

PATIENT REGISTRATION INFORMATION

Today's Date: _____

MRN # _____

PATIENT INFORMATION: (Please use full legal name)

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

DOB: _____ Social Security #: _____

Marital Status (circle one): Single/Separated/Married/Divorced/Widowed

Home Phone #: _____ Cell Phone #: _____

Email address: _____

Pharmacy: _____ Address: _____ Phone #: _____

EMERGENCY CONTACT:

Contact Name: _____ Relation: _____

Phone #: _____

INSURANCE INFORMATION: (Please provide receptionist a photocopy your insurance & ID card)

PRIMARY INSURANCE:

Self-Pay (No Insurance): Yes / No

Plan Name: _____ Insured's Name: _____

Insured's Social Security #: _____ Insured's DOB: _____

Policy/ID #: _____ Group #: _____

SECONDARY INSURANCE:

Plan Name: _____ Insured's Name: _____

Insured's Social Security #: _____ Insured's DOB: _____

Policy/ID #: _____ Group #: _____



Women's Health Care

NOTICE OF AUTHORIZATION OF TREATMENT AND INFORMATION PRACTICES

This notice describes how medical and other personal information about you may be used and disclosed. It also describes how you can get access to this information. Please review the notice carefully.

I consent to such diagnostic procedures, medical treatment and other actions which, in the judgement of the CNM/APRN may be considered necessary or advisable. Pelvic examinations including multiple exams may be required as a component of gynecological/obstetrical care, and the CNM/APRN will explain if this is necessary. I understand that if test results reveal a condition that is reportable to the local health department, according to the Florida Statutes, my personal contact information along with positive results will be reported as required. I expressly consent that Women's Health Care may contact me at the number provided. Furthermore, I understand that Women's Health Care may contact me for debt collection or payment purposes.

You entrust us with individually identifiable personal health information and financial information (referred to as "personal health information" in the rest of this notice). You are our best and most important source of information about you.

We may also collect personal information about you from others. For example, we may collect personal health information from other health care providers, employers, educational entities, and the judicial system, insurance companies or other community referral sources or partners.

EXAMPLES OF INFORMATION WE MAY COLLECT AND MAINTAIN INCLUDE:

Your name, address, telephone number, social security number, date of birth, marital status, income, email address, policy or account number, account balance, policy coverage, premium payment, claims history, medical information, motor vehicle reports, details about your transactions with state or federal agencies.

IN THE FOLLOWING SITUATIONS, WE MAY USE AND/OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION:

- To provide treatment.
- To obtain payment for treatment.
- To evaluate the quality of care that you receive.
- To an insurance authority.
- Performing mandatory licensing and regulatory compliance functions.
- For payment such as using details received from an insurance company to coordinate benefits.
- For payments such as to health care provider to identify insurance coverage or benefits.
- For health care operations to detect or prevent criminal activity, fraud and material misrepresentation.
- For public health activities such as to prevent or control disease, injury, or disability.
- To health oversight agencies for compliance purposes.
- In response to a court of administrative order.
- In response to a subpoena, discovery request, or other lawful process by another person in a dispute.
- For law enforcement purposes.
- To avert a serious threat to health or safety to you, another person, or the public.
- To federal officials for intelligence, counterintelligence, and other national security activities.
- To worker's compensation or other programs that provide benefits for work-related injuries or illness.

THOSE WHO ACT ON OUR BEHALF

Agencies who receive your personal information from Women's Health Care are required to keep your personal health information confidential. They are required to use the personal health information only to provide the services we have asked them to provide.



NOTICE OF AUTHORIZATION OF TREATMENT AND INFORMATION PRACTICES

ALL OTHER USERS AND DISCLOSURES OF PERSONAL INFORMATION

Women's Health Care will not disclose any of your personal health information for any marketing purposes. All other uses and sharing of personal health information, are not permitted or required by law, will be made only with your written authorization. You may revoke this authorization in writing. If you do, we will no longer use or share the information for the reason covered by the authorization – unless we have taken prior action based on the authorization. We are unable to withdraw any disclosures we have already made with your authorization.

YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION:

- To inspect and obtain a copy of your personal health information. Copies will be provided for a fee.
- To request that we amend your personal health information. We will consider your request but are not legally bound to accept your amendment.
- To receive details about our sharing of your personal health information.
- To request special accommodations on how your personal health information is communicated (such as alternative addresses and phones).

SECURITY OF PERSONAL INFORMATION

We maintain physical, administrative and technical safeguards to guard your information. We limit employee access to information based on essential job function.

If there is ever a breach of your protected health information, we are required by law to notify you in writing within 30 days of breach.

We are required to keep your personal information private. We are providing this notice of your legal duties and privacy practices. We will abide by the terms of those notice as currently in effect. If you believe that your privacy rights have been violated, you may send a written complaint to Women's Health Care. You may also write the Secretary of the Department of Health and Human Services. We will not take any action against you for filing this complaint.

We reserve the right to change the terms of our notice. We reserve the right to make the new notice apply to all personal information that we maintain. We will provide a new copy of any material change your next office visit. We can also mail you a copy to your last known address.

Women's Health Care has agreed to participate in an organized healthcare arrangement (OHCA) with Tampa General Hospital (TGH). We will share PHI as necessary to carry out treatment, payment, or health care operations relating to the OHCA, and as otherwise permitted by applicable law. We will do so through access through a shared electronic medical record.

I certify by signing below that I have received, read, and understand the Notice of Information Practices and have had the opportunity to ask questions regarding the above, as well as any questions regarding my registration with Women's Health Care.

Patient Signature

Date

Witness

Date



ACKNOWLEDGMENT OF COORDINATION OF BENEFITS FOR MEDICAID PATIENTS

It is the patient's responsibility to notify our office if there is other insurance in addition to Medicaid. Billing Medicaid as a primary insurance when a patient has commercial insurance is considered fraud. Commercial insurance is always primary. If there are additional patient cost, we will bill Medicaid as secondary to cover the fees. If we are not provided with the commercial insurance in a timely fashion, all fees will be patient responsibility as Medicaid will not pay for services rendered.

Thank you for your assistance in helping us comply with federal and state laws.

By signing, I understand I must provide any commercial insurance I have in addition to my Medicaid.

Signature

Date



Women's Health Care

NOTICE TO OBSTETRIC PATIENTS

(SEE SECTION 766.316, FLORIDA STATUTES)

I have been furnished information by Women's Health Care prepared by the Florida Birth-Related Neurological Injury Compensation Association (NICA), and have been advised that Women's Health Care is a participating facility in that program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor, delivery or resuscitation. For specifics on the program, I understand I can contact the Florida Birth-Related Neurological Injury Compensation Association, P.O. Box 14567, Tallahassee, Florida, 32317-4567, 1-800-398-2129. I further acknowledge that I have received a copy of the brochure prepared by NICA.

DATE: This _____ day of _____, 20_____

Patient Signature

Printed Name of Patient

Social Security #

Attest:

Representative of Women's Health Care

Date: _____

*This form is informational only, and each person, participating physician or hospital should contact their own attorney to ensure compliance with Section 766.316, Florida Statutes.



WOMEN'S HEALTH CARE HEALTH HISTORY INTAKE FORM

First Name: _____ Last Name: _____ DOB: _____

ALLERGIES

MEDICATION	TYPE OF REACTION

CURRENT MEDICATIONS

MEDICATION	DOSAGE	FREQUENCY

MEDICAL HISTORY

Do you currently have (or have had) any of the following? (check all that apply)

- | | | |
|--|--|---|
| ☐ None | ☐ Diabetes | ☐ Osteoporosis |
| ☐ Abnormal pap smears _____ | ☐ Deep vein thrombosis | ☐ Ovarian Cyst |
| ☐ Anemia | ☐ Endometriosis | ☐ PCOS |
| ☐ Anxiety | ☐ Fibroids | ☐ PMS/PMDD |
| ☐ Arthritis | ☐ Genital warts | ☐ STD's |
| ☐ Asthma | ☐ Heart murmur | ☐ Stroke |
| ☐ Blood transfusion | ☐ HIV/AIDS | ☐ Substance abuse |
| ☐ Breast problems _____ | ☐ High blood pressure | ☐ Thyroid disorder |
| ☐ Cancer _____ | ☐ High cholesterol | ☐ UTI |
| ☐ Clotting disorder _____ | ☐ Heart attack | ☐ Yeast infections |
| ☐ Depression | ☐ Heart disease | ☐ Suicide attempt |
| ☐ DES exposure | ☐ Kidney disease/stones | ☐ Violence/abuse |
| ☐ Other _____ | ☐ Liver disease | ☐ Uterine anomaly |



Women's Health Care

WOMEN'S HEALTH CARE HEALTH HISTORY INTAKE FORM

First Name: _____ Last Name: _____ DOB: _____

SURGICAL HISTORY

- | | | |
|---|--|---|
| ☐ Abdominal | ☐ Colposcopy | ☐ Tubal ligation |
| ☐ Appendix | ☐ Cosmetic _____ | ☐ Tonsils |
| ☐ Abortion | ☐ D&C | ☐ Other _____ |
| ☐ Bladder | ☐ Endometrial ablation | _____ |
| ☐ Breast | ☐ Hysterectomy (partial/complete) | _____ |
| ☐ Cesarean | ☐ Hysteroscopy | |
| ☐ Cervix (cryo/CKC/LEEP) | ☐ Oophorectomy | |
| ☐ Colon | ☐ Laparoscopy | |

GYNECOLOGICAL HISTORY

Age of first menstrual period: _____
First day of last menstrual period ____/____/____ Menstrual cycle every: _____
Regularity of periods: ☐ Regular ☐ Irregular Flow: ☐ Light ☐ Moderate ☐ Heavy
Pain with menstrual cycle: ☐ None ☐ Mild ☐ Moderate ☐ Severe
Sexually active: ☐ yes ☐ no
Number of partner(s) in the last year: _____ Partner(s) are: ☐ male ☐ female

Current Contraception

- | | | |
|---|--|--------------------------------------|
| ☐ Abstinence | ☐ Patch | ☐ Diaphragm |
| ☐ Oral birth control pills | ☐ IUD (type) _____ | ☐ DepoProvera |
| ☐ Nuvaring | ☐ Withdrawal | ☐ Nexplanon |
| ☐ Tubal ligation | ☐ Natural Family Planning | ☐ Condoms |
| ☐ Spermicide | ☐ Sponge | ☐ Vasectomy |

Menopause

Age of onset of menopause: _____
Do you have any menopausal symptoms?

☐ None	☐ Hot flashes	☐ Night sweats
☐ Vaginal dryness	☐ Mood changes	☐ Memory loss
☐ Insomnia	☐ Urinary changes	☐ Weight gain

OBSTETRIC HISTORY

Total # of pregnancies: _____ # of term deliveries: _____ # of preterm deliveries (<37 wks): _____
of miscarriages: _____ # of abortions: _____ # of twin pregnancies: _____
of living children: _____ # of ectopic/tubal pregnancies: _____

WOMEN'S HEALTH CARE HEALTH HISTORY INTAKE FORM

First Name: _____ Last Name: _____ DOB: _____

For each child, please list the following:

	Child 1	Child 2	Child 3	Child 4	Child 5
Date of birth					
Gestational age					
Type of delivery					
Gender					
Birth weight					
Anesthesia					
Place of birth					
Complications					

SOCIAL HISTORY

Tobacco use: ☐ Never ☐ Former smoker ☐ Current smoker: # PPD _____
 ☐ daily ☐ some days ☐ former smoker ☐ passive

Alcohol use: ☐ None. ☐ Type of alcohol _____
of drinks per week: _____

Drug use: ☐ Type: _____
of time per week: _____

Occupation: _____

Mark if yes:

- ☐ On a special diet
- ☐ Refuse blood transfusions
- ☐ Domestic violence/abuse
- ☐ Transportation problems
- ☐ Thoughts of self-harm
- ☐ History of abuse/violence

- ☐ Lost > 5-10 lbs unintentionally
- ☐ Homeless
- ☐ Feel would be better off dead
- ☐ Separated from father of baby
- ☐ Live alone
- ☐ Recent death of loved one

- ☐ Difficulty swallowing
- ☐ In drug/alcohol treatment
- ☐ Need help walking
- ☐ History of forced sex
- ☐ Fallen in past year



WOMEN'S HEALTH CARE HEALTH HISTORY INTAKE FORM

First Name: _____ Last Name: _____ DOB: _____

FAMILY MEDICAL HISTORY

	Mark if deceased	Breast Cancer	Ovarian Cancer	Uterine cancer	Colon Cancer	Diabetes	High Blood Pressure	High cholesterol	Heart Disease	Deep Vein Clot	Osteoporosis	Thyroid Disease	Stroke	Other _____
MOTHER														
FATHER														
BROTHER														
SISTER														
PATERNAL GRANDMOTHER														
PATERNAL GRANDFATHER														
MATERNAL GRANDMOTHER														
MATERNAL GRANDFATHER														
OTHER														

GENETIC HISTORY (OB PATIENTS ONLY)

Family member and/or spouse family or personal history of:

- | | | |
|---|--|--|
| ☐ Anesthesia problems | ☐ Ashkenazi Jewish | ☐ Autism |
| ☐ Birth defects _____ | ☐ Canavan's disease | ☐ Clotting disorders |
| ☐ Congenital heart defects | ☐ Cystic fibrosis | ☐ Down Syndrome |
| ☐ Pre-eclampsia/Eclampsia | ☐ Huntington's disease | ☐ Mental retardation |
| ☐ 2+ miscarriages | ☐ Muscular dystrophy | ☐ PKU disease |
| ☐ Preterm birth | ☐ Sick cell disease/trait | ☐ Spina bifida/neural tube defect |
| ☐ TaySach's disease | ☐ Thalassemia disease/trait | ☐ Other _____ |

PHARMACY NAME: _____

Address: _____

Phone #: _____



Women's Health Care



Women's Health Care

AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: ____/____/____

Address: _____ Last 4 digits of SS#: _____

Please send the requested information below:

☐ All medical records and reports

☐ All prenatal records

☐ Physical examination

☐ Laboratory reports

☐ Radiology reports

☐ STD results

☐ Psychiatric/psychological reports

☐ Referrals

☐ Operative reports

☐ Other _____

Reason for request: ☐ Transfer of care ☐ Healthcare ☐ Personal

Specify anything you DO NOT want released: _____

I authorize Women's Health Care to obtain records from:

Practice Name: _____

Address: _____

City/State/Zip: _____

Phone #: _____

Fax #: _____

I authorize Women's Health Care to send records to:

Practice Name: _____

Address: _____

City/State/Zip: _____

Phone #: _____

Fax #: _____

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or substance/drug abuse and/or HIV/AIDS test results. I consent to the release of information as designated above.

I understand this authorization will remain in effect for one year unless otherwise specified. I understand this authorization is revocable upon written notice to the office where the original authorization is retained. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I understand that after signing this form, there is a processing period of 7-10 business days.

Signature: _____ Date: _____

Women's Health Care • 5 Tampa General Circle, Suite 240 • Tampa, FL. 33606. •

Phone (813) 258-3309 • Fax (813) 251-4454