Advanced Women's Healthcare, SC

Account #: _____

Registration Form

Employee Initials: _____

PATIENT INFORMATION: (Please use full legal name/how it appears with your insurance company)

Last Name: _____ First Name: _____ Middle Initial: _____

Maiden Name: _____ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: ( ) _____ Home Phone: ( ) _____ Work: ( ) _____

Which number is your preferred contact number? (circle one) Cell Home Work

Date of Birth: _____ **Sex:** Female Male **Marital Status:** Single Married Divorced Widowed

Social Security #: XXX-XX-_____ Email address: _____

Employer: _____ Primary Care Physician: _____

GUARANTOR INFORMATION: (List person or insured name that is responsible for bill)

Relationship of Guarantor to the patient: Self Spouse Parent Other

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: ( ) _____ Social Security #: XXX-XX-_____ Date of Birth: _____

Employer: _____ **Sex:** Female Male

INSURANCE INFORMATION: (Please allow the receptionist to take a copy of your Insurance card or cards)

PRIMARY INSURANCE: _____ Insureds name: _____

Insured's Date of Birth: _____ Relationship to patient: _____

Policy/ID #: _____ Group #: _____ Effective Date: _____

Claims Address (on back of your card): _____

Phone Number: ( ) _____

SECONDARY INSURANCE: _____ Insureds name: _____

Insured's Date of Birth: _____ Relationship to patient: _____

Policy/ID #: _____ Group #: _____ Effective Date: _____

Claims Address (on back of your card): _____

Phone Number: ( ) _____ ****AWH, SC does not accept Medicaid/IDPA plans as secondary payor****

EMERGENCY CONTACT:

Name: _____

Relationship to patient: _____ Phone Number: ( ) _____

Preferred Pharmacy: _____ Phone Number: ( ) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Electronic Prescriptions: Our electronic medical record program assesses your prescription medication history in order for us to safely prescribe your medication and allows our office to send electronic scripts to your pharmacy of choice. By signing, you authorize this service:

Signature: _____ Date: _____

1. What category best describes your race, please circle one:

African American American Indian or Alaska Native Asian Native Hawaiian or Pacific Islander

Caucasian Decline to Answer I do not identify with any of those listed

2. Do you consider yourself to be Hispanic or Latino, please circle one:

Yes, Hispanic or Latino No, not Hispanic or Latino Decline to Answer

3. What is your preferred language? _____

Patient Portal:

I authorize Advanced Women's Healthcare, SC to send test results and patient portal information via email.

Signature of Patient: _____ Date: _____

Email Address for patient portal access: _____

PLEASE INITIAL NEXT TO EACH STATEMENT

_____ **Consent for Treatment**

I hereby authorize employees and agents of Advanced Women's Healthcare, SC to provide medical care to the patient indicated on this form. I understand that this includes evaluations and treatment as well as lab tests, education, other diagnostic procedures and in some cases, medical and/or surgical procedures.

_____ **Patient's Right to Privacy**

I acknowledge that I have had the opportunity to review the Advanced Women's Healthcare, SC Notice of Privacy Practices. These privacy practices are always available in the front office and I understand that should I desire a copy of the HIPPA privacy practice in the future, I can request a copy from the office staff.

_____ **Appointment Cancellation/No Show Policy**

Effective January 1, 2022 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office providing at least a 24 hour notice will be considered a no show and assessed a $30 fee. Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office providing at least a 24 hour notice a second time, will be assessed a $50 fee. If a third no show/late cancellation or reschedule occurs without at least a 24 hour notice, the patient may be discharged from Advanced Women's Healthcare, SC. A no show fee is charged directly to the patient, not the insurance company and is expected to be paid prior to the next appointment at Advanced Women's Healthcare, SC.

Any new patient who fails to arrive for an initial visit will not be rescheduled. If unable to make appointment date and time, please give 24 hour notice to reschedule.

We understand that at times there may be extenuating circumstances that do not allow for a greater than a 24 hour notice. You may contact Advanced Women's Healthcare, SC Monday through Friday 7:30 am to 4:00 pm. On the weekend or after hours, it is possible to send our office a non-urgent message through our website at awhcare.com. If you should experience an extenuating circumstance, please contact our Office Manager, who may be able to waive the No Show fee.

_____ **Financial Policy**

Advanced Women's Healthcare, SC accepts most insurance plans and will submit claims to those insurance plans on your behalf. It is your responsibility to provide our office with accurate insurance information so that claims can be submitted timely. It is also your responsibility to determine what services your insurance company will cover. You are obligated to pay for all services provided to you whether they are covered by your insurance company or not. This includes deductible, copayments, co-insurance amounts as well as plan limitations. Plan limitations could include such things as pre-authorization, pre-certification, referral from a PCP and medical necessity limitations set by your insurance company. Should you experience a lapse in coverages, you will able responsible for those charges. If you need to be referred to a specific lab, it is your responsibility to make your healthcare provider aware of that. We will bill a secondary insurance unless the secondary insurance is Medicaid or any of the IDPA plans. As of June 25, 2013 Advanced Women's Healthcare, SC no longer accepts any of the Medicaid/IDPA plans as a secondary payor and I understand that this means any deductible and/or copayment/co-insurance amounts left by my primary commercial payor are my responsibility to pay out of pocket. In addition, our office is not contracted with all Medicaid plans and it is your responsibility to ensure that you remain on a Medicaid plan that our office participates in for your services to be covered. Any services provided by outside laboratories (bloodwork, paps, or biopsies) will be billed to you directly by that company.

_____Financial Policy Continued

You will receive a statement showing the charges that have incurred on your account and the amount due once we have heard back from your insurance company, if you provided insurance at your visit. All patient balances are expected to be paid in full within 30 days of the date of your statement. Payment of unpaid balances must be paid prior to any new services being rendered. Appointments will not be scheduled until balances are paid in full.

OB patients will be provided with an OB Cost Estimate, in most cases within the first trimester. This will outline the anticipated costs for the pregnancy. Services not include in the OB Package are expected to be paid within the 30 days of your statement being printed. The global charges will be submitted to your health insurance following delivery. Once hearing back from your health insurance, we will bill you and expect payment in full within 30 days of the statement date. Payment plans **will not** be an option following delivery.

Should your account become delinquent and sent to an outside collection agency, you will be responsible for the costs incurred in the collection of this balance, which includes collection agency fees of 30%, court costs, and attorney fees. Any account sent to collections will no longer be able to receive future services in our office. Any check returned for insufficient funds will incur a $25 charge on the patient account.

I authorize Advanced Women's Healthcare, SC to release to my insurance company and its agents any information necessary to determine the benefits payable under their coverage. I authorize my insurance company and its carries to disclose any information requested regarding claims for medical benefits. A copy of this authorization may be used in place of the original.

I request the payment of authorized medical benefits made on my behalf to Advanced Women's Healthcare, SC for services provided to me by its providers and staff.

_____ HIPPA Consent

I hereby authorize Advanced Women's Healthcare, SC to discuss my protected health information with the following individuals:

Name: _____ Relationship to patient: _____ Phone #: _____

Name: _____ Relationship to patient: _____ Phone #: _____

Name: _____ Relationship to patient: _____ Phone #: _____

By signing below, I acknowledge that I have read and understood the Patient Registration, Consent for Treatment, Patient's Right to Privacy, Appointment Cancellation, No Show Policy, and Financial Agreement and that I agree to abide by the office policies of Advanced Women's Healthcare, SC.

Signature of Patient (or guarantor if patient is a minor): _____

Printed Name of above signature (and patient name if a minor): _____

Date of signed agreement: _____

Advanced Women's Healthcare Patient Health History

Name: _____ DOB: _____

Current Problem:

_____

_____

_____

Allergies:

_____

_____

_____

Current Medications:

_____

_____

_____

_____

Preferred Pharmacy: _____

Are you menopausal? YES NO If yes, at what age? _____

Have you had a hysterectomy? YES NO If yes, were your ovaries removed? YES NO

Are you sexually active? YES NO

Do you use any form of birth control? YES NO If yes, what kind? _____

Have you ever had a colonoscopy? YES NO If yes, date? _____

Facility performed at? _____

Have you ever had a bone density test? YES NO If yes, date? _____

Facility performed at ? _____

Menstrual History (If you are NOT menopausal)

Are your cycles regular? YES NO

Date of last menstrual period? _____

Pap Smear History

Date of last pap smear: _____ NORMAL ABNORMAL

History of abnormal pap smears? YES NO

Breast:

Ever had a Mammogram? YES NO Date of last Mammogram? _____

History of Abnormal Mammogram? YES NO Facility performed at? _____

Advanced Women's Healthcare Patient Health History

Pregnancy History: Including all miscarriages and/or abortions

#	Date	Sex Of Baby	Weight Of Baby	Weeks' Gestation	Type Of Delivery	Complications: During Pregnancy or During Labor
1						
2						
3						
4						
5						
6						

Personal History Of:

YES	NO		YES	NO	
___	___	Anemia	___	___	High Blood Pressure
___	___	Anxiety	___	___	High Cholesterol
___	___	Asthma	___	___	Hyperthyroidism
___	___	Autoimmune Disorder	___	___	Hypothyroidism
___	___	Blood Clots	___	___	Osteoporosis
___	___	Depression	___	___	Panic Attacks
___	___	Diabetes, Type 1	___	___	Recurrent UTI's
___	___	Diabetes, Type 2	___	___	Sleep Apnea
___	___	Endometriosis	___	___	Stroke
___	___	Fibroids	___	___	Urinary Incontinence
___	___	Glaucoma			

Heart problems? (If yes, please specify) _____

_____

Cancer? (If yes, please list what type) _____

_____

Sexually Transmitted Diseases? (Ever in your life): Gonorrhea Chlamydia Herpes HPV Syphilis HIV None

Please specify any other medical condition you may have that is not listed in the above section:

_____

_____

_____

_____

Advanced Women's Healthcare Patient Health History

Past Surgical History:

_____

_____

_____

Past Hospitalizations:

_____

_____

_____

Family History: List all health issues; cancer, diabetes, heart problems, etc... Please specify

Father: Alive or Deceased _____

Mother: Alive or Deceased _____

Paternal Grandfather: _____

Paternal Grandmother: _____

Maternal Grandfather: _____

Maternal Grandmother: _____

Siblings: _____

Other: _____

Social History:

- Marital Status (circle one) - Single Married Divorced Widowed
- Smoking Status (circle one)- Never a smoker Current smoker Former smoker: Quit in year _____

  If you are a current smoker, how many cigarettes per day?

  ___ 5 or less ___ 6-10 ___ 11-20 ___ 21-30 ___ 31 or more
- Illicit Drug use? YES NO If yes, what type? _____
- Alcohol Consumption - Have you had a drink in the past 12 months? YES NO

  If yes, how often?

  ___ Monthly or less
  ___ 2-4 times per month
  ___ 2-3 times per week
  ___ 4 or more times per week

  If yes, how many drinks in a typical day?

  ___ 1 or 2
  ___ 3 or 4
  ___ 5 to 6
  ___ 7 to 8
  ___ 10 or more
- In a normal day, what is your caffeine intake? _____
- In a normal week, how much exercise do you get? _____

Please complete the back side of this form

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate your answer)

0 = Not at all
1 = Several days
2 = More than half the days
3 = Nearly everyday

	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐