Elite
Women's Health

Patient Registration Form

Name (Last, First, Middle)			SSN#
Date of Birth:	Age	Marital Status	Maiden Name
Address	City, State		Zip Code
Patient Home Phone	Patient Cell Phone		Patient E-mail
Patient Business Phone			Patient Occupation
Business Address	City, State		Zip Code
Primary Language	Ethnicity		

Spouse/Parent/Guardian Name (If under age 18):			Employer
Address	City, State		Zip Code
Business Phone	Alternative Phone		Relationship (Parent, Spouse, Guardian)
In case of Emergency:			Phone:
Do you have a living will? Y N	Who referred you to our practice?		

Primary Insurance Company:		Secondary Insurance:	
Address:		Address:	
City, State, Zip Code:		City, State, Zip Code:	
Phone:	Co-Pay:	Phone:	Co-Pay:
Insured Party ID#		Insured Party ID#	
Group ID#		Group ID#	
Name of Insured:		Name of Insured:	
Sex:	Date of Birth:	Sex:	Date of Birth:
SSN of Subscriber:		SSN of Subscriber:	
Relationship to Patient:		Relationship to Patient:	

****** Payment is due at time of service. ******

Assignment and Release; I, the undersigned certify that I (or my dependent) have insurance coverage as stated above and assign to Elite Women's Health, Inc., all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am fully responsible for all charges not paid by my insurance company. I hereby authorize this practice to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all submissions. I fully understand that any outside lab work performed will be billed by that lab, independently.

Patient's Signature:	Date:

Elite
Women's Health

ph **540-940-2000 |** *fx* **540-940-2001**
1101 Sam Perry Blvd., Ste. 401 | Fredericksburg, VA 22401

PATIENT CONSENT FOR USE / DISCLOSURE OF HEALTHCARE INFORMATION

Patient Name: _____

Date of Birth: _____

SSN: _____

Previous / Other Name(s): _____

I understand that the patient's health information is private and confidential. I understand that Elite Womens Health, Inc. works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Elite Womens Health, Inc. may use and disclose the patient's personal health information to help provide healthcare to the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosure of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission.

Elite Womens Health, Inc. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I will have a right to read the "Notice" before signing this agreement.

Elite Womens Health, Inc. may update this "Notice of Privacy Practices". If I ask, Elite Womens Health, Inc. will provide me with the most current "Notice of Privacy Practices."

Under the terms of this consent, I can ask Elite Womens Health, Inc. to limit how the patient's personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that Elite Womens Health, Inc. does not have to agree to my request. If Elite Womens Health, Inc. does agree to my request, I understand that Elite Womens Health, Inc. would follow the agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

1) Signing and dating a form that Elite Womens Health, Inc. can give me called "Revocation of consent for Use and Disclosure of Health Care Information", or

2) Writing, signing, and dating a letter to Elite Womens Health, Inc. If I write a letter, it must say that I want to revoke my consent to authorize and disclose the patient's personal health information for treatment, payment and health care operations.

If I revoke this consent, Elite Womens Health, Inc. does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of Elite Womens Health, Inc. "Notice of Privacy Practices". My signature means that I agree to allow Elite Womens Health, Inc. to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

Patient / Legally-Authorized Signature: _____

Date: _____

Relationship to patient if signed by anyone other than patient: _____

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New Patient Intake History

Patient Name: _____Date: _____

Reason for Visit: _____

Preventive Health History

Date of last Pap smear: _____ Results: _____

Any abnormal Pap smears? □ YES □ NO if yes, when _____and what type of follow up _____

Date of last Mammogram: _____ Results: _____

Date of last Bone Density: _____ Results: _____

Date of Last Colonoscopy: _____ Results: _____

Date of last Gardasil injection/HPV Vaccination (if applicable) _____

I have had (circle one) 0 of 3 1 of 3 2 of 3 3 of 3 injections.

General Medical History:

Please list any major medical conditions for which you have been diagnosed:

_____ _____

_____ _____

_____ _____

Surgical History:

Date	Operation

Preferred Pharmacy: _____

Medications: (Please include all hormones, vitamins, herbs, and nonprescription medications)

Drug Name	Dose

Allergies: (Such as medications, foods and environmental, i.e. pollen, mold, ragweed, etc.)

Drug/Allergen Name	Reaction

Family History:

Family Member (Relation)	Medical Conditions	Living/Deceased
Mother		
Father		
Brothers		
Sisters		
Other:		

Gynecologic History:

First day of your ***LAST*** menstrual period _____/_____/_____

How often do you have periods? (I.e. every 28 days) _____ Are they regular? □ YES □ NO

Explain: _____

Approximate number of bleeding days during your period _____.

With your cycle, do you experience: □ Cramps □ Heavy Bleeding □ Mood Swings □ Spotting

Present method of birth control: □ Condoms □ Withdrawal □ Rhythm Method □ Birth Control Pills

□ NuvaRing □ Patch □ Skyla IUD □ Mirena IUD □ Paragard IUD □ Nexplanon □ Liletta

□ Tubal Ligation □ Vasectomy □ None

Are you happy with this method? □ YES □ NO □ Would Like to Discuss

If menopausal, have you ever used hormone replacement therapy? □ YES □ NO
If yes, are you still on therapy? _____

Have you ever had a sexually transmitted disease? □ YES □ NO
If yes, what types? _____

Do you have a history of blood clots (DVT, PE)? □ YES □ NO

Pregnancy History:

_____	_____	_____	_____	_____	_____	_____	_____
Total # Pregnancies	# Full Term	# Preterm	# Elective Abortions	# Miscarriages	# Ectopics	# Multiples	# Living

Birth Date Mo/Day/Yr	# Weeks	Birth Weight	Sex M/F	Type of Delivery	Preterm Labor?	Complications?	Location

Social History:

Relationship Status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed

□ Sexually Active □ Not Currently Active □ Never Active

□ Heterosexual □ Homosexual □ Bisexual

Current or most recent job/occupation: _____

Tobacco Use: □ Never Used Tobacco

□ Past Use: packs/day _____ Year Started _____ Year Stopped _____

□ Current Use: packs/day _____ Year Started _____

Illicit Drug Use: □ YES □ NO If yes, type: _____

Past History of Use: _____

History of Domestic Violence: □ YES □ NO _____

Do you feel safe at home now? □ YES □ NO

Alcohol Consumption: □ Beer □ Wine □ Liquor: drinks/week _____ or drinks/month _____

Exercise: □ YES Sessions/week _____

□ NO

Financial Policies

This is an agreement between Elite Women's Health and the responsible party:

LATE PATIENT POLICY If you are established patient and you arrive late to your appointment you may be asked to reschedule unless the physician's schedule can accommodate you. Priority will be given to the patient's who arrive on time. One or two late patients cause the entire schedule to fall behind and this is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible.

Likewise if you are a new patient and you arrive at the scheduled appointment time and not early as instructed, you may also be asked to reschedule. It takes more than fifteen minutes to complete the forms and the registration process.

The same terms will apply if you arrive late to an ultrasound appointment.

MISSED APPOINTMENT OR "NO-SHOW" POLICY While we make every effort to provide a reminder notifcation at least twenty-four hours before your appointment, it is your responsibility to remember your appointment. We charge a $25 fee to patients who do not keep their scheduled apointment time. All fees must be paid before a new appointment can be scheduled. After three missed apointments, the practice may at its discretion choose to discontinue your care.

Fee for completion of forms, reports, and letters: This is a non-insurance covered service; therefore, a fee of $25.00 is charged for the completion of forms or the writing of letters. All fees are due at the time the form is delivered.

Transferring of Records: All adult patients must sign a record release form if copies of your records are to be sent to another doctor or organization. A medical records copy fee may be assessed for all non-physician requests and is due at the time the records are delivered.

Payment options if you do not have proof of insurance: You are responsible for payment by cash, check or credit card on the day of service.

Monthly Statement: If you have a balance on your account exceeding $5.00, we will send you a monthly statement showing charges to the account: Unless other arrangements are approved in advance, the balance, late fee if any, are due upon receipt. If your account becomes past due, Elite Women's Health will take all necessary steps to collect this debt. If we have to refer your account to a collection agency or lawyer, you agree to pay all collection, lawyer and court fees that are incurred.

Returned Checks: There is a $25.00 fee for any checks returned by the bank.

Elite Women's Health files your insurance as a courtesy. We ask that if the account remains unpaid after 45 days that you contact your insurance company for payment.

In consideration for the professional services rendered now and in the future, the undersigned hereby agrees to pay 2% per month on all balances which are unpaid sixty (60) days after the services are rendered: plus attorney's fees which are hereby stipulated to be 33 1/3% of such outstanding balance whether suit is filed or not: plus court costs. If the undersigned fails to promptly pay for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information of the undersigned and further agrees to pay all costs of obtaining such credit information and/or locating the undersigned, as may be necessary.

The undersigned understands that medical insurance claims may be billed by the provider, as a courtesy, if the provider participates in the patient's insurance plan; and if the patient promptly furnishes the provider with all the correct insurance information. The undersigned is fully responsible for all sums due whether or not insurance coverage is available.

In the absence of prompt payment: the undersign understands that medical, personal and financial records concerning the professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with the federal "Health Insurance Portability and Accountability Act:"

I, the undersigned, certify that I ( ) am an active duty member of the US Armed Forces.

( ) am not an active duty member of the US Armed Forces.

_____ _____

Date Responsible Party