Seasons
WOMEN'S CARE

NEW PATIENT REGISTRATION FORM

DOB: _____

LAST NAME: _____ FIRST NAME: _____ M.I. _____

ADDRESS: _____ _____ APT#: _____

CITY: _____ STATE: _____ ZIP: _____

MOBILE PHONE: _____ HOME PHONE: _____

EMAIL: _____ RACE OR ETHNICITY: _____

SS#: _____ DRIVERS LIC #: _____

EMPLOYER: _____ WORK PHONE: _____

MARITAL STATUS: _____ SPOUSE EMPLOYER: _____

SPOUSE NAME: _____ SPOUSE PHONE: _____

EMERGENCY CONTACTS:

NAME: _____ PHONE: _____

RELATIONSHIP TO PATIENT: _____

NAME: _____ PHONE: _____

RELATIONSHIP TO PATIENT: _____

INSURANCE INFORMATION:

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____

PRIMARY INSURANCE: _____ PLAN ID: _____

GROUP #: _____ PHONE NUMBER: _____

SECONDARY INSURANCE: _____ PLAN ID: _____

GROUP #: _____ PHONE NUMBER: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

PHARMACY NAME: _____ PHONE: _____

IMAGING FACILITY: _____ PHONE: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE: _____

ASSIGNMENT OF BENEFITS/RIGHT TO PAYMENT AUTHORIZATION, PATIENT RESPONSBILITY & RELEASE OF INFORMATION

I, the undersigned, assign to the provider/entity referenced above ("Provider"), my rights and benefits in any medical insurance plan, health benefit plan, or other source of payment for healthcare services (each a "Plan") in connection with medical services provided by Provider, its employees, and agents. I understand that this document is a direct assignment of my rights and benefits under my Plan. I authorize my insurance company to pay Provider directly for the professional or medical expense benefits payable to me. If my current policy prohibits direct payment to Provider, I instruct my insurance company to make out the check to me and mail it directly to the address of lockbox referenced above for the professional or medical expense benefits payable to me under my Plan as payment towards the total charges for the services rendered. In addition, I agree and understand that any funds I receive from my insurance company due for services rendered by the Provider are owed to Provider and I agree to remit those funds directly to Provider. I am aware that there is a $50 no show fee for missed appointments. I am also aware that should I need any disability paperwork filled out by my doctor, there is a $50 cash fee charge for this.

Patient Responsibility

I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my Plan or for which I am responsible for payment under my Plan. To the extent no coverage exists under my Plan, I acknowledge that I am responsible for all charges for services provided and agree to pay all charges not covered by my Plan.

Release of Information

I authorize Provider and/or its agents to release any medical or other information about me in its possession to my Plan, the Social Security Administration, any state administrative agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by Provider.

Medicaid Acknowledgement

I acknowledge that Seasons Women's Care does not participate as a Medicaid provider. If I have Medicaid as a secondary insurance, I understand that I may receive a bill for services rendered by Seasons Women's Care if these services are not covered by my primary insurance.

A photocopy of this Assignment/Authorization shall be considered as effective and valid as the original.

_____ _____

Signature Name of Patient/Person Legally Responsible **Date**

_____ _____

Print Name of Patient/Person Legally Responsible **Date**

_____ _____

Relationship to Patient **Date**

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WOMEN'S CARE

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

Seasons
WOMEN'S CARE

Notice of Privacy Practices/HIPAA Acknowledgement

It is the policy of our practice that all physicians and staff preserve the integrity and confidentiality of Protected Health Information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI.

I acknowledge that I understand my right as a patient of this practice concerning my Protected Health Information (PHI). I am aware Seasons Women's Care reserves the right to change the privacy practices that are described in this Notice of Privacy Practices. I may obtain revised notice of Privacy Practices by contacting the office and requesting a revised copy be sent in the mail or asking for one at the time of my appointment.

_____ _____
Print Name of Patient or Personal Representative Date

_____ _____
Signature of Patient or Personal Representative Date

Blood Transfusion Information

In rare emergency situations, blood may need to be administered in the course of obstetrical or surgical treatment.

Is blood transfusion acceptable in an emergency? Yes/ No _____*If no, please explain: _____

*Please be aware that in the event of an emergency, our doctors will give a blood transfusion if deemed necessary in order to save your life and the life of your baby regardless of religious preferences.

_____ _____
Signature of Patient or Personal Representative Date

PERSONAL MEDICAL HISTORY

Name: Date of Birth: Place of Birth:

Reason for your visit: Did someone refer you? If so, who?

Please list all prescription medications you are currently taking:

Please list all vitamins and supplements you are taking:

ALLERGIES (To medication or food) □ No known Allergies

LAST PREVENTATIVE and SCREENING EXAMS

Pap Smear	□ no □ yes	When?	Where?	Result?
Mammogram	□ no □ yes	When?	Where?	Result?
Bone density/DXA	□ no □ yes	When?	Where?	Result?
Colonoscopy	□ no □ yes	When?	Where?	Result?

SURGICAL HISTORY (list all surgeries)

MENSTRUAL HISTORY □ N/A

First day of last period: Age at your first period: # of days you bled:

Flow: □ heavy □ medium □ light Problems with period? □ no □ yes Explain:

What do you use for birth control (including Vasectomy):

MENOPAUSAL □ N/A □ yes □ no

Age you stopped having periods: Problems or concerns? □ no □ yes:

Taking hormone therapy or other remedies? □ no □ yes – Please list:

SOCIAL HISTORY

Do You Smoke: □ yes □ no How Much? _____ Alcohol intake: □ None □ Occasional □ Moderate □ Heavy

Illegal Drugs: □ yes □ no

Diet: □ Regular □ Vegetarian □ Other Specify: _____ Caffeine: □ None □ Occasional □ Moderate □ Heavy

Exercise: □ None □ Occasional □ Moderate □ Heavy

Sexual orientation □ Heterosexual □ Homosexual □ Bisexual Are You: □ Married □ Single □ Separated □ Divorced □ Widowed

Sexually Active? □ yes □ no **In your life time how many Sexual partners:** □ >5 or □ <5

History of Sexually Transmitted infection □ yes □ no Type? _____

History of Domestic Violence □ yes □ no Sexual assault □ yes □ no

Highest level of education □ 8 □ 9 □ 10 □ 11 □ 12 □ 2yr college □ 4yr college □ Post Graduate Occupation _____

Do you wear your seat belts routinely? □ yes □ no Do you accept Blood Transfusion? □ yes □ no

GYN HISTORY

History of: Infertility	□ yes □ no	Endometriosis	□ yes □ no	Uterine Fibroids	□ yes □ no
Ovarian problems	□ yes □ no	Abnormal Pap?	□ yes □ no	PCOS	□ yes □ no
History of LEEP or Cryo?	□ yes □ no	Abnormal Mammogram?	□ yes □ no		

List All Pregnancies (including miscarriages and/or abortions):

D.O.B.	SEX	Vaginal or C-Section	Full Term or Pre-Term	Complications

Personal History Continued

Name: _____

Circle all that apply

Cancer-Breast / BRCA Tested	GI-Vitamin Deficiency	Ortho-Chronic Back Pain
Cancer-Type:	GI-Colon Polyps/Hemorrhoids	Ortho-Fractures
Cardiac-Stent, Pace Maker, MVP*	GI-Crohn's/Ulcerative Colitis	Ortho-Other
Cardiac-Heart Arrhythmia	GI-Gallbladder Disease	Psych-Eating Disorder/PMS/PMDD
Cardiac-Heart Disease *	GI- Other	Psych-Anxiety/ Depression/ADD/Bipolar
Cardiac-High Blood Pressure	Hematology-Blood Clotting Disorder/Factor V Leiden	Psych-Other
Cardiac-High Cholesterol	Hematology- Bleeding Disorder/Anemia	Pulmonary- Asthma
Cardiac Other:	Hematology-Blood Transfusion	Pulmonary-Seasonal Allergies/Allergic Rhinitis
Dermatology- Acne/Eczema/Psoriasis	Hematology-DVT/Pulmonary Embolism	Pulmonary-Sleep Apnea
Dermatology- Other	Hematology- Other	Pulmonary- Other
ENT- Hearing Loss	ID-Tuberculosis/Positive PPD	Rheumatology-Autoimmune Disease
ENT-Other	ID-Chicken Pox/Shingles/Rheumatic Fever	Rheumatology-Fibromyalgia/Chronic Pain
Endocrinology-Thyroid Problems Ex lain:	ID-HIV	Rheumatology- Arthritis
Endocrinology-Diabetes/History of Gestational Diabetes	ID-MRSA	Rheumatology-Restless Leg Syndrome
Endocrinology-Elevated Prolactin	ID-Other	Rheumatology- Other
Endocrinology-Osteopenia , Osteoporosis	Neurology-Headaches/Migraines	Urology-Hematuria (Blood in Urine)
Endocrinology-Other	Neurology- Neuropathy	Urology-Interstitial Cystitis
Eyes-Cataracts ,Glaucoma	Neurology-Seizures/Epilepsy/Stroke/TIA	Urology-Kidney Disease
Eyes- Vision Loss/Macular Degeneration	Neurology- Other	Urology-Kidney Infection
Eyes- Other	Ortho-Degenerative Joint Disease	Urology-Frequent Urinary Tract Infections
GI-Liver Disease/Hepatitis	Orthopedic- Artificial Joint*	Urology- Other
GI- Irritable Bowel Syndrome	Ortho-Chronic Back Pain	
GI-Reflux/Stomach Ulcers	Ortho-Fractures	

Anything you would like to add? _____

_____

_____

_____

Family History of Illness (Cancer, Diabetes, etc.):

Mother: Alive/Well Deceased and/or illness: _____

Father: Alive/Well Deceased and/or illness: _____

Brother: Alive/Well Deceased and/or illness: _____

Sister: Alive/Well Deceased and/or illness: _____

Patient 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