Rappahannock
Women's Health Center

PATIENT INFORMATION

Last Name:		**First Name:**		**Middle In:**	
Address:		**City:**		**State:**	**Zip Code:**
Home #:		**Cell #:**		**Social Security #(Required):**	
DOB: **Age:**	**Preferred Language:**	□ **Female** □ **Male**	**Race:**	**Ethnicity:**	**Marital Status:** □ **Single** □ **Married** □ **Divorced** □ **Widowed**
Employer:			**Employer Address:**		
Email Address:			**How did you hear about us? If a patient referred you, Please provide name:**		
Referring Physician & Phone:			**Primary Care Physician & Phone:**		

Pharmacy Information

Whenever possible, Rappahannock Women's Health Center, P.C. will electronically transmit your prescription(s) Directly

Pharmacy Name & Location:	**Pharmacy Phone Number:**

INSURANCE INFORMATION

(PLEASE COMPLETE ALL SECTIONS)

Name of Primary Insurance:		**Name of Secondary Insurance:**	
Subscriber Name:	**Relationship to Patient:**	**Subscriber Name:**	**Relationship to Patient:**
ID#:	**Group #:**	**ID#:**	**Group #:**
Subscriber DOB:	**Subscriber SSN:**	**Subscriber DOB:**	**Subscriber SSN:**

EMERGENCY CONTACT INFORMATION

Last Name:	**First Name:**	**Relationship To Patient:**	
Address:	**City:**	**State:**	**Zip Code:**
Home #:	**Cell #:**	**Work #:**	

Release of Information to Insurance: I hereby authorize DR. H JAE KIL, DR. MARY SHUMAN, DR. LESLIE MEYER, DR. SEPIDEH KHALILIAN, LAUREN JORDAN CMN and EVETTE HERNANDEZ CMN, To furnish information to insurance carriers concerning my illness and treatments. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENT OR I REMAIN A PATIENT. **Assignment of Insurance Benefits:** I, the undersigned, certify that I (or my dependent) have insurance coverage as stated above hereby assign/ authorize payment to this practice, Rappahannock Women's Health Center, P.C. for all insurance benefits, if any, otherwise payable to me for healthcare services provided to the client/patient/dependent at this practice, to be paid directly to the practice. I authorize the use of this signature on all submissions. I understand that if health insurance information is provided, this in no way relieves me of financial responsibility for services rendered now or in the future at this practice. I understand that any lab work performed will be billed by the lab itself.

Guarantee of Payment: I understand that I am financially responsible for all amounts payable with regards to fees for healthcare services rendered now and in the future by this practice. In the event of non-payment by me of any amount due to this practice after 45 days, I agree to that in addition to the original amount due, I am fully responsible to pay 18% interest per annum on all collection fees of 33 & 1/3% of the amount due, court cost and reasonable attorney's fees incurred by this practice if required to collect my debt owed.

Signature of Responsible Party:	**Date:**

Updated 8/19/2020 CML

Rappahannock
Women's Health Center

1071Care Way, Suite 101
Fredericksburg, VA 2240
540-374-3100 Fax 540-374-3102
rwhcobgyn.com

Financial Policies

This is an agreement between Rappahannock Women's Health Center, P.C. and the responsible party.

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

Self pay Patients: All services must be paid at time of service by cash, or credit card. The services provided are for our services only not any laboratory work, however if additional services arise with our practice then there will be additional charges that will also need to be paid before leaving from your appointment. The laboratory work will be billed by that company not our practice.

No Show Fee: If you no show for an appointment without calling in advance a fee of $25.00 will be assessed to your account. This policy applies to all patients new and established.

Monthly Statements: If you have a balance on your account $10.00 and over we will be sending monthly statements showing charges to your account. Unless other arrangements have been made in advance, the balance is due upon receipt. If the account becomes past due our office will take the necessary steps to collect this debt. If we have to refer your account to an outside collection agency or lawyer, you agree to pay all collection, lawyer and court fees that are incurred.

Returned Checks: There is a $75.00 returned check fee that will be added to your account.

Refunds: In the event that an overpayment is made the credit will be applied to any remaining balance after insurance has made the necessary payments. There after the monies owed to the patient will be refunded. There is a 4 % service charge applied if the patient has paid with a credit card and that will be deducted from the credit before being issued to the patient. Refunds can take up to thirty (30) days to process.

Records transfer: All adult patients must sign a medical release form if you are requesting copies of medical records and pay the necessary transfer fee.

Rappahannock Women's Health Center, P.C. files your insurance as a courtesy. We do ask our patient's that if you insurance has made payment on your claim within forty-five (45) days that you contact them for payment.
The undersigned understands that medical insurance is filed as a courtesy by the provider, if the provider participates in the patient's insurance plan; and if the patient provides 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 consideration for the professional services rendered now and in the future, the undersigned herby agrees to pay 18% interest per annum on all balance which are overdue and unpaid 45 days after the services are rendered, plus attorney fees, which are hereby stipulated to be 33 1/3% of such outstanding balance, plus court costs whether suit is filed or not. The undersigned further agrees to pay all costs of obtaining such credit information and or locating the undersigned as may be necessary.

_____ _____

Signature of Responsible Party Date

Rappahannock
Women's Health Center

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Fredericksburg, VA 22401
540-374-3100 Fax 540-374-3102
rwhcobgyn.com

PRIVACY POLICY

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that the Rappahannock Women's Health Center may use and disclose my protected health information for purposes of treatment, payment, and health care operations. I also acknowledge that I have been offered a copy of the Practice's Notice of Privacy Practices, which provides information about how the Practice and individuals involved in my care in the Practice, may use and disclose my protected health information. As provided in the Notice, I understand that I can contact the Privacy officer at 540-374-3100.

I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment and health care operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance on my prior consent.

_____ _____ _____
Patient or Legal Surrogate Date Relationship to patient

_____ _____
Witness Date

MEDICAL INFORMATION

Patient Name:	DOB:	Age:	Weight:	Height:

Reason for your visit today:	**How long have you had this problem:**
Are you under the care of any other physician?	**If yes, Please give reason:**
Doctor Name:	

First day of last period:	**Do you have regular monthly periods?** □ Yes □ No	**How often do your periods come?**	**Age of first period?**
Periods are: □ Mild □ Moderate □Heavy	**How many days do your periods last?**	**Cramps are:** □ Mild □ Moderate □ Severe	

Do you have headaches with your periods? □ Yes □ No	
Current Birth Control:	**Are you happy with this birth control?** □ Yes □ No
Age at First intercourse: / **Number of partners(lifetime):**	**Have you had a new sexual partner since your last exam?** □ Yes □ No
Do you desire testing for STD's □ Yes □ No	

Last Pap Smear: ___/___	**Have you ever had an abnormal Pap?** □ Yes □ No	**If yes, Please give year and any procedures:**
Last Mammogram: ___/___	**Have you ever had an abnormal Mammogram?** □ Yes □ No	**If yes, Please give year and any procedures:**
Last Colonoscopy: ___/___	**Last bone Density: ___/___**	**Have you ever had an abnormal Bone Density?** □ Yes □ No

Allergies:	**Reaction:**

Medications:	**Hospitalizations/Surgeries (list all <u>except</u> for pregnancy):**	**Date of surgery**

Have you ever been put to sleep? □ Yes □ No	**Had a reaction to anesthesia?** □ Yes □ No	**Have you had?** □ Epidural □ Spinal Anesthesia

Do you currently: □ Exercise regularly □ Diet-What type?_____ □ Drink Alcohol How much?_____ □ Use Recreational Drugs?	**Smoking History:** **Do you currently smoke? _____ If yes, _____ packs/day** **Have you ever smoked? _____ If yes, _____ packs/day**	**Do you do monthly breast exams?** □ Yes □ No

Updated 8/31/2020 CML

MEDICAL HISTORY CONTINUED

Name: **DOB:**

Are you experiencing any of the following:
□ Leak urine when you cough/laugh/sneeze
□ Unaware that you are leaking urine
□ Strong urge to urinate
□ Wear a pad because of urine leakage
□ Leaking after intercourse
□ Painful urination
□ Incomplete urination
□ Bloody urine
□ Difficulty beginning to urinate
□ Slow Urination
□ Straining to pass urine
□ Irregular Periods
□ Pain with your menses
□ Pain with ovulation
□ Dissatisfied with sexual relations
□ Pain with intercourse
□ Bleeding between periods
□ Bleeding after intercourse
□ Bleeding from your rectum

Continued:
□ Vaginal discharge
□ Vaginal itching
□ Vaginal burning
□ Breast/Nipple discharge
□ Lump(s) in breast
□ Breast Pain
□ Hot flashes
□ Trouble sleeping
□ Vaginal dryness
□ Night Sweats
□ Feel anxious
□ Feel sad/depressed
□ feeling of pressure or bearing down
□ Bulging from your vagina
□ Unusual hair growth
□
□

Please check the box if you have had problems with the following:
□ Skin
□ Eyes/vision
□ Ears/hearing
□ Mouth/teeth
□ Anemia
□ Cancer-What kind?_____
□ Diabetes
□ Thyroid Disease
□ Seizures/Epilepsy
□ Migraines
□ Rheumatic fever
□ Phlebitis

□ Psychiatric problems
□ Depression
□ High cholesterol
□ Heart disease
□ High blood pressure
□ Asthma
□ Bleeding problems
□ Blood transfusions
□ Hepatitis
□ Lung disease
□ Breast Lump
□ Breast discharge
□ Breast surgery
□ Heart murmurs

□ Gall bladder disease
□ Stomach Ulcer
□ Black/Bloody stool
□ Kidney
□ Bladder infections
□ Gonorrhea
□ Syphilis
□ PID
□ Hepatitis B
□ Trichomonas
□ HPV
□ Chlamydia
□ Genital warts
□ Herpes

□ HIV/AIDS
□ Broken bones
□ Back pain
□ Joint problems
□ Arthritis
□ Vaginal infections
□ Pelvic tumor
□ Pelvic infections
□ Abnormal Paps
□ Endometriosis
□ Fibroids
□ Ovarian tumors
□ Breast biopsy

Incontinence Questionnaire:
Please answer as accurately as possible.
1. Do you leak urine when you cough, sneeze or laugh? □ Yes □ No
2. Do you ever have such an uncomfortably strong need to urinate that if you reach the toilet you will leak? □ Yes □ No
3. If "yes" to #2 do you ever leak before you get to the toilet? □ Yes □ No
4. How many times do you void during the night after going to bed?____
5, How many times during the day do you urinate? _____
6, Have you wet the bed in the past year? □ Yes □ No
7. Do you develop an urgent need to urinate when you are nervous, under stress, or in a hurry? □ Yes □ No
8. Do you ever leak during or after sexual intercourse? □ Yes □ No
9. Do you find it necessary to wear a pad because of you leaking? □ Yes □ No
10. How many times do you leak during the day? _____
11. Have you had bladder, urine, or kidney infections? □ Yes □ No
12. Are you troubled by pain or discomfort when you urinate? □ Yes □ No
13. Have you had blood in you urine? □ Yes □ No
14. Dou you find it hard to begin urinating? □ Yes □ No
15. Do you have a slow urinary stream? □ Yes □ No
16. Do you have to strain to pass you urine? □ Yes □ No

Family History

Are you adopted? □ Yes □ No

Pleas check all that apply under the appropriate family member: **(for brother and sister please list which sibling or both)**

Disease	Self	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother/ Sister	Other
Alcoholism									
Anemia									
Arthritis									
Asthma/Lung Problems									
Birth Defects									
Bleeding Problems									
Blood Clots									

Bloody Stools/Colon Polyp(s)									
Breast Cancer									
Cervical Cancer									
Colon Cancer									
Depression									
Diabetes									
Heart Disease									
High Cholesterol									
High Blood Pressure									
Kidney Disease/UTI's									
Liver Disease									
Loss of Urine									
Mental Illness									
Osteoporosis									
Ovarian Cancer									
Seizures									
Stomach Ulcers									
Stroke									
Thyroid Disease									
Tuberculosis									
Uterine Cancer									

Other (please explain):

REPRODUCTIVE HISTORY

Pregnancy Summary: | Last Menstrual Period:

Total Pregnancies:	Total Full Term Pregnancies:	Total Premature Deliveries:	Total Elective Terminations:	Total Spontaneous Terminations (Miscarriages):	Total Ectopic Pregnancies:	Total Living Children:

Date of Birth:	Gestational Age in weeks:	Hours in labor:	Birth Weight:	Sex:	Delivery Type (Vaginal or Cesarean):	Anesthesia Received (i.e. Epidural)	Early Labor:	Comments or Complications:	Delivery Location:
							Yes/No		
							Yes/No		
							Yes/No		
							Yes/No		
							Yes/No		
							Yes/No		
							Yes/No		
							Yes/No		

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1071 Care Way, Suite 101 Fredericksburg, VA 22401
Tel: 540-374-3100 Fax: 540-374-3102

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #:_____

I request and authorize Rappahannock Women's Health Center to release healthcare information to the following parties:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request pertains to the following information:

□ Health information relating to the following treatment, condition, or dates: _____

_____

□ All healthcare information

□ Other: _____

□ Yes □ No I authorize the release of STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that must give specific written permission before disclosure of these test results to anyone

□ Yes □ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to The person(s) listed above.

I understand that due to HIPPA regulations that this can only be done with my consent. This consent will be in effect until the following date: _____ Unless otherwise retracted in writing.

Patient Signature: _____ Date Signed: _____

Clinical Staff Signature:_____ Date Offered: _____