SHEA WOMEN'S CARE
PATIENT REGISTRATION FORM

Provider Selection: Andrew Carter MD Sara Giali DO
Wendy Bennetch Jones MSN,WHNP-BC

Please fill out this form COMPLETELY.

Name:(Last)		(First)		(MI)
Address:		(City, State, Zip)		
Date of Birth:	SSN:	Marital Status:	Sex: Female	Student: Full / Part

**** ***Primary Contact Number for appointment confirmation:*** _____ ****

□**Home Phone #:** Leave Message: Yes/No	□**Cell Phone #:** Leave Message: Yes/No	□**Work Phone #:** Leave Message: Yes/No

Employer:		Employed: Full / Part / Retired / None
Employer Address:		
Patient's E-mail address:		
Spouses Name:	Date of Birth:	SSN:
Emergency Contact:	Relationship:	Phone #:
Pharmacy Name/Phone Number/Location:		

RESPONSIBLE PARTY: *(If someone other than the patient is financially responsible, i.e. Patient is a minor.)*

Name:		Relationship:
Address:		
SS#:	Home Phone:	Work Phone:

INSURANCE INFORMATION (COPIES OF INSURANCE CARDS REQUIRED)

Primary Insurance:	I.D. #:	Group #	Effective Date:
Name of Subscriber:	Subscriber's Date of Birth:		Relationship to Patient:
Subscriber's Home Address: (if different from patient's)			Phone #:
Subscriber Employed by:			Phone #:
Secondary Insurance:	I.D. #:	Group #:	Effective Date:
Name of Subscriber:	Subscriber's Date of Birth:		Relationship to Patient:
Subscriber's Home Address: (if different from patient's)			Phone #:
Subscriber Employed by:			Phone #:

RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS DECLARATION / INFORMATION VERIFICATION

I or my representative, recognizing the need for care, consent to all and any services as ordered by my physician, including, but not limited to, laboratory tests, medical or surgical treatment, examination, and other services rendered under specific instructions of my physician. I authorize and request that payments under my medical insurance programs be made directly to the above provider for any services furnished to me. I also authorize the provider to release any information needed for payment of claims. I further permit copies of this authorization to be used in place of the original.

Signature: _____ Date: _____

SHEA WOMEN'S CARE
FINANCIAL POLICY

YOU ARE RESPONSIBLE FOR KNOWING YOUR INSURANCE POLICY!

Authorizations - If your insurance requires a referral/authorization from your primary care physician (PCP) for ANY service, **it is your responsibility to obtain this prior to your visit.** If you do not have the necessary authorization you will be responsible for payment in full prior to any treatment.

Cash Patients – Payment for services are due at the time services are rendered. We do offer a 25% prompt pay discount at the time of service for GYN visits or treatments. Self-pay OB patients who cannot pay in full may contact our billing department for special contract information.

Insured Patients – All Co-pays, co-insurance amounts and deductible amounts are due at the time services are rendered. You will be required to provide your most current insurance card and information at the time of your appointment. Check with your insurance regarding your benefits prior to scheduling any appointments.

Returned Checks – Checks returned are subject to a $25 fee.

Statements / Payment Arrangements – As a courtesy, we file your claims for you. We will supply information as necessary however, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, disputes involving deductibles, co-payments, any non-covered charges, usual and customary charges or COBRA issues. If your insurance company has not paid the balance in full, you will receive a statement notifying you of the amount due. All patient responsibility balances are due in full within 30 days from receipt of your statement. Your account is delinquent after 31 days. You may call our billing office to request payment arrangements for any balances over $100. However, we will not do long term payment arrangements.

Collections – In the event that a delinquent account is placed with an outside agency for collections, the responsible party hereby agrees to pay all costs associated with placement including, but not limited to, a 35% collection preparation and transfer fee.

Missed Appointment (No-Shows), Late - While we make every effort to provide a reminder call at least 24 hours before your appointment, **it is your responsibility to remember your appointment**. We charge a $35 missed appointment fee to patients who do not keep their scheduled appointment time or who cancel less than 24 hours in advance. A second missed appointment will result in a $50. After three (3) missed appointments, the practice may at its discretion choose to discontinue your care. Any missed appointment fees must be paid before a new appointment can be scheduled. **As a courtesy to patients who are on time, if you are more that 15 minutes late for your appointment you may be required to reschedule.**

Remember, payment is always ultimately patient responsibility. Your insurance policy is a contract between you and your insurance company. Again, **you are ultimately responsible for the timely payment of your account** If your insurance has not paid within 30 days, you may be held responsible for charges.

By my signature below, I acknowledge that I have read and understand each item above and agree to and accept, Shea Women's Care's financial policies.

We accept VISA, MasterCard, Discover, cash, check or cashier check for your convenience.
**********WE DO NOT ACCEPT AMERICAN EXPRESS***********

Signature of patient or responsible party _____ Date _____

SHEA WOMEN'S CARE SECURE EMAIL CONSENT FORM

Printed Name_____

Patient DOB_____

Patient e-mail address_____

1. RISK OF USING E-MAIL

Provider offers patients the opportunity to communicate by secure e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:
a. E-mail can be circulated, forwarded, and stored in numerous paper an electronic files.
b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
c. E-mail senders can easily misaddress an email.
d. E-mail is easier to falsify than handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h. E-mail can be used to introduce viruses into computer systems.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:
a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c. Although Provider will endeavor to read and respond promptly to an e-mail from the patient, Provider cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time sensitive matters.
d. If the patient's e-mail requires or invites a response from Provider, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
e. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
f. The patient is responsible for informing Provider of any types of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above.
g. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
h. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
i. It is the patient's responsibility to follow up and/or schedule an appointment by phone if warranted.

3. INSTRUCTIONS

To communicate by e-mail, the patient shall:
a. Limit or avoid use of his/her employer's computer.
b. Inform Provider of changes in his/her email address.
c. Put the patient's name in the body of the e-mail.
d. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question).
e. Review the e-mail to make sure it is clear and that all relevant information if provided before sending to Provider.
f. Inform Provider that the patient received an e-mail from Provider.
g. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
h. Withdraw consent only by e-mail or written communication to Provider.

4. PATIENT ACKNOWLEDGEMENT AND AGREEMENT
ALL APPOINTMENTS WILL BE MADE BY PHONE
I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Provider and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient signature_____

Date_____

shea
WOMEN'S CARE
OBSTETRICS AND GYNECOLOGY
HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____/_____/_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

_____ _____

Please ***print*** your name Please ***sign*** your name

_____ _____

Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Last Name Only ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete health record
_____ Physical exams only
_____ Immunization record
_____ Other (please specify): _____
_____ Lab results/X-ray reports
_____ Consultation reports
_____ Billing/Statement balances and details

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the practice.

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ Any of the Above

I AUTHORIZE **INFORMATION ABOUT MY HEALTH OR TREATMENT** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ Any of the Above

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, or NEW HEALTH INFO** (i.e. flu shot clinics, new patient services) for Shea Women's Care via:

☐ Phone Message ☐ Email ☐ Any of the Above ☐ None of the above (opt out)

All authorizations above will remain in effect until revoked in writing by the patient.
Thank you for helping us comply with the newest healthcare laws! If ever you have any questions or concerns, please let us know!

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____ _____
Signature of Privacy Officer Date

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shea
WOMEN'S CARE

OB/GYN HISTORY FORM

Name	Date of Birth	Age	Date
With whom may we discuss test results or therapies?			

Past Obstetrical History – deliveries, miscarriages, ectopics, and abortions.

Date (Mo./Yr.)	1	2	3	4	5	6
Birth Weight Name						
Type of delivery (Vaginal/C-sect.)						
Complications						

Past Gynecologic History

Last Pap	Sexually Active ☐ Yes ☐ No Lifetime sexual partners (#)
Last Mammogram	Your partner is ☐ Male ☐ Female ☐ Both
Age of 1st period	Birth Control Method Are you done having children? YES / NO
Last menstrual period	Age at Menopause
Length of periods (days)	Bone Density ☐ Yes – when ☐ No
Cramps? Mild / Mod / Severe / None	Osteopenia ☐ Yes ☐ No Osteoporosis ☐ Yes No
Number of days between periods	Last Colonoscopy

Please check if you have or previously had the following	Comments
☐ Abnormal Vaginal Bleeding	
☐ Vaginal Bleeding After Intercourse	
☐ Vaginal Bleeding After Menopause	
☐ History of Abnormal Paps	☐ When ☐ Diagnosis ☐ Treatment
☐ History of Infertility	
☐ Uterine Fibroids	
☐ Endometriosis	
☐ Ovarian Cyst	
☐ Incontinence	
☐ Prolapse Bladder / Rectum / Uterus	
☐ Infections	☐ Yeast ☐ Bacterial Vaginosis ☐ PID
☐ Sexually Transmitted Disease	☐ Herpes ☐ Gonorrhea ☐ Chlamydia ☐ Genital Warts/HPV ☐ Syphilis ☐ HIV ☐ Trichomonas
☐ Cancer	☐ Breast ☐ Uterine ☐ Ovarian ☐ Vulvar ☐ Colon ☐ Thyroid ☐ Skin ☐ Other

Allergies – List Reaction	Medications & Dosage – Include Vitamins / Herbs

CONTINUE ON BACK SIDE

Reviewed by (Signature of Provider) _____ Date _____

Past Medical History – Do you have any of the following:

Diabetes Comments	☐ Yes ☐ No	Kidney Disease/UTI Comments	☐ Yes ☐ No	Blood Clots Leg/Lung Comments	☐ Yes ☐ No
High Blood Pressure Comments	☐ Yes ☐ No	Stroke Comments	☐ Yes ☐ No	Neurologic/Epilepsy Comments	☐ Yes ☐ No
Heart Attack/Disease Comments	☐ Yes ☐ No	Thyroid Dysfunction Comments	☐ Yes ☐ No	Gastrointestinal Comments	☐ Yes ☐ No
Rheumatic Fever Comments	☐ Yes ☐ No	Tuberculosis Comments	☐ Yes ☐ No	Hepatitis/Liver Disease Comments	☐ Yes ☐ No
Mitral Valve Prolapse Comments	☐ Yes ☐ No	Asthma Comments	☐ Yes ☐ No	Gallbladder Comments	☐ Yes ☐ No
Psychiatric Comments	☐ Yes ☐ No	Anesthesia Complications Comments	☐ Yes ☐ No	Other Comments	☐ Yes ☐ No

Immunization History

Have you had a flu vaccine?	☐ Yes ☐ No	If yes, when?	
Have you been vaccinated against Hepatitis B?	☐ Yes ☐ No	If yes, when?	
Have you received Gardasil vaccine?	☐ Yes ☐ No	If yes, when?	
Have you been vaccinated against Pneumonia?	☐ Yes ☐ No	If yes, when?	
Have you been vaccinated against Tetanus?	☐ Yes ☐ No	If yes, when?	
Have you had chicken pox?	☐ Yes ☐ No	If no, have you been vaccinated?	☐ Yes ☐ No
Have you had Rubella (German Measles)?	☐ Yes ☐ No	If no, have you been vaccinated?	☐ Yes ☐ No
Have you had a PPD (Tuberculosis) skin test?	☐ Yes ☐ No	If yes, ☐ positive or ☐ negative	

Surgeries or Hospitalizations (Reason & Year)		
1	5	9
2	6	10
3	7	11
4	8	12

Family History – Does your family have any of the following:

Breast Cancer Which relative:	☐ Yes ☐ No	Other Cancers Which relative:	☐ Yes ☐ No
Ovarian Cancer Which relative:	☐ Yes ☐ No	Birth Defects/Hereditary Disorders Which relative:	☐ Yes ☐ No
Uterine Cancer Which relative:	☐ Yes ☐ No	High Blood Pressure Which relative:	☐ Yes ☐ No
Colon Cancer Which relative:	☐ Yes ☐ No	Heart Disease Which relative:	☐ Yes ☐ No
Osteoporosis Which relative:	☐ Yes ☐ No	Diabetes Which relative:	☐ Yes ☐ No
Gynecological Problems Which relative:	☐ Yes ☐ No	Psychiatric Disorder Which relative:	☐ Yes ☐ No

Social History

Occupation	Marital Status ☐ Widowed ☐ Single ☐ Married ☐ Divorced	Social Drug Use ☐ Yes ☐ No Type: Amount: How Often:
Cigarettes ☐ Yes ☐ No For how long:	Pack/Day: Quit date:	Abuse/Domestic Violence ☐ Yes ☐ No Past or Present Relationship
Alcohol ☐ Yes ☐ No Amount:	Type: How often:	Advance Directives ☐ Yes ☐ No If yes, please bring copy for your chart. ☐ Yes ☐ No

Review of Systems (Check all that apply) – Negative except where noted below:

Constitutional ☐ Weight Loss ☐ Fever ☐ Fatigue ☐ Other	Genitourinary ☐ Burning with urination ☐ Blood in urine ☐ Voids/night ☐ Urinary frequency/urgency ☐ Caffeine/day ☐ Other
Neck ☐ Pain ☐ Difficulty swallowing ☐ Lumps ☐ Other	Skin/Breast ☐ Rash ☐ Lumps in breast ☐ Nipple discharge ☐ Pain in breast ☐ Other
Cardiovascular ☐ Palpitations (Rapid heart rate) ☐ Irregular heart beat ☐ Chest pain ☐ Shortness of breath ☐ Other	Neurological ☐ Frequent Headaches ☐ Dizziness ☐ Weakness ☐ Numbness/Tingling where? ☐ Other
Abdomen ☐ Pain ☐ Bloating ☐ Blood in stool ☐ Constipation ☐ Diarrhea ☐ Poor appetite ☐ Other	Psychiatric ☐ Insomnia ☐ Depression ☐ Anxiety ☐ Moodiness ☐ Other
Respiratory ☐ Cough ☐ Pain with breathing ☐ Shortness of breath ☐ Other	Lymphatic ☐ Lumps in groin, under arms, or in neck ☐ Other