NEW RIVER WOMEN'S HEALTH P.C.
Patient Registration Form

PATIENT INFORMATION

Patient Name: _____ _____ _____

(First) (Middle) (Last)

Sex: ☐ Female ☐ Male ☐ Decline to Specify

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Domestic Partner ☐ Widowed

Date of Birth: _____/_____/_____ Social Security Number: _____- _____ -_____

Mobile Number: (_____) _____- _____ Email Address: _____

Home Number: (_____) _____- _____ Work Number: (_____) _____- _____

Home Address: _____

City: _____ State: _____ Zip _____

How would you prefer we contact you regarding your appointment reminders?

☐ Voice ☐ Text ☐ E-mail ☐ Any

Preferred Pharmacy: _____

How did you hear about New River Women's Health? _____

ETHNICITY/ RACE : ☐ Hispanic or Latino ☐ Asian ☐ White or Caucasian
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Patient declines to specify

Emergency Contact:

Name: _____ Relationship to patient: _____

Phone: _____

RESPONSIBLE PARTY (if other than patient)

Guarantor's Name: _____ Phone Number: (_____) _____- _____

Address: _____ City: _____ State: _____ Zip _____

(If different from Above)

Patient Relation to Guarantor: _____ Guarantor's Employer: _____

Employer Address: _____

City: _____ State: _____ Zip _____

Guarantor Social Security #: ___ ___ ___- ___ ___ - ___ ___ ___ ___ Guarantor D.O.B _____/_____/_____

PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize New River Women's Health P.C., to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to New River Women's Health P.C of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

_____ Date: _____/_____/_____

Patient Signature (or Responsible Party)

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

SPECIFIC INFORMATION RELEASE (If applicable)

I request and authorize New River Women's Health P.C. to disclose protected health care information to the individual(s) listed here:

Name _____ Contact # _____

Name _____ Contact # _____

Name _____ Contact # _____

_____ Date: _____/_____/_____

Patient Signature

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge the Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

_____ Date: _____/_____/_____

Patient Signature

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTHCRE OPERATIONS

I hereby consent to New River Women's Health P.C. using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations. I also consent to New River Women's Health P.C. using or disclosing my protected health information for treatment activities provided by another provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operation including quality assessment and reviewing the competence of health care professionals.

_____ Date: _____/_____/_____

Patient Signature

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient

New River Women's Health
Office Policies

- Collection Agency/Attorney Fees - In the event that your account is turned over to a collection agency or attorney, you agree that you will be responsible for a collection fee equal to 33.3% of the outstanding balance due on the date the account is turned over for collection.

- Collection Costs - In the event that the account becomes delinquent and is necessary to expend costs for the collection of the account, you understand that you will be responsible for the costs. These costs could include court costs for filing suit against you.

- Cancellation / No Show for Scheduled Appointment: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

- If an appointment is not cancelled at least 24 hours in advance you will be charged a Thirty Five Dollar ($35) fee; this will not be covered by your insurance company. This appointment will also be marked as a No Show since adequate cancellation notice was not given.

- We will limit the number of No Shows or late cancellations allowed per patient. If you are a No Show three (3) times, we will no longer schedule appointments for you at our practice.

- Late Arrival for Scheduled Appointments: We understand that delays can happen; however we must try to keep the other patients and doctors on time. If a patient arrives 15 minutes past their scheduled time we will have to reschedule the appointment.

_____
Patient's Printed Name or Guardian's Printed Name

_____
Patient's Signature or Guardian Signature

____/____/_____
Date

Clinical Profile

Patient Name: _____ DOB: _____/_____/_____

Marital Status: (Circle One) Single Married Widowed Divorced Domestic Partner Separated

Sexual Orientation: Heterosexual ___ Homosexual ___ Bisexual ___ Other ___ Decline to specify ___

Your Employment / Profession: _____

Spouse / Partner's Name: _____

Preferred Pharmacy: _____

Family Doctor or Primary Care Doctor: _____

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Date of Last Menstrual Period: _____

Form of Contraception: _____

Allergies: _____

List all Current Medications and the dosage and frequency (including over the counter):

_____

_____

_____

_____

Current Tobacco Use: ☐Yes ☐No

If YES, how long: _____ how much: _____

Former Tobacco Use: ☐Yes ☐No

If YES, how long: _____ how much: _____

Alcohol Use: ☐Yes ☐No

If YES, how many drinks per week: _____

Recreational Drug Use: ☐Yes ☐No

If YES, what: _____ how often: _____

****

Date of last Women's Health Exam / Pap Smear: _____

Do you have a history of an abnormal pap? ☐Yes ☐No

If so, when? _____

Date of last mammogram: _____ Location of last mammogram: _____

Date of last colonoscopy: _____

Date of last bone density: _____

Date of last cholesterol check: _____ Results: ☐Normal ☐High

****

Pregnancy History: please check all that apply and how many of each:

Pregnancies: #_____ Vaginal Births: #_____ Cesarean Sections: #_____

Miscarriages: #_____ Fetal Demise: #_____ Elective Abortion: #_____

Patient Name: _____

Past Medical History: Please check all that apply

☐ **Acid Reflux** ☐ **Anemia** ☐ **Anxiety** ☐ **Arthritis** ☐ **Asthma/Emphysema/Lung Disease** ☐ **Cancer – What kind: _____ _____** ☐ **Chronic Kidney Disease** ☐ **Crohns/Ulcerative Colitis** ☐ **Depression** ☐ **Diabetes**	☐ **Heart Attack** ☐ **Heart Disease** ☐ **High Cholesterol** ☐ **History of Blood Transfusion** ☐ **Hypertension** ☐ **Leukemia** ☐ **Liver Disease/Hepatitis** ☐ **Lymphoma**	☐ **Migraines** ☐ **Mitral Valve Prolapse** ☐ **Osteopenia** ☐ **Osteoporosis** ☐ **Seasonal Allergies** ☐ **Seizure Disorder** ☐ **Stroke** ☐ **Thyroid Disorder** ☐ **Other: Details: _____ _____ _____ _____ _____ _____**

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Past Surgical History: Please check all that apply

Procedure	Date if Known	Procedure	Date if Known
Appendix		Tonsillectomy	
Gall Bladder		D&C	
Hysterectomy		Endometrial Ablation	
C-Section		Hernia	
Incontinence Procedure		Right or Left Ovary Removal	
Sterilization ☐ Tubal ☐Essure ☐ Partner Vasectomy			

Other surgeries: _____

_____

Family History: Please check all that apply

- ☐ Asthma
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Melanoma
- ☐ Mental Health Disorder
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Breast Cancer: Family Member: _____ Age Diagnosed: _____
- ☐ Ovarian Cancer: Family Member: _____ Age Diagnosed: _____
- ☐ Uterine Cancer: Family Member: _____ Age Diagnosed: _____
- ☐ Colon Cancer: Family Member: _____ Age Diagnosed: _____
- ☐ Other: _____

NEW RIVER
Health & Wellness

Preventive Medical Visit Patient Information

Patient,

You are seeing your provider for a preventive medical visit. This is a comprehensive, preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/ risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures. Insurance carries may or may not provide coverage for screening laboratory and diagnostic studies; rules are carrier specific. Preventive medical visits are exempt from copayments.

If an abnormality is encounters or a pre-existing problem is address during the process of performing your preventive medical evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform key components of a problem-oriented evaluation and management service, then a separate office visit code may be charged. The use of this additional code will require a co-payment, coinsurance, or deductible if one is charged by your insurance plan.

If you have any questions regarding this matter, we advise you to contact your insurance carrier directly to discuss your coverage for these services.

New River Women's Health

I certify that I have read and understand the difference between preventive and problem-oriented visits and agree to pay the associated copay should the nature of my visit change.

Signature _____ Date: _____

Printed Name: _____

NEW RIVER WOMEN'S Health

At New River Health and Wellness, we provide different services ranging from annual exams, problem visits, lab tests, and imaging services. We unfortunately do not know the coverage for these services for each insurance company. We ask that you reach out to your insurance company if you have any specific questions regarding coverage, benefits, or payments that may be due. We also are happy to provide you with services, labs, or imaging at your request, but we do ask for the patient to take the responsibility of contacting your insurance company about coverage, eligibility, payments, etc.

Thank you for understanding.

Patient Signature: _____

Date: _____