

WOMEN'S WELLNESS CENTER

Obstetrics • Gynecology • Infertility • Osteopathy

PATIENT INFORMATION

First Name: _____ Last Name: _____ M.I.: _____ Marital Status: _____

Date of Birth: _____ Social Security #: _____

Address: _____ Apt: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Contact Preference (please circle) Home Phone Cell Phone Work Phone

Email: _____ Emergency Contact: _____ Phone: _____

Parents Names (if < 18 you.): _____ Religion: _____

Spouse/Significant Other's Name: _____

Maiden Name: _____ How did you hear about us? _____

Primary Language: _____ Race: _____ Ethnicity: _____

Primary Care Provider: _____ Co-Pay: _____

I give WWC permission to obtain my medication history. Yes No

I give WWC permission to contact me through automated reminders via Phone Text Email ALL

I give WWC permission to leave detailed voice messages. Yes No

INSURANCE HOLDER INFORMATION

(IF NOT THE SAME AS ABOVE)

Policyholder's First Name: _____ Last Name: _____

Home Address: _____ Apt: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security #: _____

Relationship to Patient: _____ Employer Name: _____

Insurance Information

Please bring your insurance card to every appointment.

(As a courtesy, we will file your claim to insurance. It is your responsibility to provide requested documentation and information to your insurance carrier, as the insurance contract is between you and your insurance company. Should there be a problem we will assist you as much as possible.)

Assignment of Benefits

I authorize payment of medical benefits to Women’s Wellness Center, Prof. L.L.C. for professional services rendered.

Acknowledgement of Financial Responsibility

The above information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, regardless of insurance coverage, and the cost of collections in the event that it is not. I further understand that if payment becomes over 60 days past due, Women’s Wellness Center, Prof. L.L.C. will begin collection activity if alternative payment arrangements have not been made. This collection activity may include the involvement of a collection agency.

Release of Information

I authorize the release of any medical information necessary to process all present and future claims.

15 minute/No Show/Cancellation Policy

I acknowledge that I have reviewed and understand these policies and that cancellations made within 24 hours of my appointment will be considered a no show and I may be billed for the full charge of the appointment (NOT my insurance).

Co-Pay Policy

I acknowledge that I am responsible for paying my co-payment amount to Women’s Wellness Center, Prof. L.L.C. Prior to any appointment. If I fail to comply, I acknowledge that I will be billed a \$15.00 fee (NOT my insurance).

Notice of Privacy Practices

I acknowledge that I have been offered access to Women’s Wellness Center’s Notice of Privacy Practices via the posted form and/or a hard copy provided by the person checking in. I also acknowledge that I have reviewed the form by signing below.

Patient Signature: _____ **Date:** _____
(Or parent, if a minor)

Interpreter Signature: _____ **Date:** _____

Please fill out this form in its entirety to ensure proper handling of your account.
****Please provide your insurance card & driver's license at the reception desk for scanning. ****

WOMEN'S WELLNESS CENTER

Obstetrics • Gynecology • Infertility • Osteopathy

142 3rd St SE Suite 2 Huron, SD 57350

P: 605.554.1020 F: 605.554.1021

Medical Records Release

Name: _____ DOB: _____

Maiden (Previous) Name: _____

Authorization

I hereby authorize my physician and/or the administrative and clinical staff at: (from) _____

to use and/or disclose my protected health information to: (to) _____

Protected Health Information to be Used or Disclosed: (please initial)

_____ All Medical Records

_____ Lab Results

_____ X-ray Reports

_____ Progress Notes

_____ Other: _____

Do Not Disclose:

_____ HIV/STD Results

_____ Other: _____

Reason For Use or Disclosure:

_____ Second Opinion

_____ Relocating

_____ Continuing Medical Care

_____ Other: _____

This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance to this authorization.

I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Authorizing Signature:

I certify that the information listed above is correct to the best of my knowledge, and that I am giving this authorization voluntarily. By signing as personal representative to the patient, I certify that I have legal authority to do so.

Signature: _____ Date: _____

Relationship to Patient: _____

This authorization will expire one year from the date of signature or on _____.

AUTHORIZATION FOR DIAGNOSTIC CARE/TREATMENT: I require diagnostics and/or care in the form of medical, surgical, obstetrical, outpatient or emergency services. I consent to services deemed necessary by my physician(s) and assisting providers, and students in medical training as deemed appropriate by my physician(s). This consent shall extend to diagnosis and treatment in the care of any newborn. Additional consents must be obtained by the treating physician for non-routine procedures. I authorize the Hospital to retain, preserve, or to dispose of specimens, tissues, parts or organs taken from my body. I authorize testing for HIV and/or hepatitis should a healthcare worker have accidental exposure to my blood or other body substances.

MEDICATION HISTORY CONSENT: HRMC uses a medical record that allows electronic prescribing of medications. To coordinate care between the Hospital and other providers, I authorize access to my prescription medication history.

Yes _____ No _____ NA _____
Initial Initial

PATIENT BILLING & PAYMENT POLICY: I understand a portion of the total charges for services rendered are expected at the time of registration. I will then be responsible for any remaining balance not paid by insurance or another payer and a late payment fee may be added at a rate of 0.83% per month or 10% per year on outstanding balances. I also understand that if I have no insurance the hospital may apply for state or county assistance on my behalf. I understand physicians providing services at the Hospital may be independent contractors, not employees or agents of the Hospital, and I will receive a separate bill for their services.

ASSIGNMENT OF BENEFITS: I assign all payment of insurance benefits to the Hospital, to my physician(s), and associated providers of care.

MEDICARE NON-COVERED DRUGS: Any self-administered or oral medications given during outpatient services, including Observation Bed stays are not paid by Medicare. I understand it is my responsibility for payment of non-covered-charges. Medicare Part D beneficiaries can request an itemized description of oral or self-administered prescription drugs received to submit to their Medicare Part D Plan.

MEDICARE CONSENT: I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of my medical or related information to release to the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim.

HRMC NOTICE OF PRIVACY PRACTICES: I acknowledge receipt of the Hospital's Notice of Privacy Practices. I understand the Hospital, my physician and other providers of my care will release Protected Health Information (PHI) for treatment, payment and operations as defined in the Notice.

PERSONAL VALUABLES: I understand that the Hospital maintains a place for safekeeping of valuables and personal items. I agree to assume the risk for personal property that I chose not to deposit for safekeeping.

The following information and instructions were provided to me and I have an opportunity to ask questions:

- Patient Bill of Rights or Home Care Bill of Rights
- Patient Visitation Rights
- Advance Directives

INFORMATION STATUS: Please initial your choice for release of information. Status changes can be made at any time.

_____ GENERAL: I authorize access by telephone,
Initial visitors, deliveries, and clergy.

_____ SECURED: I do not authorize access
Initial by telephone, visitors, deliveries, and clergy.

I have read and understand the above information.

Patient Signature _____ Date _____

Or /by _____ Relationship to Patient _____

Patient unable to sign due to _____ Employee Initials _____

ADMISSION CONSENT FORM

Form A-45 Revised 3/11/14

Social History

- Do you currently smoke cigarettes? Yes No If yes, number per day _____
- Have you ever smoked? Yes No If yes, number of years _____
- Current occupation and employer: _____
 Part time Full time
- Highest level of education: _____
- Are you: Single Married Divorced Widowed
- Do you drink alcohol? Yes No
If yes, number of drinks per week _____
- How many days in the past year have you had heavy drinking consumption? (4+ drinks) _____
- Do you use street drugs? Yes No
- Are you currently sexually active? Yes No
- Have you ever been sexually active? Yes No
If yes please circle: Men Women Both
- Do you use protection with intercourse? Yes No
- Number of sexual partners in the past year _____ Number of sexual partners in lifetime _____
- Do you use your seatbelt? Yes No
- Any personal history of abuse? (please circle) Yes No
physical mental sexual
- Do you feel safe in your home? Yes No
- Do you have guns present in your home? Yes No
- Do you drink caffeine? Yes No If so, how much? _____
- Is your exercise level: none occasional moderate heavy
- Is your general stress level: low medium high
- Do you follow a special diet? Yes No
If so, please explain _____
- In the event of an emergency, do you accept a blood transfusion? Yes No
- Are you adopted? Yes No

Surgical History

Please list all surgeries and hospitalizations (other than c-sections previously listed):

Date	Surgery/Reason for Hospitalization	Doctor	Hospital	Problems/Complications

- Do you have any implants, such as artificial heart valves or hip prosthesis? Yes No
- Have you ever been told to use antibiotics prior to surgery because of a heart condition? Yes No

Symptoms/Conditions

Please check what symptoms you currently have or have had in the past year.

General

- Fatigue
- Recurrent fever
- Weight Gain _____ pounds
- Weight Loss _____ pounds

Skin

- Changes in moles
- Rashes

Ear, Nose, Mouth, and Throat

- Hearing loss
- Earache
- Sinus problems
- Recurrent sore throat
- Snoring
- Dry mouth
- Mouth ulcer

Respiratory

- Shortness of breath
- Persistent Cough
- Sputum
- Wheezing

Cardiovascular

- Chest pain
- Irregular heartbeat
- High blood pressure

Gastrointestinal

- Heartburn
- Difficulty swallowing
- Nausea
- Vomiting
- Abdominal pain
- Bowel changes
- Diarrhea
- Constipation
- Rectal bleeding

Genito-Urinary

- Blood in the urine
- Abnormal bleeding
- Flank pain
- Trouble urinating
- Lack of bladder control
- Rash
- Lesion
- Vaginal discharge
- Vaginal odor
- Vaginal itching/irritation

Endocrine

- Irritability
- Tension
- Anxiety
- Depression
- Breast pain/tenderness
- Bloating
- Overwhelmed feeling
- Hot flashes
- Night sweats
- Vaginal dryness
- Impaired memory
- Impaired concentration
- Decreased libido
- Orgasmic dysfunction
- Pain with intercourse

Muscoskeletal

- Muscle aches
- Muscle weakness
- Joint pain
- Back pain

Neurological

- Headaches
- Dizziness
- Loss of consciousness
- Weakness
- Numbness
- Seizures

Psychological

- Depression
- Alcoholism
- Sleep disturbances

Lymphatic

- Swollen glands
- Bruise easily

Immunologic

- Runny nose
- Itching
- Hives
- Frequent sneezing

NONE

Signature: _____

Date: _____

Interpreter Signature: _____ Date: _____

This page is for pregnant patients only

Genetics Screening

This includes the patient, baby's father, and anyone in either family.

- | | | |
|--|------------------------------|-----------------------------|
| Patient age 35 or older | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thalassemia (Italian, Greek, Mediterranean, or Asian background) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neural tube defect (meningomyelocele, spina bifida, or anencephaly) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Congenital heart defect | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Down Syndrome | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tay-Sachs (eg: Jewish, Cajun, French Canadian) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Canavan disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sickle Cell Disease or trait (African) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hemophilia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Muscular Dystrophy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cystic Fibrosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Huntington's Chorea | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mental Retardation/Autism | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| if yes, was person tested for Fragile X? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other inherited genetic or chromosomal disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Maternal Metabolic Disorder (eg, Type 1 Diabetes, PKU) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Patient or baby's father had a child with birth defects not listed above | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Spontaneous miscarriage or stillbirth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you used medication/street drugs/alcohol since last period? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| if yes, please list _____ | | |
| Any other genetic histories | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| if yes, please list _____ | | |

Infection History:

This includes only the patient

- | | | |
|---|------------------------------|-----------------------------|
| Do you live with someone with TB or have you been exposed to TB? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you or your partner have a history of genital herpes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had a rash or viral illness since your last menstrual period? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a history of sexually transmitted diseases? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any reason to believe you are at high risk for HIV? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any reason to believe you are at high risk for Hepatitis B? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you been immunized against Hepatitis B? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a history of Pelvic Inflammatory Disease (PID)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a history of infections of your tubes or ovaries? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have you had any problems with this pregnancy (bleeding, cramping, headaches, visual problems, vaginal discharge, etc)?
