For Office use only
Patient Account Number:

PATIENT INFORMATION

virginia physicians FOR WOMEN

Name_____ **Pharmacy**_____
Last *First* *Middle (Maiden)* **Location**_____

Preferred Name/Nickname (if applicable) _____ Age_____

Date of Birth _____Social Security Number_____

Race_____ Ethnicity-Hispanic/Latino ❑ Yes ❑ No Primary Language _____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Mailing Address_____
Street *Apt #*

_____
City *State* *Zip*

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

Primary Number **(circle one):** Home Work Cell

Email_____

Preferred Communication Method for Appointment Reminders **(circle one):** Home phone | Cell phone | Text | Email

Primary Care Physician_____Referred to VPFW by_____

Patient Employer_____Occupation_____

If you do not want test results mailed or phoned to your home, where should we contact you with the results? :

Address_____ Phone (_____)_____

In case of an emergency, please notify: Name_____ Phone (_____)_____

Primary Insurance Information:
Insurance Company Name_____

Policy Holder's Name _____
First *Middle (Maiden)* *Last*

Policy Holder's Date of Birth _____ Employer_____

Patient's Relationship to Policy Holder? ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Secondary Insurance Information:
Insurance Company Name_____

Policy Holder's Name _____
First *Middle (Maiden)* *Last*

Policy Holder's Date of Birth _____ Employer_____

Patient's Relationship to Policy Holder? ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Patient (or Parent/Guarantor if under 18) **Signature**_____**Date**_____

Revised: 6/2017

virginia physicians FOR WOMEN

Patient History

Name_____Preferred Nickname_____ D.O.B._____ Age_____
Reason for visit: □ Annual □ Returning OB patient □ Gynecologic Problem:_____
Primary Care Doctor:_____

GYNECOLOGIC HISTORY

First day of last menstrual period _____
Age of very first period _____
Have you experienced: ❑ a Hysterectomy or ❑ Menopause
If yes to either: Age at Menopause_____ Year of Hysterectomy_____
How often do your period usually occur? Every _____ days/months **or** ❑ N/A
How long do your periods last? _____ **or** ❑ N/A
Is the flow heavy, medium, or light? _____ **or** ❑ N/A
Do you use tampons or pads? _____**or** ❑ N/A
How often do you have to change tampons or pads? Every _____ minutes/hours **or** ❑ N/A
Do you experience cramps Y / N Are they mild/moderate/severe? _____ **or** ❑ N/A
Do you perform Self Breast Exams? Y / N If so, how often?_____
Last annual exam _____ Last pap smear _____ Last HPV testing _____

Are you sexually active?	Y / N	
Do you use a method for pregnancy prevention?	Y / N	Form of birth control used? (pills, condom, etc.)
Have you ever had an abnormal pap?	Y / N	If yes, what kind of treatment was done? (Colpo, Cryo, Leep, Conization)
Have you ever had an HPV test?	Y / N	Date and result:
Have you ever had an STD?	Y / N	If so, which?
Have you ever had a mammogram?	Y / N	Date of last mammogram:
Have you ever had an abnormal mammogram?	Y / N	
Have you ever had a breast biopsy?	Y / N	Results
Have you received the HPV vaccine?	Y / N	If yes, Gardasil or Cervarix? **(circle one)** All 3 Doses? Y / N
Have you ever had a colonoscopy?	Y / N	Date of last colonoscopy:
Have you ever had bone density testing?	Y / N	Date of last bone density:

Do you currently experience any of the following?

Irregular periods	Y / N	Pain with intercourse	Y / N
Heavy periods	Y / N	Decreased libido	Y / N
Bleeding between periods	Y / N	Breast lump	Y / N
Pelvic or abdominal pain	Y / N	Breast swelling	Y / N
Abnormal vaginal discharge	Y / N	Breast pain	Y / N
Sexual problems	Y / N	Nipple discharge	Y / N

OBSTETRIC HISTORY

How many times have you been pregnant? _____ Any twins or multiples? _____
How many times have you given birth? _____ How many miscarriages/ectopic? _____
How many living children do you have? _____ How many terminations/abortions? _____

Please provide details about your previous pregnancies:

Date of Delivery	How many weeks along?	How many hours did labor last?	Baby's weight	Male/ Female	Vaginal or C-section? Vacuum or forceps?	Epidural or none? Type of Anesthesia?	Complications of pregnancy or delivery?	Location

SOCIAL HISTORY

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Sexual Orientation: ❑ Heterosexual ❑ Gay/Lesbian ❑ Bisexual ❑ _____
Education _____ Are you employed? Y / N Occupation: _____
Do you diet? Y / N Do you exercise? Y / N Caffeine Intake:_____

History of physical/mental/sexual abuse	Y / N	
Have you ever smoked?	Y / N	
Do you smoke currently?	Y / N	If so, how often/how much?
Do you drink alcohol?	Y / N	If so, how much?
Do you use illegal drugs?	Y / N	If so, what type & how much?

MEDICAL HISTORY

Do you have any current illnesses? Y / N If yes, please list_____
_____
Do you have any medical problems such as Diabetes, high blood pressure, heart disease, thyroid disorder, cancer? Y / N
If yes, please list _____
Do you take any medications or over-the-counter medications (including vitamins)? If yes, please list _____
_____
Are you allergic to any medications or latex? Y / N If yes, please list medication and reaction _____
_____
Have you ever had surgery? Y / N If yes, please list surgery date & type_____
Have you had other hospitalizations? Y / N If yes, please list date & type of procedure_____

INFECTION HISTORY

Have you or your spouse/partner ever experienced any of the following:

	Self	Spouse/Partner		Self	Spouse/Partner
Chicken Pox	❑	❑	HIV/AIDS	❑	❑
Syphilis	❑	❑	Recent Gonorrhea or Chlamydia Infection	❑	❑
Rheumatic Fever	❑	❑	Tuberculosis Infection or +TB Skin Test	❑	❑
Genital Herpes	❑	❑	Exposure or Infection with Hepatitis B or C	❑	❑

REVIEW OF SYSTEMS

Do you experience any of the following symptoms on a regular basis?

- ❑ Fatigue
- ❑ Malaise
- ❑ Fever/Chills
- ❑ Night sweats
- ❑ Visual changes
- ❑ Chest pain
- ❑ Blood in stools
- ❑ Change in appearance of stools
- ❑ Loss of appetite
- ❑ Blood in urine
- ❑ Pain with urination
- ❑ Frequency/urgency with urination
- ❑ Leakage of urine
- ❑ Pain with intercourse
- ❑ Syncope
- ❑ Shortness of Breath on exertion
- ❑ Heart pounding
- ❑ Irregular heartbeat
- ❑ Cough
- ❑ Incomplete emptying after urinating
- ❑ Kidney stones
- ❑ Muscle weakness
- ❑ Joint pain
- ❑ Back pain
- ❑ Seizures
- ❑ New skin lesion/rash
- ❑ Hot flashes
- ❑ Thyroid problems
- ❑ Difficulty breathing
- ❑ Wheezing
- ❑ Diarrhea/constipation
- ❑ Leaking stool
- ❑ Nausea or vomiting
- ❑ Stomach pains
- ❑ Unintended weight gain/loss
- ❑ Bruising/bleeding easily
- ❑ Enlarged lymph nodes
- ❑ Headaches
- ❑ Vertigo/Lightheadedness
- ❑ Hallucinations
- ❑ Anxiety
- ❑ Depression
- ❑ Suicidal or homicidal thoughts

Please describe the symptoms you marked above: _____
_____

FAMILY HISTORY

Mother alive and well_____Father alive and well_____
Do you have any Brothers_____Sisters_____

Do you have a family history of any of the following? Please list the affected family member(s):

Diabetes	Y / N	Breast cancer	Y / N
High blood pressure	Y / N	Colon cancer	Y / N
High cholesterol	Y / N	Ovarian cancer	Y / N
Heart disease	Y / N	Endometrial (uterine) cancer	Y / N
Thyroid disorder	Y / N	Any other cancer	Y / N

Any other medical problems in the family? Please list _____

PREGNANT PATIENTS ONLY:

GENETIC HISTORY

Do you or your baby's biological father have any of the following in your family history?

Cystic Fibrosis	Y / N	Hemophilia	Y / N
Muscular Dystrophy	Y / N	Sickle Cell Disease/Trait	Y / N
Chromosomal Abnormalities	Y / N	Neural Tube Defects/Spina Bifida	Y / N
Congenital Heart Defects	Y / N	Fragile X	Y / N
Huntington's Disease	Y / N	Down Syndrome	Y / N
Thalassemia	Y / N	Mental Retardation	Y / N
Jewish Heritage	Y / N		

If yes to any of the above, please describe: _____

Any other family history of babies born with abnormalities?_____

Any of the following ethnic histories? Jewish/French Canadian/Creole/Cajun/Asian/Mediterranean

Virginia Physicians for Women
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact the Privacy Officer.
804-897-2100

Effective Date: April 14, 2003 Revised: 7/1/13

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice. We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: vpfw.com.

<u>Uses and Disclosures of Protected Health Information</u>

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time with another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance, to your physician, with your health care diagnosis or treatment.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be covered.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be covered. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice, which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
  - Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
  - Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
  - Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
  - Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
  - Correctional institutions: Information may be shared which is necessary for your health or the health and safety of other individuals if you are an inmate or under custody of law.
  - Workers' Compensation: Your protected health information may be disclosed by us, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies, collection agencies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing

Disclosures for any purposes which require the sale of your information All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. You may do this by providing a written request either by mail, fax or electronic methods (i.e. info@vpfw.com).

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket,in full for a service or product, unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct, along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree. This request should be in writing, addressed to the Privacy Officer. **You have the right to a list of people or organizations who have received your health information from us.**

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Privacy Officer
Fax: 804-897-9074
Mail: 10710 Midlothian Turnpike, Suite 200
Richmond, VA 23235

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 13, 2003

For Office use only
Patient Account Number

_____

virginia physicians
FOR WOMEN

Written Acknowledgement Form

Our Notice of Private Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may receive a revised copy.

I,_____(please print name) have been provided with a copy of Virginia Physicians for Women's Notice of Privacy Practices.

I have had the opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to Virginia Physicians for Women if I do not understand any information contained in the Notice of Privacy Practices.

Patient (or Guarantor) Signature_____ Date:_____

Guarantor's Relationship to Patient_____

Revised:Jan 2017

For Office use only
Patient Account Number

_____

virginia physicians
FOR WOMEN

E-PRESCRIBING PBM CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send a prescription directly to a pharmacy. Benefits data are maintained for health insurance companies by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims.

By signing this consent form you are agreeing that Virginia Physicians for Women can request and use your prescription medication history from other healthcare providers and/or third party Pharmacy Benefits Managers for treatment purposes.

Patient Name (printed) _____ Date of Birth ___ /___ /_____

Relationship (if other than patient)_____

Signature of patient (or Guarantor):

_____Date ____ /____ /_____

Revised: Jan. 2017

For Office use only
Patient Account Number

_____

virginia physicians FOR WOMEN

Disclosure to Family Members and Friends

It has been explained to me that information related to my health may be disclosed to my family and friends, or as needed for payment of health care services. I understand that Virginia Physicians for Women, Ltd. (VPFW) will only disclose information relevant to my current treatment. I agree that VPFW may disclose health information to the individuals listed below.

Patient Name:_____

Patient Signature:_____**Date:**_____

Name (first,middle,last)	**Relationship**	**This person may access my records:**
_____	_____	☐ Phone ☐ In Person w/Patient
_____	_____	☐ Phone ☐ In Person w/Patient
_____	_____	☐ Phone ☐ In Person w/Patient

****Please remember** it is your responsibility to keep this information current.**

Virginia State law allows parental access to a minor's health records.

Revised: Oct. 2016

****For Office use only****
Patient Account Number

Financial Policy

virginia physicians FOR WOMEN

Thank you for choosing Virginia Physicians for Women, LTD (VPFW) as your trusted medical provider. Please understand payment of non-covered services is due at the time of service. The Business Office will be happy to answer any questions regarding this financial policy at (804) 897-2100 option 4.

Insurance: Please bring your insurance card to each office visit. As a courtesy to you, we will file claims associated with participating insurance plans. You will receive separate bills from all providers of outside services, including laboratory, x-ray, pathology, anesthesia and the hospital. It is your responsibility to pay any deductibles, co-insurance and/or non-covered services associated with your specific insurance plan. Medicaid Plan First patients have limited benefits and will be required to make a deposit of $160 prior to services being rendered. You will receive a statement from our office indicating what your insurance has covered and the remaining patient account balance. All balances are payable upon receipt. **You are responsible for informing VPFW of changes in insurance coverage within 30 days from the date of service, or you may be responsible for any charges incurred due to delay in timely submission of your claims.**

Payment at Time of Services: You will be required to pay the estimated cost of services (including copays, additional procedures, and ultrasounds) at time of service. Financial arrangements must be made prior to services if you are unable to pay the balance in full. Self-pay patients are expected to pay their balance in full at the time of service. If the insurance payments and the amount of your payment exceed the amount owed for services, the difference will be refunded back to you.

Individualized Payment Plans: Surgical and prenatal patients will be required to make separate payment arrangements based on our OB and surgical policies prior to services being rendered. If you are a surgical or OB patient, VPFW will verify insurance coverage and prepare estimated costs of services as a courtesy to you.

Cancelled Appointments: If you are unable to keep your scheduled appointment, please contact our office at least 24 hours prior to the scheduled appointment time to reschedule. If you do not notify us prior to missing a scheduled appointment, you will be considered a "no-show" patient and a $25 charge will be added to your account. New appointments cannot be scheduled until this charge is paid in full.

Referrals: Your participating insurance carrier may require that you obtain a referral from your Primary Care Physician (PCP) prior to receiving services. Please bring that referral to your scheduled appointment. Any services received without a referral will be the responsibility of the patient.

Declined or Returned Payments: A $40 charge will be applied to your account for any checks rejected by the bank for any reason. **If a pre-arranged credit card payment plan is established and a payment declines, you may be charged $25 per declined transaction.** Please ensure that there are sufficient funds on the stored credit card to cover these payments prior to setting up payment arrangements and contact our office immediately with any changes regarding your stored card. Additional fees may be charged by your financial institution.

Patient Financial Responsibility Acknowledgement

I acknowledge full financial responsibility for services rendered by Virginia Physicians for Women, LTD (VPFW). I understand that I am responsible for any portion of the charges including co-pays, deductibles and co-insurance amounts. I understand that payment of co-pays, deductibles, co-insurance amounts and non-covered services are expected at the time of service, as well as any prior balance due that I may owe. Should this account become delinquent, I agree to pay all collection and court costs, including attorney's fees which are 31% of the total balance owed. All past due amounts may accrue interest at the rate of 1.5% per month, 18% per annum if balance is not paid within 60 days. **I understand the above financial agreement and my patient responsibilities. Should my insurance company not cover charges associated with my services at VPFW, I am aware that any non-covered charges will be my responsibility.**

Print Patient Name _____**Date**_____

Print Responsible Party Name _____**Responsible Party Date of Birth** _____

Signature of Patient or Responsible Party _____**Date**_____