer and your insurance company. We are not a party to that contract unless we have chosen to be a participating provider with the insurance plan.
- Our fees fall within a range based on the level and standard of care provided, in this regional area, and are covered up to an allowance determined by each carrier. Some carriers pay on the basis of a percentage of this usual, customary and reasonable range (UCR), and others pay on an arbitrary fee schedule, which bears no relationship to UCR. Our fee reduction is based on the prevailing Medicare Allowable, Region 1 area, participating provider rate. These fees are available in our business office for review.
- Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover, and regardless of our practice participation with a plan, payment for any non-covered services will be the patient's responsibility.

We emphasize that as a medical care provider, our relationship is with you and not your insurance company. We cannot be responsible for any loss of benefits. It is your responsibility to know your policy. If you have any questions concerning the above information, please do not hesitate to ask us. We are here to help you.

I have read and understand this financial arrangement and realize that all fees, regardless of the insurance coverage, are ultimately my responsibility.

Patient Signature

Date

I HEREBY AUTHORIZE THE RELEASE of any medical information necessary to process the direct payment of medical benefits to the named provider. I have read and understand the attached financial agreement and realize that all fees, regardless of insurance coverage, are ultimately my responsibility.

Patient Signature

Date

NAME: _____ DATE: _____

PAST MEDICAL HISTORY:

Please check if you have had any of the following conditions or diseases, indicating date and treatment

Yes	No	Condition/Disease	Date	Treatment
___	___	Anemia	_____	_____
___	___	Asthma	_____	_____
___	___	Blood transfusion	_____	_____
___	___	Blood in urine or stool	_____	_____
___	___	Cancer	_____	_____
___	___	Diabetes	_____	_____
___	___	Emotional disorder	_____	_____
___	___	German measles (rubella)	_____	_____
___	___	Heart problems	_____	_____
___	___	High blood pressure	_____	_____
___	___	Infertility	_____	_____
___	___	Kidney/bladder problems	_____	_____
___	___	Liver problems/Hepatitis	_____	_____
___	___	Lung disease	_____	_____
___	___	Migraine headaches	_____	_____
___	___	Phlebitis	_____	_____
___	___	Psychiatric condition	_____	_____
___	___	Rheumatic fever	_____	_____
___	___	Seizures	_____	_____
___	___	Syphilis/gonorrhea (STD)	_____	_____
___	___	Thyroid	_____	_____
___	___	Tuberculosis	_____	_____
___	___	Other	_____	_____

Do you SMOKE? Yes ___ No ___ If yes, how many cigarettes per day? _____

Do you DRINK? Yes ___ No ___ If yes, how many drinks per day? _____

What MEDICATIONS are you taking? Please list: _____

Do you have any ALLERGIES? _____

Please list any OPERATIONS/SURGERY you have had:

	Date	Hospital
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

GYNECOLOGICAL HISTORY:

Last normal menstrual period (first day) _____ Menarche (age when period began) _____
Interval between periods _____ Duration of flow _____

Abnormal bleeding? Yes ___ No ___ Describe _____

Bleeding after intercourse? Yes ___ No ___ Describe _____

Painful intercourse? Yes ___ No ___

Discharge? Yes ___ No ___ Describe _____

Infection in uterus, tubes or ovaries? Yes ___ No ___ When _____ Treatment _____

Infection in vagina? Yes ___ No ___ When _____ Treatment _____

Date of last Pap smear _____ Results _____ Where _____

Date of last mammogram _____ Results _____ Where _____

OBSTETRICAL HISTORY:

Total number of pregnancies _____ Number of abortions _____

Number of living children _____ Number of stillborns _____

Number of miscarriages _____ Date of last pregnancy _____

Are you presently using any method of contraception? Yes ___ No ___ Method _____

In the past, have you used any of the following contraceptive methods:

<u>Method</u>	<u>Date Started</u>	<u>Length of Use</u>	<u>Problem</u>
_____ birth control pills	_____	_____	_____
_____ condom	_____	_____	_____
_____ diaphragm	_____	_____	_____
_____ foam	_____	_____	_____
_____ IUD	_____	_____	_____
_____ natural family planning	_____	_____	_____
_____ other	_____	_____	_____

FAMILY HISTORY:

Has any member of your immediate family had cancer, heart disease, diabetes, or a genetic disease?

Yes ___ No ___ If yes, explain: _____

Are there any other health problems which you may not have covered on this form? Yes ___ No ___

If yes, explain: _____
