Patient Registration Form - Chester Women's Health

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) ________________________ (First) ____________ (MI) ______ Previous Name ______________________

Address Line 1 ____

City, State _______________________________ ZIP ___________ Pharmacy _______________ Pharmacy Phone _______________

Home Phone ______________________ Cell No. ______________________ Work Phone _________________ Ext. ___________

Primary Care Provider (PCP) ________________________________ Referring Provider ______________________________

Rendering Provider Name (this practice) ______________________________ E-Mail Address: __________________________

Date of Birth MM _______/DD _________/YYYY ___________________ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other ____________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-______-_________ Employer Name ______________________________

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name ____ First Name ____________________________

Phone Number ____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient ____ ☐ Guardian

Address Line 1 ____

City, State ________________________________ ZIP _________________

Home Phone ______________________________ Work Phone ______________________________ Ext. _________________

Referring Provider Name ____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) ___________________________ (First) ________________________________ (MI) ___________

Guarantor Account Number ____________________________ Date of Birth MM _________/DD _________/YYYY ____________

Social Security Number _______-______-________ Telephone ______________________

E -Mail Address ____ Sex ☐ F – Female ☐ M - Male

Address Line 1 ____

City, State _______________________________ ZIP ____________________

Employer ____ Employer Phone Number ________________________

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number ____ (______) ________________

Name of Insured ____ Patient Relationship to Insured ______________________

Subscriber ID (Policy Number) ______________________ Group ID _____________________ Copay Amount ___________________

Effective Date ______________________ Termination Date __________________ Date of Birth MM _______/DD _______/YYYY ______

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number ____ (______) ________________

Name of Insured ____ Patient Relationship to Insured ______________________

Subscriber ID (Policy Number) ______________________ Group ID _____________________ Copay Amount ___________________

Effective Date _________________________ Termination Date __________________ Date of Birth MM _______/DD ______/YYYY _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature ____ ***Date*** ________________

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Chester Women's Health

Consent for Treatment and Payment Agreement

I hereby authorize Chester Women's Health to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to Chester Women's Health of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Chester Women's Health**, all insurance or third party payments that I receive for services rendered to me immediately upon receipt. Patient Initial: ___________**

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to Chester Women's Health**. Patient Initial: ___________**

I request this authorization also apply to all other insurance. Patient Initial: ___________

I acknowledge that I have been given Chester Women's Health **Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Facility Privacy Official. Patient Initial: ___________**

RELEASE OF MEDICAL INFORMATION

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. I understand that I may request individuals to leave the exam room at any time.

Name of Person who is Authorized to receive information	Release info (please circle)	Allowed in exam room (please circle)
___________________________________	Y N	Y N
___________________________________	Y N	Y N
___________________________________	Y N	Y N

***If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure**

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature____

Date______________________________**Patient Date of Birth**__________________________

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name ______________________ DOB __________ Account or Med. Rec. # ______________________

By signing this paper below, I give permission to the person(s) listed in the table documented to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information that does not pertain to assisting with my health care and any copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	**Name of Individual & Relationship to Patient**	**Comments/Instructions** *(i.e.: may pick up meds, may disclose test results, etc)*	**Patient/ Guardian Initials**

THE PHYSICIANS/STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)

☐ Leave message at home with my spouse or: NAME: ______________________

RELATIONSHIP: ______________________ DOB: __________

☐ Leave message on cell phone. Cell phone number: ______________________

☐ Leave message at work. Work phone number: ______________________

☐ Leave a message on voicemail. Phone number: ______________________

☐ Leave a detailed message on answering machine. Phone number: ______________________

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Chosen Identifier/Password: ______________________

____
Signature of Patient or Legal Guardian

____
Date

____
Printed Name of Patient or Legal Guardian

____
Relationship *(if not self)*

PATIENT RIGHTS AND RESPONSIBILITIES

Each patient receiving services at Chester Women's Health has the following rights:

- To be treated with respect and dignity.
- To be informed of his/her healthcare needs in order to make appropriate decisions.
- To establish a surrogate decision-maker as permitted by law.
- To expect a reasonably safe environment.
- To help plan his/her care and make changes to it.
- To expect that teaching materials and aids will be written or presented in a manner that he/she can understand.
- To be informed of Chester Women's Health's billing process.
- To have access to his/her medical records.
- To have his/her records kept confidential beyond Chester Women's Health, except when express consent has been given.
- To expect that services be provided in a timely manner, including prompt attention to acute problems.
- To have visual and informational privacy.
- To know the professional status of the caregiver.
- To have another agency contacted if needed services are not available through Chester Women's Health.
- To refuse services.
- To communicate his/her complaints to the Chester Women's Health Practice Manager and expect to receive a follow-up without negative repercussions or changes in service.
- To receive care without discrimination because of race, religion, age, sex, disability, or ethnic origin.
- To expect the Chester Women's Health personnel to be qualified and competent in all respects to perform the services that are provided.
- To be given information on advance directives and assistance in making these decisions.
- To be assured that acceptance, as a patient, will not be based on whether or not an advance directive has been given.

Each patient receiving services at Chester Women's Health have the following responsibilities:

- To arrive on time for scheduled appointments and cancel, when necessary, with a telephone call 24 hours prior to the appointment time.
- To participate in his/her care.
- To provide timely payment for any service requested and delivered by Chester Women's Health which is not covered by insurance.
- To be under the supervision of a Chester Women's Health physician.
- To notify the staff of Chester Women's Health of any changes in his/her health status.
- To inform the Chester Women's Health staff of any pertinent changes in insurance, employment, demographic information, or relationships with other care/service providers.
- To inform Chester Women's Health, at the time an appointment is made, of any physical or mental impairment requiring special accommodation.
- To follow the recommended treatment plan.
- To accept responsibility if treatment is refused.
- To ask questions if directions and procedures are not understood.

______________________________ ____________________

Patient or Guardian Signature Date

Chester Women's Health
12801 Iron Bridge Road
Chester, VA 23831

CHESTER WOMEN'S HEALTH

New Patient History

Name: ______________________ **Age:** __________ **Date:** __________

SSN: ______________________ **Marital Status:** __________ **DOB:** __________

Reason for visit? ______________________ **Referred By:** __________

Do you experience problems with:	No	Yes	
Your menstrual cycles?	☐	☐	______
Irregular bleeding?	☐	☐	______
Cramps with your periods?	☐	☐	______
Abnormal vaginal discharge?	☐	☐	______
Pelvic or abdominal pain?	☐	☐	______
Change in bowel habits?	☐	☐	______
Urinary incontinence, burning or frequency?	☐	☐	______
Physical, mental or sexual abuse?	☐	☐	______
Have you ever had any:			
Medical problems?	☐	☐	______
Sexual problems?	☐	☐	______
Operations?	☐	☐	______
Do you have plans to attempt pregnancy THIS year?	☐	☐	______
Do you smoke?	☐	☐	How much? ______
Do you drink alcohol?	☐	☐	How much? ______
Do you use marijuana, cocaine, or other street drugs?	☐	☐	How much? ______
Do you do self breast exams?	☐	☐	
Have you found any problems?	☐	☐	______
Have you ever had any abnormal Pap smears?	☐	☐	
Did you undergo treatment?	☐	☐	______

What prescription or over-the-counter medications do you take on a regular basis (including vitamins)?
____

Are you allergic to any medications? ______________________

What do you use for birth control? ______________________

When was the first day of your last menstrual period? ______________________

How many times have you been pregnant? __________

How many liveborn children have you had? __________

How many pregnancy losses have you had (miscarriages, abortions, ectopic pregnancies)? __________

How many living children do you have? __________

Are there any problems or issues you would like to discuss? ______________________
____

HPI: ______________________
____
____

ROS: ______________________

Meds: ______________________ **All:** ______________________

FH: DM BrCA OvCA CAD

SH: Tob EtOH Drugs

THE PHYSICIAN AND STAFF OF CHESTER WOMEN'S HEALTH WOULD LOVE TO KNOW HOW YOU HEARD ABOUT US. PLEASE CHECK THE BOX BELOW THAT BEST DESCRIBES YOUR SOURCE:

- INSURANCE ASSIGNMENT
- ER
- MAILBOX FLYER
- PERSONAL REFERENCE
- SIGN/BANNER
- NEWSPAPER AD/PHONE BOOK/WEB
- INSURANCE REFERRAL/WEBSITE
- HCA PHYSICIAN REFERRAL
- JOB/COMPANY REFERRAL
- NON HCA MD
- FRIEND/CO WORKER
- OTHER:

____

____

____

WE WOULD ALSO LOVE TO HEAR YOUR FEEDBACK ABOUT THE SERVICE YOU RECEIVED DURING YOUR VISIT WITH US, FROM CHECK IN TO CHECK OUT. OUR SURVEY COMPANY, **MEDICAL GPS, M3 REPORTING**, IS OUR SURVEY PROVIDER AND SENDS THE SURVEYS VIA EMAIL. WE WOULD GREATLY APPRECIATE YOU PROVIDING US YOUR EMAIL ADDRESS SO WE CAN SUBMIT TO **MEDICAL GPS** SO WE CAN CONTINUE TO IMPROVE ON OUR CUSTOMER SERVICE.

EMAIL ADDRESS: ________________________________

THANK YOU

CHESTER WOMEN'S HEALTH PHYSICIAN & STAFF

FAMILY HISTORY CHECKLIST

CONSIDER YOUR FATHERS AND MOTHERS SIDE OF THE FAMILY

INCLUDE: SIBLINGS, PARENTS, GRANDPARENTS, UNCLES & AUNTS, NEPHEWS & NIECES

PATIENTS NAME: ______________________________ **DATE:** ______________

	BREAST & OVARIAN CANCER	SIBLINGS	AGE OF DIAGNOSIS	WHO ON YOUR FATHERS SIDE	AGE OF DIAGNOSIS	WHO ON YOUR MOTHERS SIDE	AGE OF DIAGNOSIS
Y N	Female Breast Cancer						
Y N	Male Breast Cancer						
Y N	Breast Cancer in Both Breasts or Multiple Primary Breast Cancer						
Y N	Ovarian Cancer						
Y N	Breast and Ovarian Cancer in the Same Person						
Y N	Skin Melanoma						
Y N	Do You Have a Family Member With a BRCA Mutation						
Y N	Are You of Askenazi Jewish Ancestry						

	COLON, UTERINE & ABDOMINAL CANCER	SIBLINGS	AGE OF DIAGNOSIS	WHO ON YOUR FATHERS SIDE	AGE OF DIAGNOSIS	WHO ON YOUR MOTHERS SIDE	AGE OF DIAGNOSIS
Y N	Colon Cancer						
Y N	Uterine/Endometrial Cancer						
Y N	Ovarian Cancer						
Y N	Colon and Uterine Cancer in the Same Person						
Y N	10+ Colon Polyps Found In The Same Person						
Y N	Stomach Cancer						
Y N	Small Bowel Cancer						
Y N	Kidney/Urinary Tract Cancer						
Y N	Pancreatic Cancer						
Y N	Brain Cancer						
Y N	Other Cancer						
Y N	Do You Have a Family Member With Lynch Syndrome						

FOR INTERNAL USE ONLY		
☐	Patient appropriate for further risk assessment and/or screening for Hereditary Cancer Syndromes	
☐	Testing Recommended To Patient	Provider: ______________
☐	Patient ☐ ACCEPTED ☐ DECLINED testing	
☐	Follow-up appintment Scheduled - Date:	Date: ______________