Existing Patient Registration

PLEASE PRINT	Emergency Contact Information
Last Name:	Name:
First Name:	Phone:
Middle Name:	Other:
Sex: DOB:	Patient Referred by:
Social Security Number:	Primary Care Physician (PCP):
Address:	PCP Phone Number:
Zip:	**Pharmacy**
City: St:	Name:
Home Phone:	Phone Number:
Work Phone:	Address:
Mobile Phone:	**Imaging Facility**
Marital Status:	Name:
Email:	Phone Number:
	Address:

Primary Insurance	Secondary Insurance
Insurance Plan Name:	Insurance Plan Name:
Insurance Phone Number:	Insurance Phone Number:
Policy Information	**Policy Information**
Relationship to Patient:	Relationship to Patient:
Policy Holder DOB:	Policy Holder DOB:
ID/Certification No.:	ID/Certification No.:
Policy/Group No.	Policy/Group No.:

Cancellation Policies: (PLEASE INITIAL NEXT TO EACH LINE)

_____ There is a $50 No Show Fee per visit (Office visits and ultrasounds) if 24-hour notice is not given.

_____ There is a $200 Cancellation Fee for surgeries once procedure is booked.

_____ There is a $50 CASH fee for any forms/documents that need to be completed by a provider.

TO CANCEL AN APPOINTMENT THIS CAN BE DONE THROUGH OUR AUTOMATED SYSTEM, OFFICE CALL, PATIENT PORTAL, OR IF AFTER HOURS CALL THROUGH OUR SERVICE

ASSISGNMENT AND RELEASE:

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non-covered services.
- I authorize the physician to release any information required to process this claim.

Signature: ________________________________ **Date:** ____________________

Clinical Update Form

Today's Date:______________

Name:__________________________________ Date of birth:___________________________

Reason for today's visit: ____

Date of last pap smear: ___________________ Date of last bone density scan:_________________

Date of last mammogram: _______________ Location of mammogram:______________________

Date or year of last Colonoscopy or Cologuard: ____

Date of last menstrual cycle: ____________________Birth control method: ____________________

Do you have any new medication allergies: ____

Are there any new medical problems that you have been diagnosed with since your last visit? No_____ Yes, specify: ____

____

Have you had any surgeries since your last visit? No______ Yes, specify______________________

____

Please list all the medications that you currently take (please provide your medication list if medications cannot be listed): ____

____

Are there any medications that you need refilled today? No______Yes, specify_______________

____

Are there any concerns that you have and would like to address with the doctor?

No____ Yes, specify____

____

Would you like STD (chlamydia/Gonorrhea) testing added to your pap smear? Yes or NO (THESE TEST ARE NOT COVERED BY MEDICARE INSURANCE)

Consent for Pelvic Examination

According to The American College of Obstetricians and Gynecologists, the pelvic examination is part of the evaluation of women presenting with many common conditions, including pelvic pain, abnormal bleeding, vaginal discharge, and sexual problems. Pelvic exams—both in the office and while under anesthesia— are also an important part of evaluation for gynecologic procedures to ensure safe completion of the planned procedure. Often, a pelvic examination is performed for women without symptoms while looking for gynecologic cancer, infection, and pelvic inflammatory disease.

A pelvic examination is an assessment of the external genitalia; internal speculum examination of the vagina and cervix; bimanual palpation of the adnexa, uterus, and bladder; and sometimes rectovaginal examination.

Reasons for a pelvic exam can include (but are not limited to) health screening, abnormal bleeding, pelvic pain, sexual problems, vaginal bulge, urinary issues, or inability to insert a tampon. Other indications include patients undergoing a pelvic procedure (e.g., endometrial biopsy or intrauterine device placement). Also, pelvic examination is indicated in women with current or a history of abnormal pap results, gynecologic cancers, or toxic exposures.

The potential benefits of a pelvic examination include the detection of vulvar, vaginal, cervical, uterine and ovarian cancers and precancers, yeast and bacterial vaginosis, trichomoniasis, and genital herpes, early detection of treatable gynecologic conditions before symptoms begin occurring (e.g. vulvar or vaginal cancer), as well as incidental findings such as dermatologic changes and foreign bodies. Additionally, screening pelvic examinations in the context of a well woman visit may allow gynecologists to explain a patient's anatomy, reassure her of normalcy, and answer your specific questions.
The potential risks of a pelvic exam may include (but are not limited to) fear, anxiety, embarrassment (reports ranged from 10% to 80% of women) or pain and discomfort (from 11% to 60%).
There are few alternatives to pelvic examination, the alternatives are not as effective for providing diagnostic or evaluative information and carry their own set of potential risks. If you have concerns, you should discuss with your healthcare provider.

I _________________________ understand that this Patient Consent Form is required by law. I understand that I need to sign this form to show that I am making an informed decision to have pelvic examinations and I have read and understand the above and that I am providing both written and verbal consent and that in obstetrical situations multiple pelvic exams may be necessary during the course of care and I hereby provide consent.
I understand that my provider may be involved in educating tomorrow's medical professionals and that familiarizing students with the female anatomy and instilling a physician workforce with confidence in pelvic examination skills is essential. I also consent to pelvic examination by the medical professional student under the supervision of my medical provider and I may verbally withdraw such consent at any time.

The provider or their delegate has explained to me the nature, purpose, and possible consequences of each procedure as well as risks involved, possible complications, and possible alternative methods of treatment. I also know that the information given to me does not list every possible risk and that other, less likely problems could occur. I was not given any guarantee from anyone about the final results of this procedure.

_____________________________ ___/___/_______
Signature Date

HIPAA RELEASE FORM

Patient Name: ______________________________ DOB: ________________

THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.

{If any information changes (i.e. phone number, whom information can be released to, etc.) it is MY responsibility to notify Seasons Women's Care immediately and to update my HIPAA release form.}

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

NAME	RELATIONSHIP TO PATIENT
______________________________	______________________
______________________________	______________________
______________________________	______________________

☐ Information is not to be released to anyone.

***PRIOR TO OBTAINING INFORMATION A SECURITY PHRASE/PASSWORD MUST BE VERIFIED* SECURITY PHRASE/PASSWORD:**

____

MESSAGES

PLEASE CALL: ☐My Home ☐ My Work ☐ My Cellphone

IF UNABLE TO REACH ME:

☐ You may leave a detailed message

☐ Please leave a message **ONLY** asking me to return your call

The best time to reach me is (day) _______________ between (time) ____: ____ - ____: ____

____ ____________________

Patient's Signature (or Personal Representative) Date

____ ____________________

Relationship to Patient Date

____ ____________________

Witness Date